Title: Standards of Patient Care		
Document #: 5107	**Issuing Authority:**	
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PURPOSE:
The purpose of the Standards of Patient Care is to incorporate evidence based practice and define excellence in nursing care at the Brant Community Healthcare System (BCHS). Each Nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships. All Nurses must continue to use clinical judgment, knowledge and critical thinking to ensure patient needs are met and optimal care is provided (CNO, 2014).

These Standards of Patient Care are required of Personal Support Workers (PSW) according to the PSW scope of practice as defined by BCHS (see Appendix A: Personal Support Worker: Expectations and Limitations).

This policy applies to all inpatients, surgical outpatients, emergency department, and urgent care patients within the BCHS.

POLICY STATEMENT:
The Standards of Patient Care define the minimum expectations that all patients at the BCHS can expect to receive from nursing staff. In addition to the corporate service standards outlined in this policy, each clinical area has additional Standards specific to the needs of the patients in these areas. Nurses will provide the Standard of Patient Care reflective of BCHS values to every patient, every shift. Documentation and communication is required if nursing staff are unable to meet any aspect of the standards of care.

DEFINITION (S):

Nurse – A Registered Nurse (RN) or Registered Practical Nurse (RPN)
Shift – A health care professional's scheduled hours of work on a unit

PROCEDURE:
1. Nurses practice in accordance with the College of Nurses of Ontario (CNO) Standards of Practice, and the policies and procedures of the BCHS. These include, but are not limited to scope of practice, medication, consent, confidentiality, documentation, ethics and professional standards.
    - Nurses must practice within one's competencies related to knowledge, skill, and judgement to deliver care to assigned patients.
    - Nurses are accountable for their own actions.
    - Nurses will seek guidance where appropriate and will work in collaboration with other health care providers to deliver optimal care to patients

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2. Patient and family involvement is supported and encouraged for the development of a comprehensive care plan and discharge arrangements throughout the hospital experience. The patient defines family and family includes any person identified by the patient (or substitute decision maker) as important in their life. Nurses optimize communication with the patient and family by providing on-going support as appropriate during the hospital stay.

3. Every Nurse is responsible to ensure information is exchanged at every point of transfer of care. This includes patient transfers within BCHS, discharge to another facility or site, shift reports, and when care is being transferred to another provider.

4. The Nurse shares accountability with pharmacy to ensure the best possible medication history (BPMH) is obtained from every patient (or substitute decision maker) as outlined in Policy – Medication Reconciliation Admission.

5. The Nurse will identify the need for infection prevention and control precautions and will practice in accordance with BCHS Infection Control Manual to reduce potential exposure to bodily fluids and the spread of infection.
    - Personal Protective Equipment (PPE) will be worn in accordance with BCHS Policy – Donning and Doffing of PPE

6. Rounding on patients occurs every hour or more frequently as the patient's condition warrants. This includes a "critical look" of the patient (airway, breathing, and circulation) and responding to any emotional/physical needs. Hourly rounding is accomplished by observing and/or interacting with the patient while assessing safety needs and interventions that are in place.

7. The Nurse will monitor the patient by completing assessments and appropriately responding to significant findings. The Nurse will document all significant findings in the health record and communicate these significant findings to the appropriate health care professional.

8. Nursing staff will follow professional and BCHS documentation standards (Policy Documentation – Interdisciplinary Documentation Overview) when recording all assessments, treatments, medications and evaluations of outcomes including the patient/family response.

9. The nurse will complete assessments of peripheral venous access device(s) (PVAD) and/or central venous access device(s) (CVAD) every hour for tenderness, discolouration, inflammation or infiltration.

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10. The Nurse will monitor intake and output at a minimum of every shift and more frequently as required by patient's condition.

11. Patient (and family or substitute decision maker) education and discharge instructions are provided according to the patient and family needs, considering readiness and capacity. Nurses will evaluate and document the effectiveness of education provided, accommodating teaching methods and adjusting the learning plan as required.

12. If patient is unable to perform activities of daily living independently, the patient will receive:
    - Assistance with oral hygiene at least every 8 hours;
    - Assistance with personal hygiene at least every 24 hours (Complex Care units will offer showers and/or bath at a minimum of once a week);
    - Assistance with meals, including but not limited to hand hygiene and set up;
    - Assistance with ambulation according to patient needs;
    - The opportunity for toileting every 2 hours;
    - Skin care and, if required, turning and repositioning, every 2 hours.

13. All patients will have vital signs assessed on admission and then according to unit specific Standards and/or Physician/Nurse Practitioner orders. Vital signs include temperature (T), heart rate (HR), respiratory rate (RR), blood pressure (BP), and oxygen saturation (SpO2).

14. All patients will be assessed for pain as part of Hourly Rounding and formally at a minimum of every shift, utilizing the appropriate pain scale. Documentation will include the assessment, intervention and outcome; refer to BCHS Policy Documentation – Interdisciplinary Documentation Overview.

15. Actual measured height and weight will be obtained on admission. If unable to obtain an actual height and weight, documentation should reflect why these values were unable to be obtained.

16. The Nurse will complete a bedside safety check (refer to BCHS Policy – Transfer of Accountability – SBAR). Bedside safety check must be in the presence of the registered staff assuming care and the registered staff transferring care and include the patient and or family members.

17. Falls assessments and documentation will be completed according to BCHS Policy – Best Practice – Falls and Fall Injuries – Preventing.

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18. Braden Scale will be completed according to BCHS Policy – Braden Scale, at time of admission for all patients with the exception of newborns and repeated as defined by the following risk score(s):
    - High Risk Score – every 24 hours;
    - Moderate Risk Score – every 72 hours;
    - At Risk – weekly.

19. The Nurse will provide skin care and pressure ulcer prevention and management according to BCHS Policy – Skin and Wound Care Prevention and Management Program. This will include, at a minimum the assessment, planning, interventions, discharge, transfer of care, and documentation.

20. The Nurse will initiate accurate and ongoing assessment of physical, psychosocial and spiritual needs of patients.

21. In addition to the preceding Standards, the BCHS recognizes the unique needs and criteria for different clinical settings. The following minimum Standards of Patient Care will be provided to all patients in the specified practice settings.

Unit Specific Standards of Care:

Emergency Department (ED) and Willett Urgent Care (UC):
The Standards for Emergency Nursing should be based on National Emergency Nurses Association's (NENA) Core Competencies as well as standardized education programs such as; Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Trauma Nursing Core Course (TNCC), Emergency Nursing Pediatric Course (ENPC), Canadian Triage and Acuity Scale (CTAS), and Geriatric Emergency Nursing Education (GENE). Emergency Department (ED) and Willett Urgent Care (UC) nurses are expected to adhere to the core competencies set out by NENA (2016).

The triage nurse will reassess patients waiting in the main waiting room based on the following 5 point Canadian Triage and Acuity Scale (CTAS) guidelines for adult and pediatric patients:

- **CTAS Level 1** – Continuous Nursing Care.
- **CTAS Level 2** – Every 15 minutes.
- **CTAS Level 3** – Every 30 minutes
- **CTAS Level 4** – Every 60 minutes
- **CTAS Level 5** – Every 120 minutes

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Assessment/Procedure	Directions
Physical Assessment	All patients will have a focused nursing assessment completed based on their presenting complaint. Once assessed by the Emergency Physician, the Nurse will perform ongoing patient assessments at a minimum of every 4 hours and more frequently as patient condition requires
Vital Signs	The triage Nurse will complete a full set of vital signs including a pain scale on every patient at triage. The Nurse will reassess patients based on the CTAS guidelines. Once assessed by the Emergency Physician, the Nurse will complete vital signs at a minimum of every 4 hours and more frequently as patient condition requires. Ongoing reassessment will be done regardless of location.
Medical Directives	All patients will be assessed to determine if they meet criteria for ED/UC medical directives.
Electrocardiograms (ECG)	A 12 and/or 15 lead ECG will be completed on all patients with suspected cardiac events and shown to an Emergency Physician immediately for further analysis.
Transfers	When an admitted patient is awaiting transfer from the Emergency Department to the inpatient unit, the Standards of Care specific to the receiving unit will be implemented by the Nurse.

Critical Care Unit (CCU):

The Standards for Critical Care Nursing in Ontario were developed to identify desirable and achievable critical care nursing competencies with the intent to standardize critical care nursing practice within the province of Ontario. The Standards for Critical Care Nursing in Ontario are based on the Standards of Nursing Practice of the College of Nurses of Ontario (CNO) and the Canadian Association of Critical Care Nurses (CACCN). Critical care nurses are expected to adhere to the current 7 standards,

including criteria set out by CACCN. Canadian Association of Critical Care Nurses (2017) Standards for Critical Care Nursing Practice 5th Edition.

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every 4 hours and more frequently as patient condition requires.
Vital Signs	Nurse will complete a full set of vital signs including a pain scale on every patient at time of admission to the unit. Nurse will complete vital signs at a minimum of every 4 hours and more frequently as patient condition requires
Transfers	When a patient is awaiting transfer from the CCU to another inpatient unit, the Standards of Care specific to the receiving unit will be implemented by the Nurse.

Medicine/Telemetry:

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every 12 hours and more frequently as patient condition requires.
Vital Signs	Nurse will complete a full set of vital signs including a pain scale on every patient at time of admission to the unit. Nurse will complete vital signs at a minimum: • Every 4 hours for the first 24 hours • Every 6 hours for the next 24 hours • Every 12 hours when stable Nurse will complete vital signs more frequently as patient condition requires.

Assessment/Procedure	Directions
Alternate Level of Care (ALC)	When an ALC has been designated for a patient, the Nurse will follow the Standards of Care for Alternate Level of Care (ALC), described in this policy.
Transfers	When a patient is awaiting transfer to another inpatient unit, the Standards of Care specific to the receiving unit will be implemented by the Nurse.

Surgical Inpatient:

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every 12 hours and more frequently as patient condition requires
Vital Signs	Nurse will complete a full set of vital signs including a pain scale on every patient at time of admission to the unit. Nurse will complete vital signs at a minimum: • Every 4 hours for the first 24 hours • Every 6 hours for the next 24 hours • Every 12 hours when stable Nurse will complete vital signs more frequently as patient condition requires.
Epidural	Nurse will monitor and provide care to patient according to BCHS Policy – Epidural & Spinal (Neuraxial) Analgesia And Anaesthesia – Top Up And/Or Continuous Infusion and Epidural Catheter Removal.
Alternate Level of Care (ALC)	When an ALC has been designated for a patient, the Nurse will follow the Standards of Care for Alternate Level of Care (ALC), described in this policy.
Transfers	When a patient is awaiting transfer to

Assessment/Procedure	Directions
	another inpatient unit, the Standards of Care specific to the receiving unit will be implemented by the Nurse.

Family Birthing Centre (FBC):
Antepartum:

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every shift and more frequently as patient condition requires.
Vital Signs	Nurse will complete a full set of vital signs including a pain scale on every patient at time of admission to the unit. Nurse will complete vital signs at a minimum of every shift and more frequently as patient condition requires.
Fetal Health Surveillance/Assessment	Fetal health will be assessed every 12 hours at a minimum and as required. Fetal health surveillance will be completed according to BCHS Policy - Fetal Health Surveillance – Family Birthing Centre.

Intrapartum:

Assessment/Procedure	Directions
Physical Assessment	Nurse will perform ongoing patient assessments at a minimum of every shift and more frequently as patient condition requires.
Vital Signs	Nurse will complete a full set of vital signs including a pain scale on every patient at time of admission to the unit. Nurse will complete vital signs (HR, RR, BP) at a minimum: • Every 4 hours in the **latent phase**;

Assessment/Procedure	Directions
	• Every 1 hour in the **active phase**; • Every 15 minutes x 4 during **recovery phase**, then every 30 minutes Nurse will obtain temperature at a minimum (or more frequently as patient condition requires): • Every 3-4 hours if membranes intact; • Every 2 hours if membranes rupture; • Every 1 hour if T greater than 37.5C
Fetal Health Surveillance/Assessment	Fetal health will be assessed every 12 hours at a minimum and as required. Fetal health surveillance will be completed according to BCHS Policy – Fetal Health Surveillance – Family Birthing Centre.
Epidural/Spinal	Nurse will monitor and provide care to patient according to BCHS Policy– Epidural & Spinal (Neuraxial) Analgesia and Anaesthesia – Top Up and/or Continuous Infusion and Epidural Catheter Removal.

Postpartum:

Assessment/Procedure	Directions
Vaginal Delivery • Vital Signs • Post-Partum Assessment	Nurse will complete a full set of vital signs and post-partum assessment in accordance with BCHS Policy Post-Partum Assessment and Routine Care: • At time of admission to the unit • At 4 hours post-partum • At 12 hours post-partum • Every 12 hours until discharge •
Caesarean Section Delivery • Vital Signs • Post-Partum Assessment	Nurse will complete a full set of vital signs and post-partum assessment in accordance with BCHS Policy Post-Partum Assessment and Routine Care: • At time of admission to the unit

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Assessment/Procedure	Directions
	• At 4 hours post-partum • Every 4 hours for 24 hours • Every 12 hours until discharge •
Epidural/Spinal	Nurse will monitor and provide care to patient according to BCHS Policy – Epidural & Spinal (Neuraxial) Analgesia and Anaesthesia – Top Up and/or Continuous Infusion and Epidural Catheter Removal.

Newborn/Combined Care

Assessment/Procedure	Directions
Physical Assessment	Apgar Scores will be completed at a minimum of one and five minutes of age. Nurse will complete a head to toe assessment within one hour of birth. Nurse will complete a head to toe assessment at time of admission to the unit. Nurse will perform ongoing assessments at a minimum of every 4 hours and more frequently as patient condition requires.
Vital Signs	Nurse will complete a full set of vital signs (T, HR, RR): • Within 30 minutes of birth • Every hour for first 4 hours of life • Every 12 hours and as required until time of discharge
Measured Actual Weights & Measurements	Birth weight, head circumference, chest circumference and length will be completed within first hour of life. Measured actual weights will be completed daily.
Security	All newborns will have an active security band placed on either ankle. All newborns will have two armbands (1 on wrist and 1 on ankle) that matches

Assessment/Procedure	Directions
	maternal armband.
Skin to Skin	Opportunity for skin to skin will be sought for all newborns immediately at birth for up to one hour (or longer at request of mother) uninterrupted.

Special Care Nursery (SCN):

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete newborn assessment: • Every 30-60 minutes until stable; • Every 3 hours when stable and more frequently as condition requires
Vital Signs	Nurse will complete a full set of vital signs (T, HR, RR, BP): • Every 30-60 minutes until stable; • Every 3 hours when stable (BP as ordered) and more frequently as condition requires
Measured Actual Weights & Measurements	Measured actual weights will be completed daily.
Intravenous (Neonate with IV infusing)	Nurse will complete assessment at a minimum of every hour. A Buretrol will be used for all patients up to the age of 12 years of age as per BCHS Policy - Intravenous Therapy – Neonatal Paediatric Nursing.
Security	All newborns will have two armbands (1 on wrist and 1 on ankle) that matches maternal armband.

Paediatrics:

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient

Assessment/Procedure	Directions
	assessments at a minimum of every 4 hours or more frequently as patient condition requires.
Vital Signs	Nurse will complete vital signs (T, HR, RR, BP) at time of admission to unit. • T, HR, RR will be completed at a minimum of every 4 hours. • BP will be completed at a minimum of every 12 hours.
Measured Actual Weights	Measured actual weights will be completed daily for patients less than 1 year of age.
Intravenous	Nurse will complete assessment at a minimum of every hour. All infusions will be run on pumps. A Buretrol will be used for all patients up to the age of 12 years of age as per BCHS Policy - Intravenous Therapy – Neonatal Paediatric Nursing.

Mental Health:

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments as patient condition requires.
Vital Signs	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments as patient condition requires.
Mental Health Act – Form 1	Nurse will complete assessment/rounding every 30 minutes or more frequently as patient condition requires.
Mental Health Act – Rights	All patients will be informed of their rights under the Mental Health Act.
Restraint Use	Restraints will be used in accordance with the BCHS Policy for Least Restraint.
Seclusion	Patients will be monitored by Closed Circuit

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Assessment/Procedure	Directions
	Television (CCTV) with face to face assessment.
High Risk Patients	High Risk patients will be assessed and closely monitored (at minimum every 15 minutes) up to and including Constant Observation as patient condition requires.
Mental Status Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessment every shift and more frequently as patient condition requires.

In-Patient Rehabilitation:

Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of once weekly and more frequently as patient condition requires.
Vital Signs	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of once weekly and more frequently as patient condition requires.
Functional Independence Measure (FIM)	Nursing will complete selected portions of the FIM within 1 week of admission to rehab and prior to discharge.
National Rehabilitation Reporting System (NRS) Assessment	Nurse will complete on admission and at time of discharge.
Alternate Level of Care (ALC)	When an ALC has been designated for a patient, the Nurse will follow the Standards of Care for Alternate Level of Care (ALC), described in this policy.

Complex Continuing Care, Palliative Care, Willett Transitional, and Alternate Level of Care (ALC):

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Assessment/Procedure	Directions
Physical Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every shift and more or less frequently as patient condition requires. Physical assessment may differ in palliative care, dependent on patient's condition and Palliative Performance Scale score.
Vital Signs	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every shift and more or less frequently as patient condition requires. Vital sign assessment may differ in palliative care, dependent on patient's condition and Palliative Performance Scale score.
RAI-MDS	Nurse will complete on every patient at time of admission, after 14 days of admission and every 3 months.
Transfers	When a patient is awaiting transfer to another inpatient unit, the Standards of Care specific to the receiving unit will be implemented by the Nurse.
Palliative Performance Scale (PPS) – Palliative Care	Nurse will complete the PPS assessment on every patient at time of admission to the palliative care unit. Nurse will complete the PSS assessment at a minimum of every shift.

Integrated Stroke Unit (ISU)
(Ischemic and Hemorrhagic Stroke unless otherwise indicated)

Assessment/Procedure	Directions
Assessment	Nurse will complete assessment on every patient at time of admission to the unit. Nurse will perform ongoing patient assessments at a minimum of every 12

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	hours and/or every shift as well as more frequently as patient condition requires.
Vital Signs	**Ischemic Stroke** Nurse will complete a full set of vital signs: • Every 4 hours for 48 hours then, • Every shift and prn **Hemorrhagic Stroke** Nurse will complete a full set of vital signs: • Every 2 hours for 24 hours then, • Every 4 hours for 24 hours then, • Every shift and prn
Canadian Neurological Scale (CNS)	**Ischemic Stroke** Nurse will complete a full assessment: • Every 4 hours for 48 hours then, • Every shift and prn **Hemorrhagic Stroke** Nurse will complete a full assessment: • Every 2 hours for 24 hours then, • Every 4 hours for 24 hours then, • Every shift and prn
AlphaFIM®	Completed on day 3 of acute stroke admission.
Functional Independence Measure (FIM)	Nursing will complete selected portions of the FIM within 1 week of admission to rehab and prior to discharge.
Screening Tool for Acute Neurologic Dysphagia (STAND)	Nurse will complete on hospital admission or when a patient requires food, PO fluids or PO medications as well as prn based on patient condition.

Preoperative Clinic:

Assessment/Procedure	Directions
Assessment	Nurse will complete assessment on every patient at time of admission The Nurse's focus is on validation of information and compliance to pre-procedural instructions.

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Assessment/Procedure	Directions
	The Nurse will implement pre-procedural orders.
Anaesthetic Questionnaire Review	Nurse will review questionnaire. Nurse will review patient medications.

Day Surgery:
Nursing care is appropriate to meet the patient's needs in the pre-anaesthesia phases as per the most recent edition of the Ontario Perianesthesia Nurses Association (OPANA).

Assessment/Procedure	Directions
Assessment	Nurse will complete assessment on every patient at time of admission. The Nurse's focus is on validation of information and compliance to pre-procedural instructions.
Vital Signs	Nurse will complete baseline vital signs including T, HR, BP, SpO2
Pre-Op Assessment	Nurse will complete pre-op assessment at time of admission.
Pre-Procedure Checklist	Nurse will complete pre-procedure checklist at time of admission.

Operating Room (O.R.):
Nursing care is appropriate to meet the patient's needs in the perioperative phases as per the most recent edition of the Ontario Perianesthesia Nurses Association (OPANA).

The perioperative nursing role includes those of scrub and circulating nurse. With additional education and training the perioperative RN is skilled to perform the role of Registered Nurse First Assistant (RNFA).

The scope of practice of the perioperative nurse encompasses the immediate preoperative, intraoperative, and immediate post-operative phases of the surgical experience.

Perioperative:

Assessment/Procedure	Direction
Preoperative Checklist	Nurse will complete at time of admission.

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Assessment/Procedure	Direction
Preoperative Equipment/Supplies/Instruments	Nurse will ensure availability of surgical equipment, supplies, and instruments prior to patient's admission to the O.R. Nurse will collaborate with the anaesthetic care provider to ensure all supplies and equipment is in the O.R. and functioning.
Integumentary Assessment	Nurse will complete assessment at time of admission and as required by patient's condition until discharge from O.R.
Surgical Safety Checklist	Physician will complete and document: • Prior to induction • Prior to incision • Prior to leaving the operating room
Surgical Count	Refer to BCHS Policy - Surgical Safety Checklist for roles and responsibilities.

Post Anaesthetic Care Unit (PACU):

Nursing care is appropriate to meet the patient's needs in the perianaesthesia phases as per the most recent edition of the Ontario Perianesthesia Nurses Association (OPANA).

Phase 1: Recovery

Assessment/Procedure	Directions
Airway Assessment	Nurse will complete assessment: • On admission to PACU • Continuously when unconscious (until patient can manage own airway) • Every 15 minutes when patient is fully conscious
Respiratory Assessment	Nurse will complete assessment: • On admission to PACU • Continuously when unconscious (until patient can support their own airway) • Every 5 minutes when patient is fully conscious
Cardiac Assessment – Cardiac rhythm interpretation and recognition	Nurse will complete cardiac assessment: • On admission • Every 5 minutes until conscious • Every 15 minutes when conscious
Vital Signs:	Nurse will complete assessment:

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Assessment/Procedure	Directions
• T, HR, BP, SpO2 • Level of Consciousness • Level of Sedation • Pain Score	• On admission • Every 5 minutes until conscious • Every 15 minutes when conscious • Until patient meets discharge criteria Current vital signs are assessed against the patient's pre-operative baseline
Input and Output	Nurse will complete assessment: • On admission • Every 15 minutes until discharge
Dressings and Drains	Nurse will complete assessment: • On admission • Every 15 minutes until discharge
Limb Assessment (for limb surgery): • CSM, Temperature, Pulse of operative and non-operative limb	Nurse will complete assessment: • On admission • Every 15 minutes until discharge
Modified Aldrete score	Nurse will complete assessment and documentation of a scoring system as per BCHS Policy – Discharge Criteria From All Phases of Post Anaesthesia Recovery. • On admission • Every 15 minutes until discharge
Bromage Scale/Motor Scale (for Neuraxial and Regional Anaesthesia)	Nurse will complete assessment and documentation of a scoring system as per BCHS Policy – Discharge Criteria From All Phases of Post Anaesthesia Recovery. • On admission • Every 15 minutes until discharge
Sensory Level Landmarks (for Neuraxial and Regional Anaesthesia)	Nurse will complete assessment and documentation of a scoring system as per BCHS Policy – Discharge Criteria From All Phases of Post Anaesthesia Recovery. • On admission • Every 15 minutes until discharge

Phase 2: Recovery

Assessment/Procedure	Directions
Respiratory Assessment	Nurse will complete assessment: • On admission

Assessment/Procedure	Directions
	• Every 30 minutes until discharge
Vital Signs: • T, HR, BP, SpO2 • Level of Consciousness • Level of Sedation • Pain Score	Nurse will complete assessment: • On admission • Every 30 minutes until discharge Current vital signs are assessed against the patient's pre-operative baseline
Dressing and Drains	Nurse will complete assessment: • On admission • Every 30 minutes until discharge
Limb Assessment (for limb surgery): • CSM, Temperature, Pulse of operative and non-operative limb	Nurse will complete assessment: • On admission • Every 30 minutes until discharge
Bromage Scale/Motor Scale (for Neuraxial and Regional Anaesthesia)	Nurse will complete assessment and documentation of a scoring system as per BCHS Policy – Discharge Criteria From All Phases of Post Anaesthesia Recovery. • On admission • Every 30 minutes until discharge
Sensory Level Landmarks (for Neuraxial and Regional Anaesthesia)	Nurse will complete assessment and documentation of a scoring system as per BCHS Policy – Discharge Criteria From All Phases of Post Anaesthesia Recovery. • On admission • Every 30 minutes until discharge

Ambulatory Care/Endoscopy

Pre Procedure:
Nursing care is appropriate to meet the patient's needs in the pre anaesthesia phase as per the most recently published edition of Ontario Standards of Perianesthesia Nursing Association (OPANA)

Assessment/Procedure	Directions
Assessment	Nurse will complete assessment on every patient at time of admission. The Nurse's focus is on validation of information and compliance to pre procedural instructions. The Nurse will implement pre-procedural orders.

Vital Signs: • T, HR, BP, SpO2	The Nurse will complete a baseline assessment on every patient at time of admission.
Pre Procedure Checklist	Nurse will complete the pre procedure checklist at time of admission.

Intra Procedure:

Assessment/Procedure	Directions
Airway Assessment	Nurse will monitor continuously.
Level of Pain	Nurse will complete assessment: • Every 5 minutes
Level of Consciousness	Nurse will complete assessment: • Every 5 minutes.
Vital Signs: • T, HR, BP, SpO2	Nurse will complete assessment: • Every 5 minutes

Post Procedure:

Nursing care is appropriate to meet the patient's needs in the post anaesthesia phase as per the most recently published edition of the Ontario Perianesthesia Nurses Association (OPANA) Standards.

Assessment/Procedure	Directions
Physical Assessment	Nurse performs ongoing assessment of patient's return to pre-anaesthesia status without regression to their status in previous phases.
Airway Assessment	Nurse will complete assessment: • On admission to the Recovery area • Continuously when the patient is unconscious (until patient can manage own airway) • Every 15 minutes. When patient is fully conscious
Vital Signs	Nurse will complete assessment: • On admission • Every 15 minutes • Every 30 minutes until discharge
Transfer/Discharge	Nurse will complete assessment and documentation of a scoring system as per BCHS Policy – Discharge Criteria From All

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	Phases of Post Anaesthesia Recovery.
Discharge Instructions	Nurse will provide instructions and health teaching at time of discharge

Oncology/Infusion Services

Assessment/Procedure	Directions
Assessment	Nurse will complete assessment on every patient at time of admission. The Nurse's focus is on validation and clarification of information: • Edmonton Symptom Assessment System (ESAS) • Toxicity Scale
Vital Signs • T, P, BP, RR, SpO2	The Nurse will complete a baseline assessment on every patient at time of admission.
Chemotherapy Administration Record	Nurse will complete the chemotherapy Administration Record at time of admission and as required.

RELATED PRACTICES AND / OR LEGISLATIONS:
BCHS Policy - Documentation
BCHS Policy - Medication Reconciliation
BCHS Policy – Documentation Interdisciplinary Documentation Overview
BCHS Policy – Transfer of Accountability – SBAR
BCHS Policy – Best Practice – Falls and Fall Injuries Preventing
BCHS Policy – Braden Scale
BCHS Policy – Skin and Wound Care Prevention and Management Program
BCHS Policy – Epidural & Spinal (Neuraxial) Analgesia and Anaesthesia – Top Up and/or Continuous Infusion and Epidural Catheter Removal
BCHS Policy – Fetal Health Surveillance
BCHS Policy – Post-Partum Assessment and Routine Care
BCHS Policy – Intravenous Therapy – Neonatal Paediatric Nursing
BCHS Policy – Least Restraint
BCHS Policy – Discharge Criteria from All Phases of Post Anaesthesia Recovery
BCHS Policy – Donning and Doffing of PPE
BCHS Policy – Surgical Safety Checklist

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Appendix A: Personal Support Worker: Expectations and Limitations

Expectations of the PSW at BCHS	Limitations for the PSW at BCHS
Responsible and accountable for the provision of patient care to a specific group of patients under the direction from the interdisciplinary team and in accordance with the policies and procedures of BCHS. Such duties include: • Assist with tray set-up and feeding of patients as directed by the nurses; opening packages, making patient comfortable, feeding when necessary and documenting food consumption. • Assist with ambulation toileting, and bathing, obtaining weights, bowel monitoring and personal hygiene functions (e.g. oral care under the direction of the team). • Provide physical assistance to patients as required by assisting with lifts and transfers, as directed by an interdisciplinary team. • Monitor and document patient intake and output. • Performs various patient care duties and related non-professional activities necessary in meeting patient's personal needs and comfort, and documenting as required. • Perform urine and stool specimen collection and labeling of these specimens (from clean catch specimens only). • Empty, measure, report and document ostomy and Foley catheter drainage bags and dispose of contents when directed by the nurse. • Apply non-prescription topical creams or ointments for chronic skin conditions as appropriate and in collaboration with the nurse. • Report skin assessment findings to the nurse. • Assist in the provision of a safe and comfortable environment, which may involve recreational interventions while adhering to infection control practices as required. • Must report all concerns voiced by patients and/or family to appropriate members of the interdisciplinary team and clinical manager as appropriate. • Must alert team members immediately when any change or concern about the patient's condition occurs.	• Cannot connect or disconnect intravenous lines or infusion lines. • Cannot initiate or make adjustments to patient specific equipment, such as infusion pumps, oxygen administration or related equipment, chest tubes and feeding pumps. NOTE: the PSW may reapply the patient's oxygen mask or nasal cannula where the settings have been pre-set by a regulated health care professional. • Cannot apply, remove or adjust suction apparatus. • Cannot perform dressing changes. • Cannot assist in the administration of medications, even if crushed in food. • Cannot perform or document vital signs. • Cannot perform any controlled acts authorized to the regulated healthcare professional (e.g. tracheal suctioning, catheterization, bladder scanner, nasal/rectal swabs) • Cannot perform restraint interventions. The PSW can provide assistance to the regulated healthcare professional in the application of the restraint only (as per BCHS policy: Least Restraint). • Cannot empty patient drains (e.g. JP drains, chest tubes, hemovacs). ** Foley catheter drainage bags may be measure, documented, and reported, then the contents disposed of when directed or requested by the nurse.