NURSING PRACTICE EXPECTATIONS OF CARE:

(91soc)

STANDARD 1:
Assessment and Diagnosis - The nurse collects relevant health data and analyzes the data to determine diagnoses.

Assessment:

1. Provide initial screening and vital sign assessment upon presentation at triage, arrival by ambulance or other route per Emergency Department guidelines

2. Conduct assessment upon assuming care of patient as primary nurse. Assessment to include:
   A. Complaint-based review of systems
   B. Complete set of vitals per OHSU Emergency Department Vital Sign Policy
   C. Cardiopulmonary and neurological stability
   D. Contributing or complicating Psych/Social issues
   E. Special considerations (i.e., isolation, safety risks, immune compromise)

3. Reassess relevant variances, risks and problems per individual complaint-based standards and upon assuming care of patient through assignment or shift change. Re-assessment includes:
   A. Vital signs. Refer to OHSU Emergency Department Vital Sign Policy for timing/frequency of vital signs.
   B. Patient response to treatment
   C. Chart by exception in addition to a neuro, respiratory, cardiac assessment
   D. On-going safety needs
   E. Re-evaluation of on-going treatment plan
   F. See specific emergency department standards for complaint-based assessments such as cardiac, abdominal pain, respiratory, etc.

4. Assess and adapt individual patient needs on an ongoing bases. These include cultural, spiritual, age-related, language, and physical/mental impairment or disabilities.

5. Assess for changes in patient condition indicating complex care needs and initiate needed referrals: (*) indicated physician order required) (see attachment #4 Acute Care Adult, Referral Criteria for other Disciplines)
   A. Physical Therapy*
   B. Occupational Therapy*
   C. Speech Therapy*
   D. Respiratory Care*
   E. Comfort Care*
   F. Pain Service*
   G. Chaplain
   H. Diabetes education
   I. Enterostomal Therapy
   J. Nutrition
   K. Social Work
   L. Interpreter
   M. IV therapy
   N. Case Management
   O. Patient Advocate
   P. Poison Center
   Q. Child Life

Labs/Diagnostics:

Note: All laboratory specimens will be handled and labeled in compliance with the Clinical Policy Manual: Specimen Labeling. Clin 01.30

1. Facilitate collection of specimens and completion of diagnostics.

2. Assure appropriate labeling of specimens.
3. Draw urgent labs within 30 minutes of order. Monitor lab results every 2 hours. Notify LIP for variances/all critical values.

4. Transport unstable patients to diagnostic testing (includes patients needing continuous monitoring, intubated, hemodynamically unstable).
   
   A. Include the following equipment on all transports requiring monitoring outside the Emergency Department:
      a. Resuscitation bag with face mask.
      b. Cardiac monitor (defibrillator if indicated) with continuous ECG monitoring.
      c. ACLS medication box (located in Resus 3 pyxis).
      d. Any additional monitoring equipment based on patient need. e. In addition to an RN or Tech, a Respiratory Therapist will accompany intubated patients. ED staff transporting monitored or unstable patients must be ACLS certified.

   B. Transport Documentation:
      a. Transport departure and return times. b. Patient's response to interventions during transport and procedures/tests. c. Vital signs per department standards and as patient's condition requires.

5. Obtain urine specimen for complaints of abdominal pain. Document urine HCG on female patients between the ages of 12 and 50 with presenting complaints of abdominal pain, vaginal bleeding, dizziness, and syncope or per LIP order. All pediatric patients will have a culture added to the urinary analysis.

6. Record Peak flow on patients with asthma history presenting with asthma-related complaints as patient tolerates.

7. Record peak flows before and after treatment on patients receiving medication by meter dose inhalers or nebulizers as patient tolerates.

8. Obtain CBG on patients presenting with signs/symptoms of hypo/hyperglycemia, altered mental status, seizure, sepsis, and per LIP order.

Admissions:

1. All patients being admitted will have a name band and allergy band placed in sight on an extremity.

2. A belongings checklist will be completed on all admissions (inpatient and ED observation) in EPIC, Patient to sign printed copy. One copy will remain in the department.

3. Patients’ experiencing admission delays of 4 hours or more, will have holding orders placed in EPIC by MD; a care plan and data base [except for Review of Systems (ROS)] will be completed by RN prior to the 4th hour of the bed request placement. The ROS will be completed by the RN if the patient remains in the department 23 hours post bed request.

STANDARD 2:

Outcome Identification - The nurse identifies individualized expected outcomes for the patient. Expected Outcomes:

1. Pain management plan is effective in maintaining pain <4 on 0-10 scale or level acceptable to patient.

2. Patient/family members state understanding of discharge instructions. Patient demonstrates ability to care for self, demonstrates appropriate use of assist devices, or patient/family states knowledge/plan for discharge to other care facility. If patient unable to care for self, document plan for patient discharge (i.e., with family member to provide care, to care facility, etc) and that patient/family has been provided information in writing on follow-up care.

3. Patients and families are invited to return to the ED with any unexpected change in patient status or concern.

4. Safety is maintained during the course of emergency care, without evidence of hospital- associated injury.

5. Patient/family verbalizes an understanding of role of hand washing in the prevention of infection.

STANDARD 3:

Develop and Implement Plan of Care - The nurse develops and implements a plan of care to assist the patient in achieving expected outcomes.

Procedures/Treatments:

1. Patients will be placed in gown for initial evaluation. Patients placed in the interview/psych rooms will be placed in paper scrubs.
Adults with isolated distal extremity injuries or isolated facial/dental complaints may remain clothed until written as order by LIP.

For patients connected to and using infusion pumps, machines, or other medical or monitoring equipment, initiated prior to arrival at hospital, take the following steps (i.e., home vents, C-PAP, Baclofen pumps, etc.):

A. Obtain LIP order for same or different therapy

B. Presence of any home medical equipment or pumps.
   - For BIPAP, CPAP, or ventilator: notify Respiratory Therapy. See In-Hospital Use of Patient’s Home BIPAP, CPAP and Ventilator Equipment (Clin 09.02.02) for complete policy and document equipment on Patient Belongings Disposition Form.
   - For use of approved personal infusion devices see: Use of Personal Insulin Pumps. Clin 05.35 and Remodulin (Tresprostinil sodium) on Patient’s Personal Infusion Pump. Clin 05.36
   - For other equipment see: Medical Equipment Management Program (ASM 10.04.01)

2. Ensure ongoing communication with patient/family regarding lab and medical testing, and other anticipated waits.

3. Continually facilitate communication between patient/family and healthcare team.

Nutrition/IVs:

1. For diabetic patients that are not NPO, care that exceeds five hours, or other special circumstances, obtain LIP order for dietary considerations.

2. Initiate saline lock on unstable patients, triage level 1 or 2. Obtain orders for fluid administration.

3. Verify patency of pre-hospital IV prior to use. Blood cultures may not be drawn on pre-hospital IV starts without LIP order.

4. Closely monitor IV infusion pump for rate and volume to be infused.

5. Document IV start, gauge and site on nursing documentation form.

Medications:

1. Limited medications may be administered at triage following the Nurse initiated Order sets.

2. Medications will be checked off in the MAR in EPIC

3. Identify patients per Patient Identification Medication Administration Process Policy.

4. Team Pause will be documented prior to invasive procedures per hospital policy.

5. Check allergies prior to administration of medication.

6. Inform patients of medications administered and possible side effects to be aware of.

7. Observe patient taking medication. Narcotics taken out over the prescribed amount, or not given are to be wasted with a witness within 15 minutes of sign out.

8. Notify LIP if pain management plan is ineffective (>3) or pain level is unacceptable to the patient.

9. Initiate Tetanus/diphtheria booster (Td 0.5 ml IM) with a history of initial vaccine and documented booster status >10 years for lacerations, scrapes, and abrasions. Obtain LIP order prior to patient discharge.

10. Run all sedative, analgesia, vasoactive, inotropic and antiarrhythmic drips via an infusion pump using the Alaris guardrail library.

11. Do not give bolus doses of medication into lines with an antiarrhythmic, vasoactive or blood product infusing.

12. Prior to infusing drugs together in the same IV line use an infusion compatibility chart to verify compatibility.

13. Label all infusions with the name of the medication, amount of medication, date and time using Medication Labels. If infusing on pump, also label line on the Alaris pump using the guardrail library.

Activity/Safety:

1. Verify/ensure ID bands on all patients.
2. Maintain patient safety on admission and with changes in patient condition (i.e., seizure precautions, fall risks, use of ambulatory assist devices).

3. Beds rest in low position, wheels locked and side rails in appropriate position for the patient's condition and needs.

4. Elevate HOB for comfort and as patient tolerates.

5. Turn immobile patients at least every two hours and assess skin status.


7. Provide Isolation per patient condition in accordance to ED specific standards and OHSU infectious control policy.

8. If necessary initiate the safety policy and procedures regarding Restraint for Medical Surgical Intervention and Interruption of Care and Treatment. Initiate Behavioral Restraint and Seclusion policy as patient condition and LIP order mandates.

9. Maintain emergency equipment at bedsides as follows:
   A. Triage area
      a. Refer to Triage Manual and Standards of Care
   B. Resuscitation Rooms
      a. Refer to Trauma Manual and Standards of Care
   C. Acute Rooms (excludes Interview 20, 21 and 22)
      a. BVM (infant, child and adult)
      b. Oxygen flowmeter
      c. Suction canister, tubing and Yankauer
      d. Cardiac monitor (includes leads, BP cuff sized appropriately, pulse oximetry)

STANDARD 4:

Evaluation - The nurse evaluates the patient's progress toward attaining expected outcomes and revises the plan of care accordingly.

Teaching/Discharge Planning:

1. Review pain rating scale, pain control options, patient pain goal, changes from patient usual routine, and role in treatment/recovery.

2. Prepare family for discharge or admission as appropriate.

3. Review/reinforce teaching about overall plan of care, treatment goals, changes from patient usual routine, and role in treatment/recovery.

4. Provide information about medications: purpose of medication, when and how to take it, significant side effects and precautions. Check discharge prescriptions against LIP orders before giving to patient.

5. Review warning signs and what to do if they occur.

6. Provide information on any activity restrictions, including activity restrictions due to medications.

7. Document teaching provided or barriers to learning in the teaching section of EPIC. All patients will receive written discharge instructions. Note exceptions, (i.e. interpreter services via phone).

8. Anticipate discharge planning and refer to Case Manager or Social Work for continuing care, home health needs or psych/social needs upon discharge.

Bibliography:


2. Oregon State Board of Nursing, Position Statement for Pain Management 2004


Related Forms:

1. Health System Intranet Nursing Policy and Procedure Manual
2. BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK (NU4729)
3. Interventions for Patients at Risk for Falls
4. Acute Care Adult: Referral Criteria for Other Disciplines
5. OHSU Doernbecher Pediatric Acute Care Referral Criteria for Other Disciplines
6. OHSU Emergency Department Triage Manual
7. OHSU Emergency Department Vital Sign Management
8. OSHU ED Oral Rehydration Protocol
9. Pain Management (Adult & Pediatric pain scales included)
10. Correct Site Universal Protocol
11. OHSU ED Specific treatment guidelines, (abd pain, soft tissue injury, etc.)
12. Medical Equipment Management Program, OHSU (adm 10.04.01)
13. OHSU ED Triage Treatment Guidelines.
14. OHSU Nursing policy and procedure Intravenous: Blood Culture (HC-PCS:IVC-P006)
15. Patient Identification Medication Administration Process Policy, OHSU (HC-PCS-PAC-P024)
16. Controlled Substances: handling process
17. Restraint And Seclusion, Use Of
18. Restraint for Medical Surgical Intervention and Interruption of Care and Treatment, Initiate Behavioral Restraint and Seclusion policy, OHSU

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