NURSING PRACTICE EXPECTATIONS OF CARE:

(90soc)

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

Assessment and Documentation:

1. Conduct initial assessment including vital signs upon admission of patient and with shift change.
   
   A. Routine assessments not otherwise specified will occur every 4 hours. Intervals between assessments (i.e., every 4 hours, every hour).
   
   B. Vital signs not otherwise specified will be documented a minimum of every 4 hours following ED Standards of Care Vital Sign, or more frequently as patient condition dictates.

2. Admission assessment to include vital signs and a complete hospital standard biopsychosocial nursing assessment.

3. Page one of the Admission Data Base will be completed within four hours of patient admission. Document obstacles to completion. Complete page two of the Admission Data Base within 24 hours of admission.

4. Reassess variances, risks and problems per individual complaint-based guidelines and LIP orders, and upon assuming care of patient through assignment or shift change.

5. Assess individual patient needs including cultural, spiritual, age related, language, and physical/mental impairment or disabilities, and intervene as needed.

6. Assess for changes in patient condition indicating complex care needs and initiate needed referrals:
   
   (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

* indicated physician order required

Cardiac Monitoring/Continuous Pulse Oximetry Monitoring:

1. Provide continuous ECG monitoring for all cardiac/chest pain/syncpe patients unless otherwise ordered. May initiate cardiac or pulse oximetry monitoring without LIP order. Monitoring ordered by an LIP will not be discontinued without an LIP order.

2. Monitor ST elevation/ST analysis as ordered.

3. All alarms will be turned on at admission. Limits will be modified according to patient condition and LIP orders.
A. Verify appropriateness of alarm limits at shift change/assignment change and adjust according to patient condition.

4. Replace electrodes as needed for increased artifact, loose or poor contact, skin redness or erythema and as needed for cleanliness.

5. Print and mount 6 second rhythm strip every shift, with rhythm changes, or as ordered.

6. Notify LIP and obtain 12-lead ECG with rhythm changes or onset of chest pain/angina equivalent.

7. Enter patients name and medical record number into Acuity Monitoring System within 30 minutes of initiating cardiac or pulse oximetry monitoring.

8. Assess skin and rotate continuous pulse oximetry sites every 4 hours to prevent skin breakdown and burns.

Vital Signs:

1. Refer to OHSU Emergency Department Policy and Procedure Vital Signs, and Emergency Department Standards of Nursing Care – Vital Signs.

Labs/Diagnostics:

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

1. Assure appropriate labeling of specimens.

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

3. An RN will accompany patients that become unstable and require diagnostic testing outside of the observation unit.
   A. Include the following equipment with transports on all patients requiring continuous monitoring:
      a. Resuscitation bag with face mask
      b. Cardiac monitor (defibrillator if indicated) with continuous ECG monitoring
      c. ACLS drug box
      d. Any additional monitoring equipment based on patient need

   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

4. Obtain one urine specimen for dipstick on trauma patients if not completed in department.

5. Record Peak flow on patients per Asthma Standards of Care.

6. Obtain CBG on patients presenting with signs/symptoms of hypo/hyperglycemia, altered mental status, sepsis, seizure, and per physician order. Document all CBG’s on Diabetic Record.

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; sedation level <2.

2. Patient/family members state understanding of discharge instructions. Patient/family demonstrates ability to care for self, ambulate or carry (child) from department, demonstrates appropriate use of assist devices, or patient/family states knowledge/plan for discharge to other care facility. Patient/family has been provided information in writing on follow up care.

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

4. 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. 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, (home vents, C-PAP, Baclofen pumps, etc.).
   A. Obtain LIP order for same or different therapy.
   B. Change to an OHSU issued pump/equipment per OHSU Medical Equipment Management Program. (adm. 10.04.01)
   C. Change to OHSU issued pump/equipment and/or Clinical Engineering approval as applicable.
   D. Patients with own/home Bi-PAP, C-PAP or ventilators notify Respiratory Therapy and Clinical Engineering.
2. Ensure ongoing communication with patient/family regarding lab and medical testing, and other anticipated waits.
3. Provide for assistance in meeting activities of daily living.
4. Assist with bathing as appropriate. Include daily personal hygiene.
   NOTE: Do not place patient in shower while connected to electrical or battery powered equipment or pumps.
5. Wound care for trauma patients: soap and water cleaning, followed by topical antibiotic ointment once a shift.
6. Measure and record input and output (I&O’s) every eight hours for all pediatric patients, and as ordered for adults.
7. Prepare patient for ordered tests and procedures (in accordance with patient learning ability) including:
   A. Orient patient to expected procedure or treatment.
   B. Provide instructions on any responsibilities patient will assume.
   C. Assess ability to participate, emotional response and coping; mutually plan to meet patient needs prior to procedures/treatments.

Nutrition/IVs:

1. Verify patency of IV prior to use. Blood cultures may not be drawn on pre-hospital IV starts without physician order.
2. Closely monitor IV infusion pump for rate and volume to be infused.
3. Use an infusion compatibility chart to check for compatibility prior to infusing drugs together.
4. Label all infusions with the name of the medication, amount, date and time using Medication Labels.
5. Document IV site, gauge and site assessment on nursing graphics form every 12 hours.
6. Provide nutritional interventions/meals per patient condition. Consider individual needs and preferences, age appropriateness, and LIP diet specific order.

Medications:

1. Identify patient per Patient Identification Medication Administration Process Policy
2. Check allergies prior to administration of medication.
3. Medication will be documented on the MAR’s.
4. Team Pause will be documented prior invasive procedures per hospital policy.
5. Inform patients of medications administered and possible side effects to be aware of.
6. 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.
7. Notify LIP if pain management plan is ineffective (<4) or pain level is unacceptable to the patient.
8. Parents may administer prescribed oral medication to children during direct supervision of an RN or LIP.
9. Do not give bolus doses of medication into lines with a blood product infusing.

Activity/Safety:

1. Turn/re-position every two hours (q 2 H) or independent in repositioning self.
2. Maintain patient safety on admission and with changes in patient condition (i.e. seizure precautions, fall risks, use of ambulatory assist devices).
   A. Insure that necessary measures will be taken to prevent injury. Eliminate unnecessary clutter.
   B. Orient patient to environment; keep upper side rails in up position.
   C. Keep bed in low position with wheels locked and call bell and personal items within reach.
   D. Assure correct identification band is on patient.

3. Maintain emergency equipment at bedsides at all times as follows:
   A. BVM (infant, child and adult)
   B. Oxygen flowmeter
   C. Suction canister, tubing and Yankauer

STANDARD 4:
Evaluation - The nurse evaluates the patient's progress toward attaining expected outcomes and revises the plan of care accordingly.

Plan of Care
1. Close Plan of Care on discharge.

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 nursing notes or on discharge papers. All patients will receive written discharge instructions. Note exceptions (i.e. interpreter services via phone)

Bibliography:

Related Forms:
1. Guidelines For Involving the Diabetes Clinical Nurse Specialist (CNS) in Diabetes Education
Supersedes:
January 2006 (No changes)

Reviewed:
36 Months

Author:
Denise Langley RN, BSN, CEN, Nursing Practice Education Coordinator, Emergency Department

Review Committee:
Reviewed By:
- Emergency Department UBNPC CQI/Education Council
- Barbara Hughes RN, ED Manager
- Karen Ellmers, CNS ED Division
- Jeff Disney MD
- Denise Langley RN, BSN, CEN, Nursing Practice Education Coordinator, Emergency Department (No Changes), April 2008

Revised By:
- Suzanne Hurford MS, RN, CWOCN, CNS, Wound & Ostomy Department January 2006 (Braden Scale - Skin & Pressure Ulcer form Update)
- Mary Stock MN CNS, Nurse Mgr 9C Neurology, (Heinrich Tool for Fall Risk updates), December 2005
- Margie Harvey, RN, MSN, Quality Management (Pain Scale update), March 2008

Approved By:
- ED UBNPC
- Acute Care Specialties Cluster Council
- Nursing Practice Council, June 22, 2005

Approved By:
Practice Council

Document History:
Updated:
- June 24, 2010