Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. ER-IV-01
Title: Standard of Care - Emergency Department	☐ **Policy** ☐ **Procedure** ☒ **SOP**
Category: Emergency Nursing Standard **Dept/Prog/Service:** Patient Care Services Emergency/Trauma Services	**Distribution:** Emergency/Trauma Services
Approved: Executive V.P., In-Patient Care Programs **Signature:**	**Approval Date:** Oct. 2001 **Reviewed/Revised Date:** Dec. 7, 2011 Sept. 2018 **Next Review Date:** Sept. 2021

Cross reference: Oxygen Titration Policy PAT-5-139, Wound Prevention and Care-Pressure Ulcers: Prevention of # PAT-5-85, Standard – Intravenous Therapy # PAT-2-18, Admissions of Obstetrical, Well Newborn and Post Partum Patients policy PAT-1-24, Infection Control: Effective Hand Hygiene # IPC-2-12, medication administration policy PAT-3-33, medication – narcotic and controlled drugs policy PAT-3-26, , Identification of a Patient SAF-1-04, Professional Standards of Behavior # HR- tce – 08, Code of Conduct # HR-tce-10, Dress Code-Uniform ADM-2-06 and Mandatory Educational Records # SE – 01.

Medical Directives: Patients Presenting with Chest pain Suggestive of Acute Coronary Syndrome (ACS) PCS-MD-17, Urinalysis and Urine bhcg PCS-MD-45, and Fever-Emergency Department PCS-MD-71, Telemetry- Temporary Discontinuation of PCS-MD-87

Table of Contents	Page

I. PURPOSE

The objective of a standard of care for Thunder Bay Regional Health Sciences Centre (TBRHSC) Emergency Department (ED) is to have nurses deliver quality standard of care within the model of patient and family centred care (PFCC) to all patients.

The ED is committed to providing care based on standards identified in this policy. The ED will collaborate with patients and families when developing plans of care and setting patient goals. The ED will encourage feedback from patients and families to assist in ensuring safe and comprehensive PFCC. These standards will be reviewed annually and revised as required to maintain this level of care.

II. POSITION STATEMENT

- All staff in the ED will function as a team
- All emergency nurses are accountable and responsible to identify and seek out learning opportunities.
- All emergency nurses are professionally accountable to ensure they maintain competency set out by TBRHSC and the College of Nurses of Ontario.
- All nurses will adhere to the policies/procedures and guidelines of TBRHSC. The nurse will comply with best practice/evidence based practice guidelines; if no policy exists, use the reference text Clinical Nursing Skills: Basic to Advanced Skills by Smith & Duell (most current edition) for procedures without hospital policy.
- Nurses will work in a collaborative practice with the inter-professional team.
- All nurses that have identified a change in patient status will notify the emergency physician/MRP and document assessments, interventions, response and follow-up.
- All patients will be assessed and managed in a safe, efficient manner with appropriate health teaching and documentation of all care and teaching delivered.
- All nurses will treat each other with compassion and respect following TBRHSC mission and values.
- All nurses will **NOD** - provide name and occupation and then explain what she/he is there to do.
- Nurses will wear their uniform in accordance with TBRHSC policy **ADM-2-06** and must display their ID badge
- Nurses will recognize that emergency nursing is a specialty and to ensure competency in caring for the emergency patients nurses will maintain:
    - Basic Cardiac Life Support (BCLS)
- Recommended courses for emergency nurses:
    - Advanced Cardiac Life Support (ACLS)
    - Paediatric Advanced Life Support (PALS)
    - Trauma Nursing Core Course (TNCC) certification
    - Neonatal Resuscitation Program (NRP)
- Suggested additional courses such as Emergency Nursing Certification (ENC), Emergency Nursing Paediatric Course (ENPC), and Course in Advanced Trauma Nursing II (CATN II) as recognized by National Emergency Nursing Affiliation (NENA) are encouraged.

**Certification in emergency nursing, as recognized by Canadian Nursing Association (CNA), validates that a specialized body of knowledge is required for emergency nursing practice. TBRHSC emergency department strongly encourages all RNs to consider obtaining their ENC (Emergency Nurse Certification).

III. RESPONSIBLE STAFF

All emergency department nurses which includes; Nurse Practitioners Extended Class (NP); Advanced Practice Nurses (APN); Registered Nurses (RN); and Registered Practical Nurses (RPN).

IV. COMMUNICATION

- All nurses will NOD- provide name , occupation, and then explain what she/he is there to do
- When communicating with patients and family members nurses will monitor verbal, physical, and emotional cues on an ongoing basis – based on these cues nurses will demonstrate therapeutic communication strategies/skills at every opportunity during the patients ED visit
  Nurses will modify their communication strategies to suit patients and family members in special situations (ie: depressed, anxious, aggressive or angry patients or family members)All nurses will clearly communicate to patients the plan for care and when possible the timelines associated with the care they are provided in the ED

V.TRIAGE

- All patients will have presenting complaint determined **within 15 minutes** of presentation to the ED.
- All patients presenting to the ED via Emergency Medical Service (EMS) or triage will have an electronic triage record completed
- All patients will be screened for febrile respiratory illness (FRI) prior to entering the healthcare environment utilizing the infection control risk assessment tool as outlined in the TBRHSC electronic triage format.
- TBRHSC ED will use a systematic approach including first and second order modifiers as outlined by the Ontario Hospital Association (OHA) guidelines as referred to in the Canadian Triage and Acuity Scale (CTAS) Participant's Manual.
- The standard time to complete the triage process has been set as a triage goal of 3 - 5 minutes
- The triage nurse will reassess the patients in the waiting area based on triage acuity and guidelines and reprioritizes as necessary
- Reassessments will be completed using the template below as a guideline
  - Level I continuous nursing care
  - Level 2 – every 15 minutes
  - Level 3 – every 30 minutes
  - Level 4 – every 60 minutes
  - Level 5 – every 120 minutes
- Medical Directives may be initiated when appropriate and criteria present if the waiting room length of stay (LOS) extends greater than the reassessment time
- A nurse with previous ED experience will work in the department approximately 6 months prior to being assigned triage and at least 2 years with no previous ED experience
- The nurse will implement Patients Presenting with Chest pain Suggestive of Acute Coronary Syndrome (ACS) **PCS-MD-17**for patients presenting with chest pain suggestive of acute coronary syndrome
- All patients with a known or suspected infection will be screened for sepsis using the SIRS (systemic inflammatory response syndrome) criteria

VI. RESUSCITATION

All emergency nurses will be accountable for maintaining their competencies and knowledge of emergency nursing.

- Previous nursing experience will assist in determining the timeline for a resuscitation room assignment.
- Registered nurses will be given resuscitation room orientation when the nurse manager in collaboration with the emergency clinical educator determines that the RN demonstrates the necessary skills and experience to move in to this room assignment.
- ACLS, PALS and TNCC certifications are recommended within one year of working in the resuscitation area.
- It is imperative that ED nurses maintain their competency and self advocate for their learning needs.

- Nurses will read and be accountable for the information provided in the cardiac arrest response learning package.
- All ED nurses will be certified in cardiac arrest response (CAR) within 1 year of employment and are required to re-certify annually as per policy Controlled Acts and their Delegation for Health Professionals(ADM-2-02).

VII. NURSING ASSESSMENT

- Triage nurse will complete **a full set of vital signs** on every patient, including those arriving with EMS, **including a pain scale.**
- CTAS Level 1, 2, or 3 will have a head-to-toe assessment completed and documented within an appropriate time after the transfer of care from triage to the primary nurse.
- CTAS Level 4 or 5 will have a focused assessment based on the presenting complaint completed and documented within an appropriate time after the transfer of care from triage to the primary nurse.
- In the event the ED physician assesses and discharges the patient prior to nursing assessment, the nursing documentation will reflect these events.
- The patient will be reassessed and/or observed based on clinical judgment, protocols, and patient acuity.
- The ED standard is to document vital signs (including neurological scale assessments and vitals):
    - **Stable admitted patients at a minimum of every 4 hours**
    - **Unstable patients will be a minimum of every hour** or more frequently (as indicated by condition) for all patients with an emergent or life threatening problem, including drug overdose and head injury.
- Vital signs will be recorded minimally:
    a) **Q15min on unstable critical patients, prn and as ordered.**
    b) **Q1hrs on stable critical patients**
    c) **Q2hrs for all patients with an urgent problem**
    d) **Or as ordered by a physician**

Documentation will describe the following:

- Clear signature, initials and designation.
- Patient appearance.
- Significant patient issues/concerns.
- All interventions performed and related outcomes.
- All Medications administered including time, dose, route, and patient outcome.
- All prn and stat medication will be documented and underlined in red ink.
- Pre and post vital signs, with the administration of medication with the ability to alter respiratory or hemodynamic status.
- Initiation of pre-printed direct orders and medical directives.
- Reports of abnormal finding(s) to physician(s).
- Referral to specialists.
- Reasons for delays from the expected and explanations to patients and significant others.
- Patients will be assessed for pain using a recognized pain scale.

VIII. PRIMARY ASSESSMENTS (ABC's & DISABILITY)

Airway & Cervical Spine Precautions

- Assess patency and maintain cervical spine precautions as identified by mechanism of injury.
- Nurses trained in Canadian C-spine rules will assess patient for removal of c-spine precautions when criteria met.
- Emergency physicians must order and be present when a patient is log rolled off a backboard.
- Assess for possible airway obstruction.

Breathing

- Assess for spontaneous respirations by observing rate, chest movement for symmetry and adequacy.

Circulation

- Assess colour and presence of pulses for rate and quality.

Disability

- Assess level of consciousness.
- All patients with an altered level of consciousness will have the appropriate Glasgow Coma Scale completed every 15 minutes for 1 hour, every 30 minutes for 2 hours, and then hourly until otherwise ordered

IX. SECONDARY ASSESSMENT

Full set of vital signs

- All ED patients CTAS level 1 and 2 will have a full set of vitals on initial assessment by the primary care nurse

Family Presence

- The emergency nurse will facilitate family presence in support of PFCC when appropriate and ensure adequate support

History

- The emergency nurse will include objective and subjective data, presenting complaint, open and closed ended questions when obtaining the history for all emergency patients

Assessment

1. The emergency nurse will complete a focused assessment on all adult and paediatric patients using the appropriate documentation tool
2. Assessments will include inspection, palpation, and auscultation of body systems
3. The emergency nurse will complete the following assessments:

Secondary Assessment	Assessment Standard
General Appearance	• Assess body position and posture, and any unusual odour(s)
Head, Face & Neck Assessment	• Inspect for ecchymosis, edema, abrasions, lacerations, contusions, avulsions, puncture wounds, drainage and presence of foreign objects • Palpate for areas of tenderness and crepitus • Determine visual acuity, papillary response and extraocular eye movements for patients with neurological or ocular presenting complaints • Inspect for signs of trauma including periorbital or post auricular ecchymosis, auricular or nasal drainage • Presence of dental injury • Presence of jugular vein distention and position of trachea • Presence of tenderness, numbness, tingling, dysphasia, or dysphonia (hoarseness)

Respiratory and Cardiovascular Assessment	• Airway management is the primary concern. • Consult registered respiratory therapists (RRT) for any complex airway or respiratory management needs. • Nurses will have knowledge and the skill to manage patients requiring low and high flow methods of oxygen delivery. • Re-assessments after each inhalation/meter dose inhaler(s) will include auscultation, heart rate, respiratory rate, work of breathing and pulse oximetry. • Awareness/recognition of airway management is essential for resuscitation room assignment. • All patients with complaints of chest pain or those who are hemodynamically unstable will be placed on a cardiac monitor and the RN prints the initial electrical cardiogram (ECG) strip with interpretation. • An electrocardiogram (ECG) will be completed on all patients with suspected cardiac events within 15 minutes and be shown to the emergency physician as per the medical directive Patients Presenting with Chest pain Suggestive of Acute Coronary Syndrome (ACS) PCS-MD-17. • Bilateral blood pressures will be completed on all patients with cardiac events. • ECG strips will be printed with interpretation of rhythm initially and then every 4 hours or when there is a change in the patient's cardiac rhythm. • **ECG Strips will be mounted on the chart with the patients name, date and time. The rhythm will be documented with the rate, PR intervals, QRS intervals, T wave abnormalities, as well as ST segment elevation.** • Inspect rate, depth, symmetry, and adequacy of chest movement • Inspect for abrasions, lacerations, ecchymosis, edema, crepitus, puncture wounds, impaled objects, and scars • Assess presence and quality of breath sounds including presence of wheezes and crackles • Palpate chest for tenderness, numbness, crepitus and deformities • Assess heart sounds for S1 & S2 and for any abnormal heart sounds Nurses will have knowledge and the skill to manage patients requiring low and high flow methods of oxygen delivery. • Will deliver oxygen (O_2) as outlined in Oxygen Titration Policy (PAT-5-139).
Neurovascular Assessment	• The appropriate paediatric and adult Glasgow Coma Scale will be used for patients with a suspected or confirmed head injury, neurological deficit, and/or a change in level of consciousness • All patients with an altered level of consciousness will have the appropriate Glasgow Coma Scale completed **every 15 minutes for 1 hour, every 30 minutes for 2 hours, and then hourly until otherwise ordered.**
Gastrointestinal and Genitourinary Assessment	• Inspect for abrasions, lacerations, ecchymosis, edema, crepitus, puncture wounds, impaled objects, distention, pulsating masses and scars. • Auscultate for the presence or absence of bowel sounds. • Gently palpate abdomen for tenderness, rigidity, masses.

	• Assess for presence of blood at the urethral meatus and/or inability to void. • Inspect for priaprism. • Ensure physician has performed a rectal exam for male trauma patients prior to inserting foley catheter. • Please refer to **medical directive "Urinalysis and Urine bhcg PCS-MD-45**" if patient meets inclusion criteria. • Last menstrual period will be included in all women with an obstetrical / gynecological (OBS/Gyn) issue.
Integumentary Assessment	• Inspection and identification of potential or actual breaks in skin integrity will be performed and documented • Utilize Braden skin risk assessment tool when indicated. Refer to policy **Wound Prevention and Care-Pressure Ulcers: Prevention of PAT-5-85.**
Extremity Assessment	• Inspect for abrasions, lacerations, ecchymosis, edema, crepitus, puncture wounds, impaled objects, spontaneous movement and scars • Assess for pain, pulses, parasthesia, pallor, temperature, and capillary refill • Inspect splints for immobilization above and below the suspected injury, skin integrity, neurovascular status and apply/reapply splints when necessary

X. SPECIAL CONSIDERATIONS

A. Paediatric (16 and under)

- All paediatric patients will have a full set of vital signs completed on arrival to the ED (this includes temp, pulse, respiratory rate, blood pressure, and O2 sat), weight in kilograms measured and documented.
- Refer to CTAS "C = Chief Complaint, I = Immunizations or Isolation (exposure), A = Allergies, M = Medications, P = Past Medical History, E= Events surrounding Illness or Injury D = Diet or Diapers" (CIAMPEDS) or PALS for assessment processes.
- Age appropriate considerations for growth and development must be considered.
- Utilize IV infusion devices for intravenous infusion therapy and for medications. Refer to policy **Standard – Intravenous Therapy (PAT-2-18)**
- Double check on any medication calculation prior to medication administration.
- For children who present with fever, please refer to **medical directive "Fever-Emergency Department PCS-MD-71"** if patient meets inclusion criteria.
- Newborns will have a documented birth history.(ie: weeks gestation at delivery, vaginal vs c-section)

B. Obstetrical

- Last menstrual period will be included in all women with an obstetrical / gynecological (OBS/Gyn) issue.
- Para and gravida is recorded for all women with OBS/GYN issues.
- **Fetal heart rate** will be attempted on all patients **over 12 week's gestation.**
- Childbearing age is considered from the age of menarche to 50 years of age.
- If patient is greater than 20 weeks gestation with a pregnancy related issue OBS is advised and the patient transferred. The patient will remain in the ED if medically unstable or for non pregnancy issues. Please refer to policy **Admissions of Obstetrical, Well Newborn and Post Partum Patients policy (PAT-1-24)**

- Please refer to **medical directive "Urinalysis and Urine bhcg (PCS-MD-45)**" if patient meets inclusion criteria.

C. Pain

- Numeric Likhert Scale, Wong Baker FACES scale, and the Visual Analogue Scale will be used to document pain scores.
- Pain scale will be 1-10 scale.
- Pain will be measured at triage, with the primary assessment and with vital signs.
- Patients in acute pain will be assigned the next higher triage level based on utilization of CTAS and the pain modifiers.
- Pain will be reassessed after administration of analgesics and documented.

D. Medical Directives

- Will be initiated on any patient that meets criteria
- Documentation will reflect the directive used, date and time of initiation and any reassessment needed

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E. Defibrillation/ Temporary Pacing

- RNs who have been certified in CAR and meet criteria of TBRHSC Controlled Acts and their Delegation for Health Professionals policy **ADM-2-02** can defibrillate an adult or child as well as administer life saving drugs in the absence of a physician. .
- RNs who have been certified in CAR and meet criteria of TBRHSC Controlled Acts and their Delegation for Health Professionals-policy ADM-2-02 can initiate transcutaneous pacing for adult patients in the absence of a physician PAT-5-18

F. Infection Prevention and Control (IPAC)

- All nurses will comply with Infection Prevention and Control (IPAC) policies.
- All admitted patients will be asked the antibiotic resistant organism (ARO) screening questions and if applicable the necessary swabs sent.
- Isolation precautions will be adhered to by **ALL** TBRHSC staff and the necessary personal protective equipment (PPE) to be worn when the patient's condition warrants.
- All patients will be screened for febrile respiratory illnesses as outlined by the Ministry of Health and Long-term Care.
- Triage/emergency nurses will identify patients requiring isolation and take appropriate action including the usage of appropriate signage and adherence to PPE guidelines.
- All staff will use hand sanitizer or hand washing prior to walking into a patient room, prior to any procedure, after exposure to blood or body fluids and on leaving the patient room. Please refer to policy **Infection Control: Effective Hand Hygiene IPC-2-12.**

G. Admitted Patients

- **Stat or emergent orders** are completed on all admitted **patients immediately**. If **4 hours or more expires** and no in-patient bed available, the ED RN will then **complete all admission orders written** by the ERP or MRP to ensure continuity of care and patient safety.
- A best possible medication history will be completed on all emergency department patients, recognizing that the comprehensive history and med reconciliation must be completed within 48 hours of admission
- Admission infection control screening will be completed utilizing the infection control and risk assessment tool. All swabs will be obtained in the emergency department if criteria are met.
- We will strive as an ED to ensure continuity of care and provide the standard of care required for each admitted patient while the patient is in the ED awaiting placement in the hospital.

H. Documentation

- Documentation of events/actions/assessments is accurate, true and honest.
- Documentation is clear and concise.
- Value judgments or labeling are avoided by using objective data and client statements to describe behaviors.
- Writing is legible and in non-erasable ink
- **Nurse's signature must be legible and include full name and professional designation.**
- **If your signature is illegible you must also print your name.**
- Duplication of information is avoided unless absolutely necessary.
- Documentation is never deleted, altered or modified and additional comments are added in a separate entry and dated and signed.
- Mistaken entries are to be crossed out so the incorrect information is visible. It needs to be clear the information was incorrect and include the name of the person who corrected it.
- Late or forgotten entries are entered at the next available space and clearly identified as a late entry; example 1300 late entry for 0950 documentation
- Ensure that every entry identifies the caregiver and includes a full signature.
- Documentation is completed as soon after the event as possible and in a chronological fashion.
- Documentation reflects both the time of recording and the time the event occurred.
- Empty lines for someone else to document are avoided.
- Documentation is to be written by the person who saw or performed the action with the exception of code/trauma situations where there is a recorder. Recorder must specify the staff member performing the intervention
- A line is drawn from the end of the documentation to the signature when making written entries.
- Abbreviations that might have multiple meanings and cause confusion are avoided
- Flow sheets are legally recognized as part of the permanent record and must identify the caregiver
- When co-signing for blood or narcotics, the nurses are aware of what both signatures mean.
- Patient safety checks will occur with each transfer of information
- ED documentation flow sheets will be used until the patient is admitted
- **Any documentation of abnormal vital signs will be reassessed and documented every 1-2 hours or as necessary.**
- **Documentation of vital signs will be done every 2-4 hours on all patients as well as a written note regarding patient status every 1-2 hours while the patient is in the ED.**
- Documentation will be **legible and must follow College of Nurses of Ontario (CNO) documentation practice standards**

XI. CONSIDERATIONS:

****** Verbal orders are to be taken in an emergent situation only. The order must be signed by the physician. ******

- All medications administered will include time, dose, route and patient outcome per TBRHSC medication administration policy **PAT-3-33** and CNO medication practice standards.
- All narcotic discrepancies in Omnicell Med-Station will be resolved every shift. Narcotic counts in Omnicell Med-Station will be done a minimum of once per week (Sunday night).
- Narcotics received from pharmacy that are not to be administered immediately will be counted and witnessed by two nurses and locked in the lock box in the C-Area Medication room. When narcotics are present in the lock box they will be counted a minimum of twice in a 24 hour period. Narcotic keys must be kept by an RN or RPN as per medication – narcotic and controlled drugs policy **PAT-3-26**.
- Initiation of standard orders/protocols/guidelines/medical directives will be reflected in the nursing documentation.
- Allergies must be listed on the triage record and an allergy band must be applied upon triage of the patient.

- All patients with telemetry monitoring that require a diagnostic or surgical procedure can have telemetry removed if the patient has no symptomatic dysrhythmias, chest pain or shortness of breath as outlined in **medical directive "Telemetry-Temporary Discontinuation Of" PCS-MD-87**.
- Fall assessments will be completed on all patients. Wound and skin assessment will be completed if the patient is holding greater than 4 hours.

A. Discharge

- Time of discharge
- Patient condition
- Interventions prior to discharge
- **Vital signs within 2 hours of discharge or within 30 minutes for any patient with abnormal vital signs**
- Intake and Output will be summarized
- Education/follow up instructions provided will be recorded
- Accompaniment and means of discharge (walking, wheelchair, and ambulance) will be recorded with time of discharge and full signature and designation
- Nurses are expected to utilize Emergency Department Discharge Instruction **Form CS-432** upon patient discharge.

B. Transfer of Care

- Completion of the appropriate SBAR form. **CS - 495**, CS-719, or CS-515 or the electronic equivalent
- Pt safety checks at each transfer of information.
- Nursing documentation in patient chart will include time transfer of care was given and time the patient left the ED.
- Demographic data (patient's name, age, gender, room number, language spoken).
- Name of Most Responsible Physician and acceptance of responsibility.
- Reason for admission to hospital and diagnosis if known.
- Allergies.
- Infection control precautions.
- Current or desired consultants and if they have been notified.
- Any planned surgical interventions.
- Level of consciousness, orientation, changes in status and/or Canadian Neurological Stroke Scale (CNSS) score when appropriate.
- Physical assessment findings, by system, if significant (if "not within defined limits"— i.e. abnormal breath sounds, compromised or altered neurovascular status, abdominal distention, absence of bowel sounds, impaired skin integrity etc.
- Pertinent patient history and medical/physical limitations, most recent vital signs (blood pressure, heart rate, respiratory rate, temperature and SPO2).
- Cardiac rhythm if patient is monitored.
- Tests/treatments performed (labs, x-rays, aerosols, etc) in the past 24 hours, highlighting abnormal results and actions taken to address.
- Tests/treatments pending or not completed
- Medication (routine and PRN) received within the past 12 hours
- Highlight medications due in the next 4 hours
- Intravenous (IV), Central Venous Access Device (CVAD) status, tubes/drains, dressings etc. (quantity and quality of drainage)
- Disposition of clothing, valuables, sensory aids, prosthesis, mobility aids to include who it was given to or where the items could be located
- Identified social issues
- Discharge plans if applicable (i.e. Homecare, LTC, Social Work)

C. Patient Identification

- Positive identification of the patient will include a minimum of two patient identifiers as per Identification of Patient policy **SAF-1-04**. The two identifiers can be:
    - Patient name and birth date
    - Patient name and medical record number.
- All lab samples and medication administration must follow this policy.
- Each patient will have a name band placed on at triage/registration.

D. Safety

- All nurses will utilize TBRHSC **Outpatient Fall Assessment Screening Tool** to assess the Fall Risk potential of all patients accessing emergency care and apply an orange fall risk bracelet on those patients who are deemed a fall risk.
- TBRHSC supports a least restraint environment and views restraints as a temporary and an exceptional intervention.
- Positive identification of the patient will include a minimum of two patient identifiers including ER number, patients verbal identification, patient bracelet must be made before procurement of specimens/tests or procedures. Refer to **Identification of a Patient policy SAF-1-04.**
- Utilize all resources for "Access and Disability" patients (i.e. hearing, vision disturbances) such as clipboards, blue stickers and patient paging system.
- Staff will employ any methods available to promote safe discharge of patients and facilitate transfer home in a safe and timely manner

E. Equipment

- All nurses will ensure that all supplies and equipment necessary are available for the care and safety of the emergency patient.
- All nurses will immediately remove faulty equipment from the patient care area and reports utilizing Biomed maintenance form on the intranet.
- All nurses will follow the outlined recommendations on the Falls Risk assessment and apply the appropriate strategies

F. Professionalism

- All nurses will treat each other with compassion and respect. As per policy Professional Standards of Behaviour HR- tce - 08
- All nurses will work collaboratively with patients, visitors and other health care professionals.

G. Code of Conduct

- We will maintain confidentiality. We will be mindful of what is said, where it is said and the impact on others. Please refer to policy **Code of Conduct HR-tce-10**
- We will treat patients (those who receive service) in a professional manner that demonstrates respect, dignity, caring and compassion for each individual. This includes but is not limited to:
    - arriving on time and ready to contribute
    - being pleasant and courteous
    - adherence to the dress code
    - acknowledging the patients presence upon their arrival
    - wearing name tags that have not been disfigured or changed in any manner
- We will communicate with all patients in a clear, timely, truthful manner and demonstrate attentiveness through eye contact, choosing the appropriate environment, responding and using a calm and helpful tone.
- We will identify ourselves by name and department when greeting a customer and/or answering the telephone.
- We will offer assistance to anyone within the building or on the hospital grounds who appears distressed or in need of help.

- We will treat all individuals with dignity, honouring their uniqueness and value. We will not tolerate discrimination in any form.
- We will address all patients by their preferred name.
- If we do not have the resource to address a patients concern or need, we will connect the patient to an individual or department who can meet the need.

H. Annual Competency

- **All staff must complete annual mandatory MEDworxx reviews prior to December 31st of each year** (required organizational practice). As per policy **Mandatory Educational Records SE - 01**

XII. References:

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