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Any documents appearing in paper form are not controlled and should be checked against the document (titled as above) on the file server prior to use. | |  |   **Scope:**  This policy applies to Emergency Department (ED) nurses who have received appropriate theoretical preparation to care for patients across all life spans in a Huron Perth Healthcare Alliance Emergency Department. | | **Policy:**  The ED is committed to providing care based on standards identified in this policy. | | **Purpose:**  The purpose of this policy is to provide guidelines for nurses and their managers at the HPHA related to Emergency Department practice and documentation standards. It is expected that all nurses willadhere to the principles outlined in this policy. | | **Definitions**  **Abnormal vital signs:** Refers to vital signs that differ from values that are considered typical or expected for a given patient’s age, weight, gender and overall health. | |  | | **Appropriate time:** refers to the amount of time which is necessary to do what is required, as soon as circumstances permit and as close as possible to the event/intervention occurring. | | **Competency Requirements**   * All emergency nurses are accountable and responsible to identify their opportunities for learning and seek out learning opportunities. * All emergency nurses are professionally accountable to ensure they maintain competency set out by the College of Nurses of Ontario. * Nurses will recognize that emergency nursing is a specialty andwill maintain competency in:   + Basic Cardiac Life Support (BCLS)   + Advanced Cardiac Life Support (ACLS)   + Cardiac Arrhythmia & 12 Lead ECG Interpretation   + Canadian Triage and Acuity Scale (CTAS) education   + Non-Violent Crisis Intervention (NVCI) * The following courses for emergency nurses are recommended but not limited to:   + Paediatric Advanced Life Support (PALS)   + Trauma Nursing Core Course (TNCC)   + Neonatal Resuscitation Program (NRP)   + Emergency Nursing Pediatric Course (ENPC) * **Unstable patients:** refers to patients who may present or develop one or more of the following symptoms: altered mental status, loss of consciousness, shock, hypotension, respiratory distress or worsening chest pain. |   **Nursing Assessment**   * During triage, the nurse will complete **a full set of vital signs** **including a pain scale** on every patient including those arriving with EMS. * Triage and reprioritization of patients in waiting areas will be completed as per the Canadian Triage and Acuity Scale guidelines. * All emergency patients will have a focused assessment completed based on the presenting complaint and documented within an *appropriate time* after the transfer of care from triage to the primary nurse. * The focus based assessment may be deferred or postponed if it should delay the Physician’s Initial Assessment. Nursing documentation will reflect this deferral. * In the event the ED physician assesses and discharges the patient prior to a nursing assessment, the nursing documentation will reflect these events. * The ED standard is to document vital signs (including pain if applicable) as follows:   + **Stable patients at a minimum of every 2-4 hours** or more frequently (as indicated by condition and/or physician order).   + **CTAS 4s and 5s will have vital signs repeated (according to their underlying condition) and at the discretion of the nurse throughout their ED stay.**   + **Unstable patients at a minimum of Q15min and as ordered** or more frequently (as indicated by condition) for all patients with an emergent or life threatening problem.   + **Any abnormal vital sign will be rechecked prior to the patient being discharged from ED care.** * When in the department, the patient will be reassessed and/or observed based on physician orders, clinical judgment, medical directives, and patient acuity. * Pre and post vital signs will be taken and recorded with any intervention including but not limited to administration of medication with the ability to alter respiratory or hemodynamic status. * All significant changes in terms of vital signs must be reported and documented. * Triage/emergency nurses will identify patients requiring isolation and take appropriate action including the usage of appropriate signage and adherence to PPE guidelines.   **Documentation**  The following will be documented at a minimum on all ED patients on the electronic health record, ED paper chart or both:   * Infection Control Risk Screen * Violence Assessment Tool (including violence prevention strategies as appropriate) * Triage Assessment * Allergies * Best Possible Medication History (refer to [HPHA Medication-Medication Reconciliation policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=10766&lang=1)) * Secondary/Reassessment including:   + Focused assessment according to chief complaint   + Social Support * Safety Checks (including a visual check for patient at risk for falls) * Isolation requirements * Transfer of Accountability * Nursing Workload * Discharge assessment   **Documentation will also describe/reflect the following as appropriate (please refer to Special Considerations below):**   * Documentation will be chronological and completed during, or as soon as possible after, the care or event. * Will be clear, concise, relevant and legible and will follow College of Nurses of Ontario (CNO) documentation practice standards. * Duplication of information is avoided unless absolutely necessary. * When an entry is late, indicate the date and time of the actual occurrence in documentation. * Provide full signature, initials and designation on the ED paper chart. * Document both objective and subjective data including all interventions performed and related responses. * Include physician and interdisciplinary communication. * Will be written by the person who saw or performed the action with the exception of code/trauma situations where there is a designated recorder. Recorder must specify the staff member performing the intervention. * Family and caregiver communication. * As appropriate, document consent obtained from patient/SDM regarding treatment. * All medications administered including time, dose, route, nurse initials and patient response as appropriate. * Document independent double checks according to the [HPHA Medication-High Alert policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=8669&lang=1). * Do not use dangerous abbreviations, symbols and acronyms in accordance with the [HPHA Dangerous Abbreviations, Symbols and Acronyms policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1563&lang=1). * Initiation and completion of pre-written direct orders (i.e. for consults). * When cardiac monitoring has been initiated according to medical directive and/or physician orders. Nurses may refer to the [HPHA Cardiac Monitoring Guidelines policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=12520&lang=1). * Documentation should reflect a nurse’s observations and should not include unfounded conclusions, value judgments or labelling.   Refer to specific HPHA medication policies for practice standards and documentation of cytotoxic hazardous medications and controlled substances.  **Special Considerations:**  **Pediatric:**   * Patient weight in kilograms will be measured and documented in the patient’s health record. * Newborns will have a documented birth history. * Blood pressure and capillary refill will be completed as appropriate for patient age and condition.   **Obstetrical:**   * Last menstrual period will be included in the triage assessment and/or secondary assessment for all women with an obstetrical/gynecological presentation. * GTPAL (Gravida, Term, Preterm, Abortion/Miscarriage, Living children) will be recorded in the triage assessment and/or secondary assessment for all women with an obstetrical/gynecological presentation. * A fetal heart ratewill be attempted on all patients over 14 week’s gestation. * For obstetrical patients 20-24 weeks, refer to the [HPHA Obstetrical Patients Presenting to an HPHA Emergency Department Standard Work](https://intranet.hpha.ca/myalliance/Default.aspx?cid=13395&lang=1).   **Admitted Patients:**   * A Medication Reconciliation-Admission (including last taken) will be completed once it is known the patient will be admitted to hospital. See [HPHA Medication-Medication Reconciliation policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=10766&lang=1). * Nurse will complete the Transfer of Accountability assessment in Meditech in addition to providing a verbal report. * Stat or emergent orders will be completed on all admitted patients. * When antibiotic therapy is ordered, the first dose will be initiated promptly when ordered and should not be delayed more than 60 minutes from the time of order. See [HPHA Medication-Orders and Prescribing policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=8145&lang=1). * Complete all admission orders when notification is received that the patient will not receive a bed in a reasonable amount of time.   **Overflow Patients Admitted as Emergency Room Over Flow (EROF):**   * Strive to ensure continuity of care and provide the same standard of care of an admitted patient who is awaiting placement in the hospital. * Nurses will complete and document the Transfer of Accountability.   **Situations That May Preclude Electronic Documentation:**   * A patient note shall be completed in the electronic health record referring to the scanned clinical record in the following situations:   + Unstable patients where documentation would delay aggressive emergent care.   + Trauma   + Code Blue/Pink (see [HPHA Code Blue-Cardiac Arrest/Medical Emergency-Adult policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1337&lang=1) and [HPHA Code Pink-Cardiac Arrest/Medical Emergency Child/Infant polic](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1342&lang=1)y for documentation requirements)   + Code White (see [HPHA Code White-Violent Person policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1345&lang=1))   + Inter-hospital Transfers   + Meditech Downtime (see [HPHA Downtime-Clinical Meditech Documentation policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=10762&lang=1))   **Mental Health**   * Restraint application and frequency of observation will be documented. * Patients in 1-5 point restraints will be on constant care. Documentation will reflect all care provided. * The SADPERSONS screening tool will be utilized and documented on when screening adult patients for suicide risk.   **Medical Directives**   * Nurses must first refer to the “*Authorized To*” section of the medical directive to determine their eligibility to implement ED medical directives. * Nurses will ensure they have met the competency requirements outlined in each medical directive prior to being eligible to implement. * Medical directives will be initiated on any patient that meets criteria. * The following will be documented in the order section of the chart when implementing a Medical Directive:   + name and number of the directive,   + name, signature and designation of the implementer   + name of the attending physician * Drug dose, time, route and response as applicable.   **Discharge**   * Workload will be completed on all patients upon discharge. * The *ER Discharge Assessment* will be completed on all ED patients. * For patients that leave “AMA-against medical advice” the nurse will select the most appropriate AMA type from the disposition look up options.   **Practice Standards**  **All ED nurses will:**   * Ensure that all supplies and equipment necessary are available for the care and safety of the emergency patient. * Immediately remove faulty equipment from the patient care area and enter a Service Anyware ticket and affix a maintenance tag. * Treat each other with compassion and respect. * Work collaboratively with patients and visitors in a professional manner that demonstrates respect, dignity, caring and compassion for each individual. * Work collaboratively with other health care professionals. * Share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses, other nurses and other health-care providers. * Maintain confidentiality. * Arrive on time and be ready to contribute in a pleasant and courteous manner. * Offer assistance to anyone within the building or on the hospital grounds who appears distressed or in need of help.   **Related Documents**   * [HPHA Downtime-Clinical Meditech Documentation policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=10762&lang=1) * [HPHA Medication-Medication Reconciliation policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=10766&lang=1) * [HPHA Code Blue-Cardiac Arrest/Medical Emergency-Adult policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1337&lang=1) * [HPHA Code Pink-Cardiac Arrest/Medical Emergency Child/Infant polic](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1342&lang=1)y * [HPHA Code White-Violent Person policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1345&lang=1) * [HPHA Falls Prevention Program](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1583&lang=1) * [College of Nurses of Ontario Documentation practice standard](http://www.cno.org/globalassets/docs/prac/41001_documentation.pdf) * [HPHA Medication-High Alert policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=8669&lang=1) * [HPHA Dangerous Abbreviations, Symbols and Acronyms policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=1563&lang=1) * [HPHA Cardiac Monitoring Guidelines](https://intranet.hpha.ca/myalliance/Default.aspx?cid=12520&lang=1) * [HPHA Obstetrical Patients Presenting to an HPHA Emergency Department policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=13395&lang=1) * [HPHA Documentation-Interdisciplinary Documentation Standards policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=13404&lang=1) * [HPHA Medication-Orders and Prescribing policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=8145&lang=1)   **References:**   * College of Nurses of Ontario. (2008). Documentation practice standard. Retrieved from <https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf> * Thunder Bay Regional Health. (2011). Standard of Care-Emergency Department. * Canadian Association of Emergency Physicians & CTAS National Working Group. (2012). Canadian Triage and Acuity Scale Combined Adult/Pediatric Educational Program Participant’s Manual. |
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