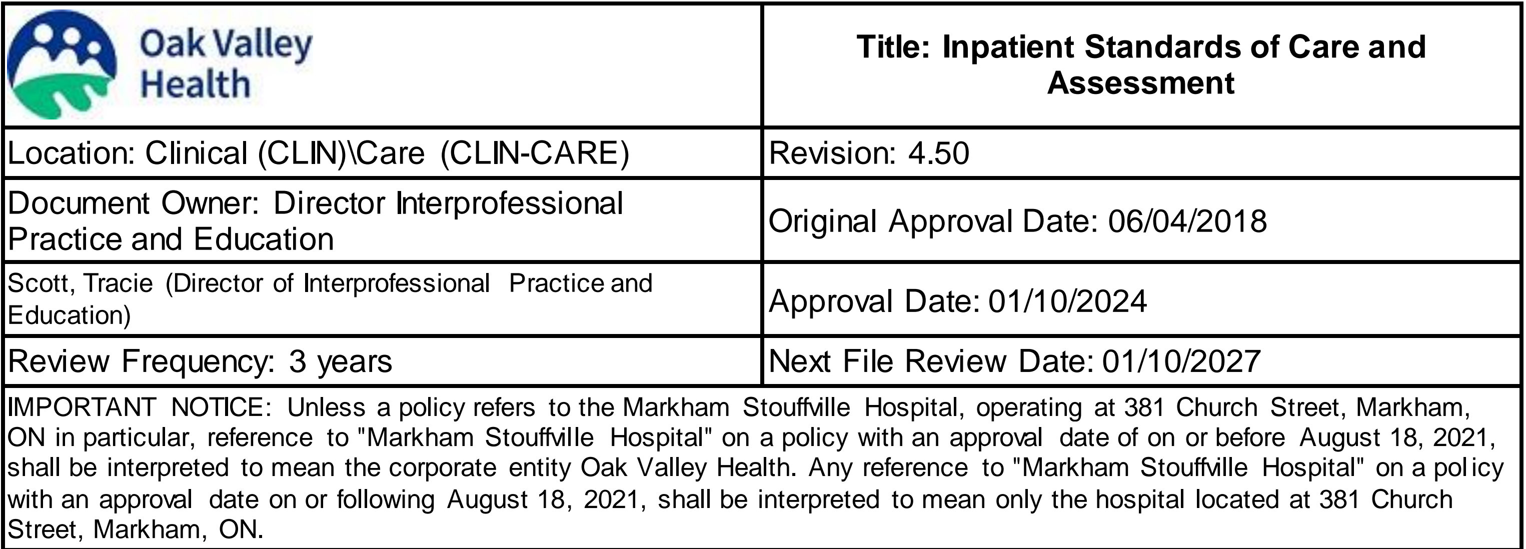

Oak Valley Health	Title: Inpatient Standards of Care and Assessment
Location: Clinical (CLIN)\Care (CLIN-CARE)	Revision: 4.50
Document Owner: Director Interprofessional Practice and Education	Original Approval Date: 06/04/2018
Scott, Tracie (Director of Interprofessional Practice and Education)	Approval Date: 01/10/2024
Review Frequency: 3 years	Next File Review Date: 01/10/2027
IMPORTANT NOTICE: Unless a policy refers to the Markham Stouffville Hospital, operating at 381 Church Street, Markham, ON in particular, reference to "Markham Stouffville Hospital" on a policy with an approval date of on or before August 18, 2021, shall be interpreted to mean the corporate entity Oak Valley Health. Any reference to "Markham Stouffville Hospital" on a policy with an approval date on or following August 18, 2021, shall be interpreted to mean only the hospital located at 381 Church Street, Markham, ON.	

PURPOSE AND SCOPE:

The purpose of this document is to outline the expected care for an inpatient at Oak Valley Health.

POLICY STATEMENT(S):

All inpatients at Oak Valley health will receive individualized care, as outlined herein, at a minimum, or as ordered in a care pathway.

All inpatients at Oak Valley health will be individually assessed for their specific needs, as outlined herein, and as ordered. Assessment of the patient's current condition is completed by comparing clinical findings with a set of "Standard Defined Limits" (or Parameters for "Within Defined Limits")

***Detailed clinical area standards can be found in the appendix of this document.**

Patient assessment and/or changes in the patient's status that **do not** meet "Standard Defined Limits" are identified and appropriate actions are taken and documented.

PROCEDURE:

Unit Standards of Care	
	1. Review and update patient infection control precautions. Ensure appropriate Personal Protective Equipment (PPE) is stocked by patient rooms. 2. Ensure every bed space has proper suction equipment set-up (suction regulator, suction canister, suction tubing, Yankauer oral suction). 3. Ensure every patient bed space has a functioning oxygen flowmeter attached to oxygen outlet. 4. Ensure patient is wearing a patient identification band. Follow Positive Patient Identification policy to positively identify patients, using 2 identifiers, at every patient interaction (e.g. name, date of birth). 5. Review orders and implement plan of care each time care is assumed. 6. Patients requiring electrocardiograms will have their electrocardiograms

	acquired and transmitted digitally through the Marquette Universal System of Electrocardiography (MUSE) system. 7. Involve patient/substitute decision maker (SDM) in the plan of care and treatment/care decisions. 8. Patients will be informed of the names of their care team members. 9. My CTE principles bedside handover, update whiteboard, team rounding. 10. A working call bell is placed within easy reach (Exception: Mental Health unit is assessed on individual basis). 11. Appropriate safety measures implemented to prevent injury (e.g. falls prevention strategies, restraint minimization strategies). 12. Purposeful rounding on all patients occurs every hour. 13. Patients with limited mobility are repositioned at least every two hours, and skin care is provided, as patient condition allows. 14. Oral hygiene is encouraged as needed or provided at least every eight hours. 15. If the patient is not able to perform activities of daily living independently, the following are provided according to patient needs: a. assistance with personal hygiene provided at least every 24 hours including peril-care (postpartum patient provided peril-care at least every four hours); b. assistance with meals; c. assistance with ambulation; d. assistance with toileting; 16. Screening of any potential risk for violence occurs on admission and as needed throughout the patient's admission. Patients screened as at risk for violence will have an Alert for Behavioral Care (ABC) safety plan in place. 17. Documentation of unit standards of care will occur as follows: a. The transfer of accountability document (i.e. shift handover summary, is used to document if the standards of care was adhered to during the shift. This is documented at least once per shift, at the end of each shift.). b. By documenting the unit standards of care, it is acknowledged that all aspects of care outlined in the unit standards were provided with the frequency indicated in the standard and at the level required by the patient. c. If the patient refuses aspects of care or the unit standards of care are not met, the details are documented in the appropriate assessment screen and in a focus note. 18. Patients will have diet texture downgraded where a regulated professional believes that a patient is at risk for choking or as per patient preference. 19. The patient will be referred to additional appropriate care professionals as required. A prescriber order is required for treatment. Refer below for treatment order definitions. Any member of the interprofessional team can make a referral for an assessment; providing a referral is obtained when/if intervention(s) are required. The following process will be followed upon receipt of referral; a. The care provider will assess appropriateness of referral and will prioritize assessment b. The assessment and care plan will be documented

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	c. The clinician will update the team and document when there are significant changes to the care plan d. A note will be documented when the services are no longer required 20. Patient will have appropriate discharge planning initiated upon admission. Patient will have appropriate discharge referrals made (i.e. clinical appointments, home care etc.).
Assessment Standards	
Clinician	1. Documents assessment standards as outlined in appendices herein for the specific care units. 2. Determines whether the findings fall "Within Defined Limits (WDL). The parameters for WDL for each assessment are defined within the electronic medical record. 3. Determines where exceptions exist and documents a focus note and applicable assessment as appropriate. **Note:** Documentation reflects findings of the patient assessment at that point in time. Leaving blanks in sections/queries is acceptable if there are no findings or the sections/queries do not apply to the patient at that time. 4. Follows the minimum care standards where patient care is/are not defined by provider orders or a clinical pathway.

DEFINITION(S):

Within Defined Limits (WDL): Assessment parameters are defined for specific patient populations at Oak Valley Health. A finding of WDL" means that all of the parameters have been assessed, and all current findings fall within the defined limits. If assessment information does not pertain to the patient, that section or question may be left blank

Shift: Every shift (this is the shift that the healthcare provider is working)

Hourly/Purposeful Rounding: Patients are visited, every hour on all shifts, for "pain, potty, position and pumps, possessions". Purposeful Rounding may be completed by any member of the health care team, as part of their patient care delivery. This ensures that patients are checked on regularly and care needs are addressed.

System Assessments: May include, but are not limited to, an assessment of neurological, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal and integumentary systems.

Order for Treatment: Includes providing any of the following treatments as per professional scope, but is not limited to;

- Mobilizing patient as per assessment
- Adjusting diet order (changing texture, adding nutritional supplements, changing therapeutic diet) as per assessment

- Clinical swallowing assessment

REFERENCE(S):

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Ontario College of Social Workers and Social Service Workers (2008). Code of Ethics and Standards of Practice Handbook Second Edition. *Retrieved on March 24, 2017, from http://www.ocswssw.org/wp-content/uploads/2017/03/Code-of-Ethics-and-Standards-of- Practice-March-2017.pdf*

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cpm.ca/documents/10179/24937/com_electronic_records_handbook-e.pdf

RELATED DOCUMENTS:
100.914.917.010 Patient Information Exchange at During Care Transitions
160.914.914.015 Documentation Standards
210.914.914.005 Restraint Minimization
320.606.010 Enteral Feeding and Feeding Intolerance Guidelines in the NICU
360.914.914.035Standard for Pain Management and Opioid Monitoring
360.914.916.050 Care of the Patient who has Received Intrathecal Analgesic
530.501.085 Observation and Privilege Levels in Inpatient Mental Health
530.914.914.015 Falls Risk Reduction and Injury Prevention Program
190.914.740.002 ECG – MUSE Acquisition, Transmission and Recall Alert for Behavioral Care

RESPONSIBILITY:

Required Endorsements	Sponsor	Approval Authority
Collaborative Practice Advisory Committee Medical Operations Committee Mental Health Operations Committee Surgical Operations Committee DI CRS Operations Committee Childbirth Services Paediatrics and NICU Operations	PPL, Corporate Nursing	Director, Interprofessional Practice & Education

DOCUMENT HISTORY:

Type	Individual/Committee	Date	Outcome
Revised	Professional Practice Leader	31/05/2018	approved
Revised	PPL, Corporate Nursing	23/06/2022	approved
Revised	PPL, Critical Care	15/12/2023	Approved

APPENDICIES:
REFERENCE(S)
APPENDIX A: Acute Care (Medicine and Surgery)
APPENDIX B: Acute Care (Critical Care)
APPENDIX C: Acute Care (Level 2 Critical Care Stepdown Unit)
APPENDIX D: Acute Care Childbirth Services
APPENDIX E: Acute Care – NICU
APPENDIX F: Acute Care – Paediatrics
APPENDIX G: Non Acute Care (LTLD, Rehab, ALC, Palliative, CCC) and Mental Health
APPENDIX H: Inpatient Allied Health – Clinical Dietetics
APPENDIX I: Allied Health – Occupational Therapy
APPENDIX J: Allied Health – Physiotherapy
APPENDIX K: Allied Health – Speech-Language Pathology
APPENDIX L: Allied Health – Social Work
APPENDIX M: Allied Health – Therapeutic Recreation

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Appendix A: Acute Care (Medicine and Surgery)

<table>
<tr><th>Clinical Situation</th><th>Acute Care (Medicine and Surgery)</th></tr>
<tr><td>Admission</td><td><u>Within 12 hours:</u>
Complete antibiotic Resistant Organism Assessment
<u>Within 24 hours:</u>
Complete nursing admission history & assessment in Electronic Medical Record (EMR)
Document allergies within EMR’s
Complete nicotine assessment/management
Write admission focus note
Complete Best Possible Medication History and document in EMR’s home medication routine
Confirm SDM noted
Review advance care directives orders and document in EMR
Screen adult patients for nutritional risk. This includes obtaining the patient’s weight and assessing the patient’s weight history. Any patients deemed at nutritional risk will have a dietitian referral entered.
<u>Exceptions: Markham Stouffville Hospital</u>
Patients pre-admitted through Surgical Assessment Clinic (SAC) will have admission history and assessment done in SAC
Admitting day surgery nurse reviews SAC assessment with patient and documents any changes within the day surgery admission assessment</td></tr>
<tr><td>Room / Equipment Set-up</td><td>All Emergency Cart/Kit are checked as indicated on unit-specific checklists
Ensure oxygen flowmeter and all suction equipment is present, checked and functional at the beginning of each shift and after each use
Rinse used suction equipment (tubing/Yankauer) with sterile water after each use
Suction equipment changed (soft liner/tubing/Yankauer) every 24 hours, and “changed date” placed on outside of yankauer package
Suction catheters are to be thrown out after every use – they are SINGLE USE ONLY.
Yankauer after use to be will be placed inside the original package and secured so that it will not fall onto the ground. If it falls onto the ground it MUST be thrown out and a new Yankauer is obtained.</td></tr>
</table>

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	o Sterile water bottle used for suctioning to be labelled "Suction only". Pour sterile water into a cup first, labeled with date and change cup every 24 hours. • For patient with a tracheostomy, ensure following is available at bedside: o Emergency Trach Bin – containing a tracheostomy tube of the same size, one size smaller and a cuffed tracheostomy tube. Provided by Registered Respiratory Therapist. o Multiple spare inner cannulas (change q shift and PRN) o Obturator o Complete suction setup with Yankauer o Spare suction catheters (12F or 14 F) o Resuscitation bag
Head to Toe Assessment	• Complete system assessments at a minimum every shift • IPAC Nursing Precautions • Document full system assessment where significant findings are identified • When significant findings identified, complete that assessment at a minimum of every eight hours and PRN • Write focus note when significant findings identified
Additional Assessments/ Interventions	• Additional assessments may be required, but not limited to the following • Reproductive • Psychosocial • Ice Application • Epidural • PCA • Sleep Apnea Monitoring • Patient Education • Isolation Precautions • Epidural/Spinal/Regional • Pain • Wound/Surgical/Incision • CADD Pump and Monitoring • CIWA Alcohol Withdrawal • Education Ostomy • Drain(s) • IV Central Line Site • Neurological • Tracheostomy • The frequency of additional assessments are completed based on orders, specific related policies/procedures/pathways and Clinician assessment • If patient is admitted with an infusion or dressing or any type of

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	intervention not started in hospital, an order must be obtained for continuation or discontinuation, refer to appropriate relevant policies (i.e. insulin pump). This must be documented in a focus note and the correct assessments added and completed
Assessment parameters not met or Significant findings	**When "Significant Findings" is identified;** • Complete a full system assessment • Document a focus note **<u>Exception:</u>** • A focus note is not required if all system assessment parameters are met except for the presence of a documented longstanding health condition(s)
Clinical Situation	**Acute Care (Medicine and Surgery)**
Blood & blood products	• Document relevant blood product(s) in the "IV Fluid Volume" assessment • Complete the Laboratory Transfusion Record • Write a focus note • Ensure consent has been obtained (unless in emergency situations) • Monitor for transfusion reaction as per policy
Parenteral Fluid/Fluid Status Monitoring	• Document Intake and output from all sources throughout the shift on "Intake and Output" screen • Document Intravenous (IV) fluid intake q1h on the "IV Fluid Volumes" screen • Document dose of complex medication infusions q1h • Complete vascular access (i.e. Triple lumen central line, Peripherally Inserted Central Catheter (PICC), IV peripheral) assessment and change tubings as per policy • Document Enteral Feeding q1h or as ordered and change tubing and bag as per policy • Document Continuous Bladder Irrigation 1h on the "Genitourinary" screen • Document a 24 hour fluid balance as well as cumulative balance
Voiding History & Bowel Function	• Assess and document every 4 hours
Vital Signs	A complete assessment of vital signs includes: • Respiration rate • Temperature • Heart rate • Blood pressure • SpO2 • Pain

	VS should always be documented in the GEN Vitals screen Complete and document vital signs as per specific orders/policy/pathway or based on assessment findings, and in the following circumstances: • On admission • Before, during and after the administration of medications or application of therapies that affect cardiovascular, respiratory or temperature-control functions as applicable (e.g., digoxin) • Before, during and after a transfusion of any blood product • When patient reports specific symptoms of physical distress (e.g. feeling “funny” or “different”) • When patient’s general physical condition changes (e.g. loss of consciousness, increase intensity of pain) • Before, during and after a surgical or invasive diagnostic procedure • Postoperatively every 1 hour x 3, then every 4 hours x 24 and then every 8 hours or as ordered
Neuro Vitals	• Complete and document as ordered or clinically indicated • Follow Stroke pathway for additional neurological assessment (i.e. Canadian Neurological Scale (CNS))
Monitored Bed	• ECG strip analysis will be completed; at minimum every four hours, on initiation, beginning of shift, with any changes in rate, rhythm or patient clinical presentation • Captured ECG strips and analysis will be saved in MEDITECH • Review of alarm at minimum every 4 hours and includes: check to ensure they are turned on, settings and history • Telemetry alarms are configured to send notifications as per department settings to MobileConnex mobile devices carried by nurses caring for telemetry patients (refer to MobileConnex Policy) • At start of shift and/or at resumption of tele monitoring perform hard disconnect of patient cable from telemetry pack to verify alarms are transmitting to central station and MobileConnex device • Telemetry batteries shall be changed at minimum daily • After 48 hrs, telemetry order to be reassessed by MRP • Notify MRP and obtain order for 12 and/or 15 lead ECG; if patient experiencing chest pain, change in status and/or further interpretation • Temporary discontinuation of telemetry requires an “Telemetry Pass” order from the MRP specifying reason
Weight	**Obtain patient weight on approved medical grade scale as ordered** **or clinically indicated:** • On admission • At minimum every 7 days or as per orders

Falls Risk Assessment	**Complete and document falls risk assessment:** • On admission • On transfer • Daily • Post fall • With any significant change in cognitive or mobility status
Mobility, ADLs &Nutrition	• Assess and document activities of daily living (ADL) every shift • Assess and document food/enteral intake every shift • Assess and document mobility level and mobility attained every shift
Wound Surgical	• Complete and document Wound/Dressing assessment every 8 hours or as per orders, and as needed
Braden Scale	**Complete and document Braden Scale :** • Within 24 hours of admission and • Daily • Upon transfer • With any change in patient condition
Mental Status	• Complete the Confusion Assessment Method (CAM)and document daily between 1500h and 1900h
Clinical Situation	**Acute Care (Medicine and Surgery)**
Shift Summary	• Document shift summary at the end of every shift • Verify that the unit standards of basic care have been met. • Document a focus note if standards not met
Interprofessional Kardex	• Review/update each shift and with any change in plan of care or new orders received
Restraint use	• Complete the Restraint Minimization Assessment when patient displays behaviours harmful to self or others • If restraints have been implemented document the Restraint Monitoring Record assessment per Restraint Minimization Policy
Change in Condition/ or/unexpected occurrence or Critical Event	• Document detailed assessment of relevant system(s) • Write a focus note • Complete any relevant paper-based forms as indicated (e.g. cardiac arrest record) • Refer to policy escalation care of det / MD location
Transfer to Another Unit/Department/ or Level of care within Facility	• Write a focus note • Ensure Medication reconciliation (completed by the receiving unit) within 12 hours of transfer • Complete the Situation, Background, Assessment, Recommendations Documentation (SBARD) prior to transfer (this includes transfer to Diagnostic Imaging) • Refer to internal pt transfer policy

Transfer to another Facility	• Ensure Medication reconciliation is completed
	• Write a focus note
	• Complete transfer forms as required and outlined by receiving facility
	• Provide telephone report to receiving facility using SBARD if patient is transferred unaccompanied
	• If patient is on telemetry monitoring, obtain orders for transfer
	• If accompanying patient ensure all medication given prior to departure and/or obtain medications as ordered for transfer
	• If patient requires cardiac monitoring on transfer an appropriate health care provider nurse with telemetry monitoring certification must accompany patient
	• Follow appropriate transfer policy:
	  o *Patient Transfer Protocol – Oak Valley Health*
	  o *External Patient Transfer*

Discharge	1. Ensure Medication reconciliation completed
	2. Complete discharge plan & checklist
	3. Complete Discharge / health teaching screen as required
	4. Ensure patient has prescription(s), follow-up appointments and discharge instructions
	5. Write a focus note to include:
	  o time of discharge
	  o health teaching
	• valuables returned

Appendix B: Acute Care (Critical Care)

Clinical Situation	Acute Care (Critical Care)
Admission	**Within 12 hours:** • Complete antibiotic Resistant Organism Assessment Baasda **Within 24 hours:** • Complete nursing admission history & head to toe assessment • Document allergies within the MEDITECH allergy routine • Complete nicotine assessment/management • Write admission focus note • Complete Best Possible Medication History and document in MEDITECH home medication routine • Review advance care directives orders and document in MEDITECH • Adult patients are screened for nutritional risk on admission. This includes obtaining the patient's weight and assessing the patient's weight history. Any patients deemed at nutritional risk will have a dietitian referral entered.
Room / Equipment Set-up	**Limit the quantity of supplies brought into the room to avoid potential contamination / wastage ** **All Emergency Cart/Kits are checked as indicated on unit-specific checklists** • Ensure oxygen flowmeter and all suction equipment is present, checked and functional at the beginning of each shift and after use. • Ensure oral airway and bag valve mask available at bedside • Rinse used suction equipment (tubing/Yankauer) with sterile water after use. Suction equipment is to be changed (soft red liner/tubing/Yankauer) q 24 hours. • Ensure you place the "changed date" on the outside of the yankauer package. • Suction catheters are to be thrown out after every use – they are SINGLE USE ONLY. • After use, the Yankauer will be placed inside the original package and secured so that it will not fall onto the ground. If it falls onto the ground it MUST be thrown out and a new Yankauer is obtained.
Clinical Situation	**Acute Care (Critical Care Unit)**

	• Label the sterile water bottle that is used for suctioning "Suction only". Pour the sterile water into a cup. The cup is to be dated and changed q24 hours
	• For patient with a tracheostomy - place at the bedside:
	  o Same size and one size smaller tracheostomy tube
	  o Spare inner cannula (change q shift and PRN)
	  o Obturator
	  o Complete suction setup with Yankauer
	  o Spare suction catheters (12 F OR 14 F)
	  o Resuscitation bag
	• 1 set of ECG cables including 12 lead cables
	• 1 arterial monitoring cable
	• 1 spo2 monitoring cable with probe
	• 1 noninvasive blood pressure monitoring cable and cuff
	• 1 stocked supply cart

Head to Toe Assessment	• Complete system assessments at a minimum q4h • GEN isolation precautions • Document full system assessment where significant findings are identified • When significant findings identified, complete that assessment <u>at a minimum</u> of every q2-4 hours and PRN • Write focus note when significant findings identified
Additional Assessments/ Interventions	• Additional assessments may be required, but not limited to the following, Reproductive, Psychosocial, Ice Application, Epidural, PCA, Sleep Apnea Monitoring, Patient Education, Isolation Precautions, Intrathecal Single Dose, Pain, Wound Pressure Ulcer, CADD Pump, CIWA Alcohol Withdrawal, Education Ostomy, Drain, central lines, Neuro Scale, Invasive and Non-Invasive Ventilation, tracheostomy. The frequency of these assessments are completed based on orders, specific related policies/procedures/pathways and Clinician assessment • If patient admitted with an infusion or dressing or any type of intervention not started in hospital, an order must be obtained for continuation or discontinuation, refer to appropriate relevant policies (i.e. insulin pump) This must be documented in a focus note and the correct assessments added and completed • Note: medications are not left at bedside for self-administration
Assessment parameters	**When "Significant Findings" is identified;**
Clinical Situation	**Acute Care (Critical Care Unit)**

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not met or Significant findings	• Complete a full system assessment • Document a focus note **<u>Exception:</u>** • A focus note is not required if all system assessment parameters are met except for the presence of a documented longstanding health condition(s)s
Blood & blood products	• Document relevant blood product(s) in the “IV Fluid Volume” assessment • Complete the Laboratory Transfusion Record with two healthcare providers • Write a focus note • Ensure consent has been obtained (unless in emergency situations) • Monitor for transfusion reaction as per policy
Parenteral Fluid/Fluid Status Monitoring	• Document Intake and output from all sources (including enteral feeds) throughout the shift on “Intake and Output” screen • Document Intravenous (IV) fluid intake q1h on the “IV Fluid Volumes” screen • Document dose of complex medication infusions q1h • Complete vascular access (i.e. Triple lumen central line, Peripherally Inserted Central Catheter (PICC), IV peripheral) assessment and change tubings as per policy • Document Enteral Feeding q1h or as ordered and change tubing and bag as per policy • Document Continuous Bladder Irrigation 1h on the “Genitourinary” screen • Document a 24 hour fluid balance as well as cumulative balance
Voiding History & Bowel Function	• Assess and document every 4 hours
Vital Signs	**All patients in the Critical Care /Stepdown unit must be connected to continuous cardiorespiratory monitoring.** **A vital signs assessment includes:** • Respirations, SpO2, temperature, heart rate/pulse, blood pressure and a pain assessment • Vital signs are documented q1h or as ordered • Use of recognized pain assessment tool (i.e. Critical Care Observation Tool – CPOT) • Patients that require cooling or warming require continuous temperature monitoring • Admissions direct from the OR require vital signs on arrival to ICU and q15mins x4, q30mins x2 then q1h or asordered
Clinical Situation	**Acute Care (Critical Care and Stepdown Unit)**

	Complete and document vital signs as per specific orders/policy/pathway or based on assessment findings and in the following circumstances: • On admission • Before, during and after the administration or titration of medications or application of therapies that affect cardiovascular, respiratory or temperature-control functions • Before, during and after a transfusion of any type of blood products • When patient reports specific symptoms of physical distress • When patient's general physical condition changes (e.g. loss of consciousness, increase intensity of pain • Before, during and after a surgical or invasive diagnostic procedure
Continuous Cardiac monitoring	• Obtain a paper monitor rhythm strip at the beginning of the shift and q4h and post on chart • Perform a rhythm analysis including PR, QRS, & QT interval and based on this analysis make an interpretation of the rhythm & document minimally q4h and prn • Obtain additional rhythm strips with any change in rate, rhythm or change in patient status • Review alarm settings and ensure all alarms are on • Review alarm history minimally q4h and tailor alarms • Change electrodes q48h • Obtain a 12 lead ECG if further interpretation required and/or patient experiencing chest pain and change in status as per MD orders
Advanced pressure monitoring	**If patient has advanced pressure monitoring follow procedure below** • Continuous monitoring of the arterial monitor waveform and document q1h and PRN • Assess arterial line site q1h and accuracy of waveform as per policy • CVP monitoring to be done with every central line and document q1h or as ordered • Continuous monitoring of pulmonary artery waveform and document q1h and PRN and accuracy of waveform as per policy • PAWP as ordered • Obtain paper copy of all pressure monitoring waveforms and post on chart • Cardiac outputs as ordered obtain paper documentation to be placed in chart • Change all IV tubing q96h as per policy • Zero and calibrate pressure monitoring lines at the beginning of

	the shift, post blood taking or any interruption in monitoring • Abdominal pressure monitoring q1h or as ordered, zero and calibrate line and change tubing q96h
Clinical Situation	**Acute Care (Critical Care Unit)**
Neuro Vitals/Head Injury Routine	• Complete and document as ordered or clinically indicated • If patient is receiving neuromuscular blocking agents obtain train of four (TOF) as per policy • Complete Glasgow Coma scale q4h and prn • Canadian neurological stroke assessment tool as ordered
Temporary Pacemaker	**For temporary transvenous pacemakers** • Document settings post insertion and then at the beginning of the shift • Document rate, MA, sensitivity, battery function and select pacer mode on cardiac monitor • Assess intact connections and secure pacemaker to patient • Ensure orders for daily CXR and daily MD assessment of settings **For trancutanous pacemaker** • Place pads on chest of patient • Document settings, rate, MA • Full code cart with defibrillator at bedside

Clinical Situation	Acute Care (Critical Care Unit)

Ventilator monitoring	**Invasive ventilation**
	• Q1h monitoring of ventilator parameters including mode of ventilation, respiratory rate, tidal volume, minute volume, airway pressures, FiO2
	• If patient requires high frequency oscillation ventilation(HFO) follow specific policy
	• Continuous sPo2 monitoring
	• Document endotracheal (ETT) size and placement q shift
	• Ensure patient has an ETT securement device in place
	• Adjust ETT securement device position q24h to avoid pressure ulcers
	    o **NOTE: this procedure requires 2 people to perform (i.e. RN/RRT)**
	• Suction orally and via ETT prn and document secretions
	• Q2h mouth care
	• Follow protocol for the prevention of Ventilator Associated Pneumonia (VAP)
	    o Head of bed greater than or equal to 30 degrees
	    o Daily sedation interruption and spontaneous breathing trials performed
	    o Oral gastric drainage tube
	    o Q12h chlorhexidine mouthwash
	
	Non Invasive Ventilation
	• Q1h monitoring of non-invasive parameters including respiratory rate, tidal volume, minute volume, airway pressures, FiO2, litre flow
	• Continuous SpO2 monitoring
	• During high flow oxygen therapy and intermittent breaks off BiPAP
	    o Suction orally and document secretions
	    o Q2h mouthcare
	• Head of bed greater than or equal to 30 degrees
	• Oral/nasal gastric drainage tube while on high flow oxygen therapy
	• NPO if on BiPAP

Weight	**Obtain patient weight on approved medical grade scale as ordered or clinically indicated:** • On admission • Daily or as ordered

Falls Risk Assessment	**Complete and document falls risk assessment:** • On admission • On transfer • qshift • Post fall • With any significant change in cognitive or mobility status
Mobility, ADLs &Nutrition	• Assess and document activities of daily living (ADL) every shift assessment • Assess and document food/enteral intake every 4 h for oral intake and q1h for enteral feeding • Assess and document mobility level for critical care and mobility attained every shift following mobility protocol
Wound Surgical	• Complete and document Wound/Dressing assessment every 4 hours or prn or as per orders
Braden Scale	• **Complete and document Braden w**ithin 24 hours of admission and then daily • Upon transfer
Clinical Situation	**Acute Care (Critical Care Unit)**
	• With any change in patient condition
Mental Status	• Complete CAM-ICU/RASS q4h and document
Shift Summary	• Document shift summary at the end of every shift • Verify that the unit standards of basic care have been met Document a focus note if standards not met
Interprofessional Kardex	• Review/update each shift and with any change in plan of care or new orders received
Restraint use	• Obtain consent and provider orders • Complete the Restraint Minimization Assessment when patient displays behaviours harmful to self or others and • If restraints have been implemented document the Restraint Monitoring Record assessment per policy
Change in Condition/unexpected occurrence or Critical Event	• Document detailed assessment of relevant system(s) • Write a focus note • Complete any relevant paper-based forms as indicated (e.g. cardiac arrest record)
Transfer to Another Unit/Department/ Level of care	• Write a focus note • Ensure Medication reconciliation is completed prior to transfer • Complete the Situation, Background, Assessment, Recommendations Documentation (SBARD) prior to transfer

Transfer to another Facility	• Ensure Medication reconciliation iscompleted • Write a focus note • Complete transfer forms as required as outlined by receiving facility • Provide telephone report if not accompanying patient • If accompanying patient ensure all medications given prior to departure and/or obtain medications as ordered for transfer • Attach patient to portable monitor • Obtain any additional orders to support safe transfer of patient (i.e. orders for external pacing) • Follow transfer policy
Discharge	• Ensure Medication reconciliation completed • Complete discharge plan & checklist • Complete Discharge / health teaching screen as required • Ensure patient has prescription(s), follow-up appointments and discharge instructions • Write a focus note to include; time of discharge, health teaching and valuables returned

Appendix C: Level 2 ICU

Clinical Situation	Acute Care (Level 2 ICU)
Admission	**<u>Within 12 hours:</u>** • Complete Antibiotic Resistant Organism Assessment • Document allergies within the Meditech allergy routine **<u>Within 24 hours:</u>** • Complete nursing admission history & head to toe assessment • Complete nicotine assessment/management • Write admission focus note • Ensure Best Possible Medication History is completed • Review advance care directives orders and document in Meditech • Screen for nutritional risk on admission. This includes obtaining the patient's weight and assessing the patient's weight history. Enter a dietitian referral for any patients deemed at nutritional risk • If patient admitted with an infusion or dressing or any type of Intervention not started in hospital, an order must be obtained for continuation or discontinuation. Refer to appropriate relevant policies (i.e., insulin pump; refer to Continuous Subcutaneous Insulin Infusion Therapy in the Hospital Setting **https://mshdms.labqms.com/sthlabFrame.asp?nNegU=T&DID=15905**). This must be documented in a focus note and the correct assessments added and completed **Note:** medications are not left at bedside for self-administration **<u>Exceptions: Markham Stouffville Hospital</u>** • Patients pre-admitted through Surgical Assessment Clinic (SAC) will have admission history and assessment done in SAC • Admitting day surgery nurse reviews SAC assessment with patient and documents any changes within the day surgery admissionassessment
	Limit the quantity of supplies brought into the room to avoid potential contamination/wastage **All Emergency Cart/Kits are checked as indicated on unit-specific checklists** • Ensure oxygen flowmeter and all suction equipment is present, checked and functional at the beginning of each shift and after use. • Ensure oral airway and bag valve mask available at bedside • Rinse used suction equipment (tubing/Yankauer) with sterile water after use. Suction equipment is to be changed (soft red liner/tubing/Yankauer) q24h.

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Room/Equipment Set-up	• Ensure you place the “changed date” on the outside of the Yankauer package. • Suction catheters are to be thrown out after every use – they are SINGLE USE ONLY. • After use, the Yankauer will be placed inside the original package and secured so that it will not fall onto the ground. If it falls onto the ground, it MUST be thrown out and a new Yankauer is obtained. • Label the sterile water bottle that is used for suctioning “Suction only”. Pour the sterile water into a cup. The cup is to be dated and changed q24h • For patient with a tracheostomy - place at the bedside: o Emergency Trach Bin – containing a tracheostomy tube of the same size, one size smaller, and a cuffed tracheostomy tube. (Provided by the Registered Respiratory Therapist). o Multiple spare inner cannulas (change q shift and PRN) o Obturator o Complete suction setup with Yankauer o Spare suction catheters (12F or 14F) o Resuscitation bag • 1 set of ECG cables including 12 lead cables • 1 arterial monitoring cable • 1 SpO_2 monitoring cable with probe • 1 non-invasive blood pressure monitoring cable and cuff 1 stocked supply cart
Head to Toe Assessment	• Complete system assessments at a minimum q4h • Head to toe assessments to be reflected on “ICU/CCU Admission Non-Vented Patient” intervention set • GEN isolation precautions • Document full system assessment where significant findings are identified • When significant findings identified, complete that assessment at minimum of every q 2-4 hours and PRN Write focus note when significant findings identified
	• Additional assessments may be required, but not limited to the following: • Reproductive • Psychosocial • Ice Application • Epidural • PCA • Sleep Apnea Monitoring • Patient Education

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Additional Assessments/ Interventions	• Isolation Precautions • Intrathecal Single Dose • Pain • Wound Pressure Ulcer • CADD Pump • CIWA Alcohol Withdrawal • Education Ostomy • Drains • CVADs • Canadian Neurological Scale • Non-Invasive Ventilation • Tracheostomy The frequency of these assessments are completed based on orders, specific related policies/procedures/pathways and Clinician assessment
Assessment Parameters Not Met or Significant Findings	**When "Significant Findings" are identified:** • Complete a full system assessment • Document a focus note **Exception:** A focus note is not required if all system assessment parametersare met except for the presence of a documented long-standing health condition(s)
Blood & Blood products	• Ensure consent has been obtained (unless in emergency situations) • Document relevant blood product(s) in the "IV Fluid Volume" assessment • Complete the Laboratory Transfusion Record with two healthcare providers • Write a focus note Monitor for transfusion reactions as per policy
Parenteral Fluid/Fluid Status Monitoring	• Document intake and output from all sources (including enteralfeeds) throughout the shift on "Intake and Output" intervention • Document intravenous fluid intake q1h on the "IV FluidVolumes" intervention • Document dose of complex medication infusions q1h Document Enteral Feeding q1h or as ordered and change tubing and bag as per policy
Voiding History & Bowel Function	Assess and document q4h
Vital Signs	**All Level 2 patients must be connected to continuous cardiorespiratory monitoring. A vital signs assessment includes:** • Respiration rate, heart rate, SpO_2, temperature, blood pressure and pain assessment as per orders Use a recognized pain assessment tool (e.g., Critical Care Pain

	Observation Tool – CPOT) **Complete and document vital signs as per specific orders/policy/pathway or based on assessment findings and inthe following circumstances:** • On admission • Before, during and after the administration or titration of medications or application of therapies that affect cardiovascular, respiratory or temperature-control functions • Before, during and after a transfusion of any type of blood product • When patient reports specific symptoms of physical distress • When patient's general physical condition changes (e.g. loss of consciousness, increase intensity of pain) Before, during and after a surgical or invasive diagnosticprocedure
Continuous Cardiac monitoring	• Perform a rhythm analysis including PR, QRS, & QT interval and, based on this analysis, make an interpretation of the rhythm & document minimally q4h and prn • Obtain additional rhythm strips with any change in rate, rhythm or change in patient status • Review alarm settings and ensure all alarms are on • Review alarm history minimally q4h and tailor alarms • Change electrodes q24h Obtain a 12 lead ECG if further interpretation required and/or patient experiencing chest pain and change in status as per MDorders
Advanced pressure monitoring	If patient has advanced pressure monitoring, follow the applicable procedure below: • Continuous monitoring of the arterial monitor waveform and document q1h and PRN • Assess arterial line site q1h and accuracy of waveform as perpolicy • CVP monitoring performed and documented as ordered • Abdominal pressure monitoring performed and documented as ordered • Change all IV tubing q96h as per policy All invasive pressure monitoring should be zeroed and calibrated at the beginning of every shift, post blood taking or any interruption in monitoring
Neuro Vitals/Head Injury Routine	• Complete and document as ordered or clinically indicated • Complete Glasgow Coma scale q4h and PRN Canadian neurological stroke assessment tool as ordered
Oxygen therapy	• q1h monitoring and documentation including respiratory rate, FiO_2, litre flow • Continuous SpO_2 monitoring

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	• Oral/nasal gastric tube as ordered while on high flow oxygen therapy **Heated High Flow Nasal Cannula (HHFNC)** • FiO_2 0.50-0.80 • Flow Rates 30 – 60 LPM • Inspection of the skin under and around the nasal cannula with q1h vitals Refer to Policy: Heated High Flow Nasal Cannula Oxygen Therapy for Adults
Non-Invasive Ventilation	• Non acute Home CPAP and BiPAP units • Oral/nasal gastric tube as ordered while on CPAP/BiPAP • Continuous SpO_2 monitoring while on CPAP/BiPAP Refer to: **Care of the Adult Surgical Patient with Obstructive Sleep Apnea**
Weight	**Obtain patient weight on approved medical grade scale as ordered or clinically indicated:** On admission and as per order (ensure the accuracy of the numerical value and the unit of measure)
Falls Risk Assessment	**Complete and document falls risk assessment:** • On admission • On transfer • qshift • Post fall With any significant change in cognitive or mobility status
Mobility, ADLs & Nutrition	• Assess and document activities of daily living (ADL) every shift • Assess and document food/enteral intake q4h for oral intake and q1h for enteral feeding Assess and document mobility level for Level 2 ICU and mobility attained every shift following mobility protocol
Wound Surgical	• Complete and document Wound/Dressing assessment q4h or PRN or as per orders
Braden Scale	• Complete and document Braden Scale within 24 hours of admission and then daily • Upon transfer With any change in patient condition
Mental Status	• Complete Richmond Agitation and Sedation Scale (RASS) q4h and PRN Complete Confusion Assessment Method for ICU (CAM-ICU) q12h and PRN
Shift Summary	• Document shift summary at the end of every shift • Verify that the unit standards of basic care have been met Document a focus note if standards not met
Interprofessional Kardex	• Review/update each shift and with any change in plan of care or • new orders received
Restraint use	• Obtain consent and provider orders • Complete the Restraint Minimization Assessment when patient displays behaviours harmful to self or others

	• If restraints have been implemented document the Restraint Monitoring Record assessment per policy
Change in Condition/Unexpected Occurrence or Critical Event	• Document detailed assessment of relevant system(s) • Write a focus note • Complete any relevant paper-based forms as indicated (.e.g., cardiac arrest record)
Transfer to Another Unit/Department/ Level of Care	• Write a focus note • Ensure Medication Reconciliation is completed prior to transfer (Transferring MRP to complete Medication Transfer Order) • Use the "Internal Patient Transfer Checklist" as criteria for patient escort by the most appropriate health care provider • "Internal Patient Transfers" Policy (580.914.917.015) • Complete the Situation, Background, Assessment, Recommendations Documentation (SBARD) prior to transfer
Transfer to Another Facility	• Ensure Medication Reconciliation is completed • Write a focus note • Complete transfer forms as required as outlined by receiving facility • Provide telephone report if not accompanying patient • If accompanying patient ensure all medications given prior to departure and/or obtain medications as ordered for transfer • Attach patient to portable monitor • Obtain any additional orders to support safe transfer of patient (i.e., orders for external pacing) • Follow "External Patient transport" policy (580.914.914.015)
Discharge	• Ensure Medication Reconciliation completed • Complete discharge plan & checklist • Complete "Patient Discharge Plan Checklists" intervention as required • Ensure patient has prescription(s), follow-up appointments and discharge instructions • Write a focus note to include time of discharge, health teaching and valuables returned

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Appendix D: Acute Care Childbirth Services

Clinical Situation	Acute Care Childbirth Services
Room Set-up and Emergency Equipment checks	**Limit the quantity of supplies brought into the room to avoid potential contamination / wastage ** All Emergency Carts/Kits are checked according to frequency directed by unit-specific checklists, and sign off as completed. CN or CL will delegate who will complete safety checks **<u>Birthing rooms</u>** **Infant:** All resuscitation equipment (T-Piece resuscitator , flow inflating bag, suction equipment is to be present, checked and functional on the infant radiant warmer prior to delivery of baby. Primary nurse assigned to patient is responsible to check equipment **Mother:** Oxygen flowmeter, simple mask, resuscitation bag, and all suction equipment is to be present, checked and functional at beginning of each shift and changed after every use **Ante/Postpartum Services:** Ensure oxygen flowmeter and all suction equipment is present, checked and functional at beginning of each shift and after every use. Ensure flow inflating bag and 10F suction catheter is present and functional in the sealed bedside drawer
Clinical Situation	**Acute Care Childbirth Services** **Antepartum women greater than 20 weeks gestation are cared for in CCS whenever possible**

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MATERNAL ANTEPARTUM ADMISSION AND ASSESSMENTS	**On Admission** • Screen for COVID-19 using Acute Respiratory Screening Tool • Complete antibiotic Resistant Organism Assessment • Complete admission history & assessment Review Ontario Antenatal records including medical and obstetrical history • Document allergies within the MEDITECH allergy routine • Complete nicotine assessment • Write admission focus note • Complete Best Possible Medication History and document in MEDITECH home medication routine • Review advance care directives orders and document in MEDITECH • Assess and document Falls risk • Review labour birth and post-partum plan with patient and revise if indicated • Review generic unit standards of care expectations • Adult patients are screened for nutritional risk on admission. This includes obtaining the patient's weight and assessing the patient's weight history. Any patients deemed at nutritional risk will have a dietitian referral entered • Refer to specific guidelines for care and management of patients requiring blood and blood products **Medication reconciliation:** Complete process on admission, transfer and discharge **Vital Signs** (BP, T, P, and R): Assess on admission and as per pre-printed order set. With prelabour rupture of membranes (PROM) assess temperature q4h while awake or as per pre-printed order set. Consult primary care provider's specific antepartum orders based on patient diagnosis and condition.
Clinical Situation	**Acute Care Childbirth Services** **Antepartum women greater than 20 weeks gestation are cared for in CCS whenever possible**

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	Auscultate fetal heart on admission and as ordered by MRP Perform Non Stress Test (NST) as ordered. Classify, interpret and respond based on SOGC Guidelines (2020) Classification Table See Appendix Complete maternal assessment for vaginal bleeding, Amniotic fluid (amount,colour,odour), vaginal discharge, as ordered. Teach/Review importance of "fetal movement count" (FMC) prn, if indicated, and document q8hrs while awake. Assess for uterine activity and consult CN/CL if transfer to L&D is indicated Assess and document pain score, headache, epigastric pain, and blurred vision q 8 hrs as ordered by MRP. For patients with an IV, assess Site Q1h while infusion is runnning and document as per Policy 250.914.914.005 Intravenous Catheterization Monitor and document intake and output q 12 hrs. or as ordered Assess patient's psychosocial welfare daily. Initiate social work or Public health (Healthy Baby, Healthy children – HBHC) referral as indicated. **Test Urine as ordered** Assess and document bowel function q 12 hours Assess and document Falls risk daily, on transfer, with any significant change in cognitive or mobility status and post fall Provide and document all health teaching as needed based on admission diagnosis and according to primary provider's order
Discharge	• Complete medication reconciliation • Provide all necessary health teaching • Complete discharge plan and checklist • Complete discharge focus note • Refer to Breastfeeding Clinic and or FAB Clinic as indicated • Ensure appropriate follow-up appointments in place for newborn care

Clinical Situation	Acute Care Childbirth Services Antepartum women greater than 20 weeks gestation are cared for in CCS whenever possible
Transfer to another Facility	• Ensure medication reconciliation is completed • Document a focus note related to transfer • Complete all required transfer forms • Ensure a complete copy of patient chart is sent to receiving facility
Clinical Situation	**Acute Care Childbirth Services Maternal Intrapartum**

<table>
<tr><td>Admission and Assessment</td><td><u>Upon admission:</u>
•<u>Screen for COVID-19 using Acute Respiratory Screening Tool</u>
____Complete Antibiotic Resistant Organism Assessment and order swabs as required
• (Presenting diagnosis and/or maternal/fetal risk status may require an abbreviated history & assessment to initiate immediate treatment)
• Complete admission history & assessment
• Review Ontario Antenatal records including medical and obstetrical history, if missing have Unit Secretary follow-up with MRP office for missing records
• For missing Lab results, Ultrasounds, microbiology results use Connecting Ontario if available
• Document allergies in MEDITECH
• Review labour birth and post-partum plan (LBPP) with patient according to LBPP policy
• Complete Best Possible Medication History (BPMH) and document home medications in MEDITECH
• Review advance care directives orders and document in MEDITECH
• Assess and document “Falls” risk
• Review generic unit standards of care expectations in policy
• Complete nicotine assessment
• Write admission focus note
• Adult patients are screened for nutritional risk on admission. This includes obtaining the patient’s weight if ordered and assessing the patient’s weight history. Any patients deemed at nutritional risk will have a dietitian referral entered
• Refer to specific guidelines for care and management of patients requiring blood and blood products
Medication reconciliation: Complete process on admission, transfer and discharge

FALLS RISK: Assess and document Falls risk daily, on transfer, with any significant change in cognitive or mobility status and post fall

Complete labour admission in Meditech
Intrapartum care is documented on High Risk Labour and Birth Flowsheet . Completion of this form is the responsibility of the intra-partum nurse(s) caring for the birthing person.</td></tr>
<tr><td>Clinical Situation</td><td>Acute Care Childbirth Services
Maternal Intrapartum</td></tr>
<tr><td></td><td>**<u>After delivery of placenta</u>, electronic documentation is commenced for subsequent maternal assessments and care.</td></tr>
</table>

<table>
<tr><th colspan="2">INTRAPARTUM CARE AND ASSESSMENT
The following minimum standards of care are a guideline. More frequent (but not less) assessments may be required based on individual patient needs or as ordered by most responsible provider (MRP)</th></tr>
<tr><td>Vital Signs</td><td>Vital Signs (BP, T, P, R)
• Refer to IPAC Guidance if birthing person has 2 consecutive temperatures over 37.5C at any phase of labour
<u>Latent phase</u>*:
• On admission and q 4 hrs.;
• Assess q 2 hrs. if membranes ruptured,
• Assess q1 hr. if temperature is greater than 37.5 C

<u>Active phase</u>**:
• On admission and q 2 hrs.;
• Assess <u>q 1 hr.</u> when membranes ruptured

<u>When pushing</u>:
• q 1hr

Oxygen Saturation
• As indicated, based on patient's clinical condition and if concerns r/t maternal circulation or oxygenation status
Note:
<u>**For epidural insertion, oxytocin initiation or Cervical ripening and other high risk patient care, follow Order Sets for specific requirements for maternal and fetal assessments</u>

Fetal Heart Rate (FHR)
Use "Intermittent Auscultation" (IA) or Electronic Fetal Monitoring (EFM) as indicated in FHSL policy (550.601.100)

IA of FHR is recommended for fetal health surveillance in labour (FHSL) with a healthy term pregnancy <u>without</u> risk factors for adverse perinatal outcomes during labour</td></tr>
<tr><th>Clinical Situation</th><th>Acute Care Childbirth Services
Maternal Intrapartum</th></tr>
<tr><td></td><td>Continuous EFM is recommended when risk factors for adverse perinatal outcomes are identified (see indications for EFM in FHSL policy) or as ordered by MRP</td></tr>
</table>

Ongoing Care and Assessments	**<u>Intermittent Auscultation</u>** **Latent Phase**: q 60 minutes **Active Phase**: q 15-30 minutes **Passive Second Stage**: q 15 minutes **Active Second Stage:** q 5 minutes or immediately following each contraction **<u>Electronic Fetal Monitoring</u>** **Latent Phase**: q15 minutes **Active Phase**: q 15 minutes **Passive Second Stage**: q15 minutes **Active Second stage:** q 5 minutes **<u>Uterine Activity</u>**: Palpate uterus for contraction frequency, duration, intensity and resting tone with every FHR assessment (frequency as above for FHR) **<u>Vaginal Discharge/Show/Amniotic Fluid</u>** Assess colour, amount and odour **q 1 hr.** **<u>Pain management/Comfort level</u>** Assess while awake **q4 hrs.** in latent phase, **q1hr** in active phase using numeric pain scale score (0-10). **<u>Coping/Supportive Care in Labour</u>** Provide 1:1 nursing care and emotional support during the active phase of labour.
Clinical Situation	**Acute Care Childbirth Services** **Maternal Intrapartum**

	Note: 1:1 is defined as the nurse being continuously present in the patient's room whenever possible. Provide ongoing education and support utilizing non-pharmacological and pharmacological methods for pain management options as indicated in patient's "Labour, Birth, Post-partum plan". Patient expectations will be evaluated on an on-going basis throughout labour and alternative pain relief methods offered as requested. **<u>Intake</u>** Encourage ice chips, fluids or light snacks/meals according to labour status. If IV fluids are initiated, document intake **q shift** **<u>Output</u>** Encourage patient to empty her bladder **q 2 hrs**. If a Foley catheter is in-situ, document output **q shift.** Empty collection device at q shift or as required and document volume **<u>Fluid Balance Activity</u>** Encourage ambulation and position change according to labour status. Avoid supine position due to risk of "supine hypotension" causing maternal BP and FHR abnormalities **<u>Labour Progress (Vaginal Exam- V/E)</u>** **Active Labour**: assess progress (perform V/E) at least **q 4 hours** Satisfactory progress is considered to be a minimum of 2 cm in 4 hours in the active phase of labour. Follow specific practice guidelines based on patient's risk status and interventions implemented (i.e. continuous EFM, IV oxytocin etc.) In the active second stage, adequate progress is defined as follows: **Nulliparous**: continuing descent of the presenting part with
Clinical Situation	**Acute Care Childbirth Services** **Maternal Intrapartum**

	active pushing; up to 3 hrs. with an epidural or 2 hrs. without; as long as fetal & maternal well-being is reassuring. **Parous:** continuing descent of the presenting part with active pushing; up to 2 hours with epidural, or 1 hour without; as long as there are no concerns about fetal & maternal well-being is **<u>Second Stage management:</u>** Refer to and utilize second stage decision tree specific to Nulliparous or Parous patient with or without an epidural to optimize patient care **Other specific indications for performing a vaginal examination include (but are not limited to):** rupture of membranes, prior to analgesia or anesthesia, atypical or abnormal fetal heart pattern, patient has urge to push, prior to initiating oxytocin, for scalp stimulation, etc. **<u>At birth:</u>** If maternal and neonatal condition permits, encourage uninterrupted skin-to-skin contact immediately following birth for at least one hour or until completion of first feeding or as long as birth person wishes Ensure all bloodwork and specimens are collected, as ordered, (cord gases, placenta, cord blood collection) labelled and dispositioned as per lab policies **<u>Third Stage of Labour:</u>** Ensure continuous patient assessment and support MRP, as indicated, based on perineal repair requirements, type of birth and patient outcomes **FALL'S RISK:** Assess and document "Falls risk" daily, on transfer, with any significant change in cognitive or mobility status and post fall **<u>DEFINITIONS:</u>** * **Latent phase**: precedes the active phase. It is the presence of uterine activity resulting in progressive effacement and dilation of the cervix. It is complete when a nulliparous woman reaches 3-4 cm dilatation and a
Clinical Situation	**Acute Care Childbirth Services Maternal Intrapartum**

	parous woman reaches 4-5 cm. Cervical length should usually be less than 1 cm. (SOGC) ** **Active phase**: the presence of regular painful contractions leading to cervical dilation from 4 cm to full dilatation (SOGC) **Ensure all <u>paper and electronic documentation</u> is completed for assessments and actions, as indicated by patient condition, prior to transfer of care** *** **For a laboring woman who requires a C/S, refer to operating room standards for intra-operative care and follow O.R. policies for scrub circulate and documentation requirements in the "MEDITECH Operating room module"*****
The following minimum standards of care are a guideline. More frequent (but not less) assessments may be required based on individual patient needs or as ordered by most responsible provider (MRP)	
RECOVERY PERIOD FOLLOWING VAGINAL & C/S BIRTH	**Within first 1-2 hrs. after birth:** Close monitoring of vital signs, assessment of fundus, lochia, bladder and perineum. Assess for signs & symptoms of post-partum hemorrhage. Support mother with uninterrupted skin to skin contact, if possible. Monitor newborn transition during skin to skin contact. Discharge folder may be given to parents prior to transfer to post-partum area. Education in preparation for discharge may be commenced if patient's clinical condition allows. **The nurse is required to provide 1:1 continuous monitoring of the mother and newborn, at a minimum, in the first hour of post-birth recovery.** Computers are provided in each labour room to facilitate ongoing documentation **<u>Vital Signs</u>** <u>(BP, T, P, R),</u> **<u>Fundus, Lochia, Bladder & Perineum:</u>** See detailed assessment descriptions of "fundus, lochia, perineum & bladder" below
Clinical Situation	**Acute Care Childbirth Services Maternal Intrapartum**

	First hour: q 15 mins x 1 hour if stable. Then q 1 hr. until stable Assess q1 hr. if temperature is greater than 37.5 C (refer to IPAC guidance if 2 consecutive Temperatures above 37.5 C.) Temperature is only required once in first hour if within normal limits Assess intravenous site, infusion and complete intake and output balance based on intra-partum care needs. Empty and document urine output if patient is catheterized in recovery period Assess sensory & motor levels prior to ambulation. 2 person assist for first ambulation due to risk of falling. Offer analgesia and comfort measures as needed Observe and assess an initial BF attempt within 1- 2 hrs in recovery period. Assist with breast feeding and newborn care as requested by parents. Encourage patient to void before transfer to post-partum care. Offer bedpan if unable to weight-bear especially if lochia is heavy or uterus is deflected from midline FALLS RISK: Assess and document Falls risk daily, on transfer, with any significant change in cognitive or mobility status and post fall Assess epidural site (if applicable) and remove epidural catheter. Ensure catheter and black tip are intact. Provide health teaching for removal of site dressing when patient showers Consult patient -specific orders based on diagnosis and intra-partum care needs. Ensure all paper and electronic documentation is completed for assessments and actions, as indicated by patient condition, prior to transfer of care
Clinical Situation	**Acute Care Childbirth Services Maternal Intrapartum**

Addition Care Post C/S Delivery	<u>**IN ADDITION TO ABOVE, FOR RECOVERY FOLLOWING C/S BIRTH:**</u> Prior to patient's arrival in PACU, ensure that safety checks have been completed including operation of suction and oxygen set-up, as well as bedside supplies The circulating nurse usually assumes the recovery nurse role and accompanies patient with the anesthesiologist or delegate. In the event TOA is required, verbal report will include: • Procedure performed • Type of anesthetic administered • Opioids administered • Patient allergies, medical/OB history intra-operative concerns • Newborn outcome **The nurse is required to provide 1:1 continuous monitoring of the mother and newborn, at a minimum, during the first hour of post-operative recovery** **The Anesthesiologist will decide if C/S recovery is required in an alternative location (i.e. Main adult PACU). Note: Cardiac monitoring is not available in the L&D PACU** For a patient requiring transfer to "Main PACU", CN/CL will make arrangements with PACU staff and Anesthesiologist will accompany patient to PACU with L&D nurse. Anticipate the following care may be required on arrival to PACU: o Oxygen via face mask at liters/min after general anesthetic o Oxygen via nasal prongs at 3 liters/min after a spinal anesthetic and as needed after oxygen mask is discontinued to keep oxygen saturation greater than 90% or as ordered o Oral suction o Assessment of breath sounds and quality of respirations if any respiratory concerns
Clinical Situation	**Acute Care Childbirth Services Maternal Intrapartum**

	The Anesthesiologist or delegate will remain with patient until primary nurse accepts responsibility of patient. The Anesthesiologist is primary contact for any non-obstetrical recovery period issues (i.e. airway or pain management concerns) ***The PACU nurse will:*** Assess Vital signs (BP, T, P, and R), oxygen saturation, gently palpate fundus, check lochia and abdominal dressing upon admission to PACU and q 15 mins x 1 hour if stable. Then assess q1hr until transfer to post-partum care. Patient will only be transferred when assessment parameters are within normal range and patient no longer requires 1:1 monitoring. Consult MRP or OB on call for patient-specific orders in the event of recovery complications (i.e. PPH) Assess temperature q1 hr. if greater than 37.5 C (refer to IPAC Guidance if patient has 2 consecutive temperatures of 37.5 C.) Temperature is only required once in first hour if within normal limits Perform sedation score, as indicated. Complete "Epimorph/Intrathecal" monitoring as ordered by Anesthesiologist Assess pain score and offer analgesia as ordered. Assess for nausea and itching and treat as ordered Assess intravenous infusion(s) and Foley catheter output. Complete fluid balance prior to transfer of care Ensure patient safety with stretcher side rails up and wheels locked Complete paper and electronic documentation for all assessments and actions required prior to transfer of care
Clinical Situation	**Acute Care Childbirth Services Admission to Post-Partum Care Unit**
The following minimum standards of care are a guideline. More frequent (but not less) assessments may be required based on individual patient needs or as ordered by most responsible provider (MRP)	

ON - GOING POSTPARTUM CARE FOR VAGINAL BIRTH & C/S	• Review all medical, pregnancy, labour, birth and initial recovery history. • Assess for maternal/newborn risk factors that may require specific interventions i.e. o Assisted birth o Birth Person and partner Hepatitis B status o HIV status o Blood group & Type o Group B Strep status o Type 1 or Type 2 diabetes o Gestational diabetes o Rubella status o Previous h/o depression o Use of SSRI's in late pregnancy o Gestational age less than 37 weeks or greater than 42 weeks o SGA/LGA status o Prolonged Rupture of membranes > or= 18hours o Concerns for Chorioamnionitis o Maternal Fever > or= 38C o Fetal Tachycardia o Maternal Labetalol use • Assess maternal psychological response to labour and birth and birth person and partner's response to postpartum period. • Bonding with newborn will be observed and documented. • A general review of the childbirth philosophy of rooming –in, visiting policy, safety issues (including family's responsibility in their own safety), car seat information, availability of breastfeeding support, medication reconciliation, pain management and discharge criteria. • Physical assessment of fundus lochia, perineum, breasts, bladder, bowels, wound, mobility, pain and general physical status. **Medication reconciliation:** Complete process on admission, transfer and discharge. Transition from L&D to post-partum is not considered a transfer of care. This applies to transfer of "care service" only (i.e. Obstetrical service to medicine or MW care to OB) **Vital Signs** (BP, T, P, R), **Fundus, Lochia, Perineum:**
Clinical Situation	**Acute Care Childbirth Services** **Admission to Post-Partum Care Unit**

	• On admission to post-partum care and **q 8 hr.** until discharge or as ordered • Assess Temperature q1 hr. if greater than 37.5 C X2 refer to IPAC Guidance **Fundus:** Note fundal tone (check gently for C/S), location and displacement from midline. Estimate fundal height distance in fingerbreadths above or below the umbilicus. Check and document fundal height and position after patient voids or catheter removal **Lochia:** Assess lochia colour, amount, consistency, odour & presence of any clots. Assess for signs and symptoms of post-partum hemorrhage, notify MRP for further management orders **Perineum:** Assess integrity of perineum and for bruising, hematoma, edema, discharge, or signs of infection and hemorrhoids. Kegel's exercises are encouraged as soon as mother feels able and comfortable. Kegel exercises help restore perineal muscle tone and facilitate bladder/bowel control in the postpartum period **NOTE**: If patient is unable to do self-care, peri-care will be provided minimum of every 4 hrs **REFER TO POSTPARTUM VAGINAL DELIVERY & CAESAREAN SECTION ORDER SETS FOR DETAILED STEPS IN MANAGEMENT** **Pain management:** Assess severity of patient's pain using pain scale score **q 1h until stable (q 8h while awake)** and provide support as indicated (ice, initiate comfort measures for hemorrhoid/perineal discomfort). **FOR VAGINAL DELIVERY ONLY:** Initiate self-administration medication (SAM) package, as ordered, if patient meets inclusion criteria. Refer to MRP orders if pain is not well controlled with SAM and consult "Acute pain service" as needed**.**
Clinical Situation	**Acute Care Childbirth Services** **Admission to Post-Partum Care Unit**

	FOR C/S: **Dressing**: assess amount and type of any oozing or bleeding **q8h**. Dressing may be removed on 2nd day post-op or as ordered by MRP Following shower, incision is left uncovered. **Incision:** incision should be assessed for redness, swelling, oozing and gaping **q8h** once dressing has been removed (2nd day post-op). **For women following C/S, optimal pain management is achieved through regular administration of co-analgesia. Refer to applicable orders** Provide PRN analgesia as ordered. **If on PCA/Intrathecal/Epidural opioid:** Follow preprinted orders for detailed assessments (i.e. Sedation score) Offer SAM package, only when PCA is discontinued **Mobility/Weight-bearing:** • Encourage early and regular ambulation. Patient's ability to ambulate is assessed using "OB Falls Risk Assessment" tool. • Utilize mobility device to avoid patient fall and staff injury • Assess for edema, encourage ankle turning and elevation of feet to facilitate circulation and reabsorption of extracellular fluid. • Assess ambulation for signs of symphysis integrity. • Arrange physio as needed. Advice regarding resumption of activity is individualized to patient comfort, energy level and pain management **FALLS RISK:** Assess and document Falls risk daily, on transfer, with any significant change in cognitive or mobility status and post fall. All patients ambulating for the first time or those at risk of falls must be a two person ambulation or with the use of the ambulation assistive device. **FOR C/S:** Encourage patient to sit up in chair &/or ambulate in her room within 6 – 12 hrs. post-op (earlier if tolerated)
Clinical Situation	**Acute Care Childbirth Services** **Admission to Post-Partum Care Unit**

	<u>Bladder:</u> Encourage patient to void regularly following transfer to post-partum care. Assess if patient voids and is able to empty bladder. If unable to void within 6 hrs of last voiding or Foley catheter removal <u>refer to Bladder Managerment Policy</u> Support and accompany patient as needed based on clinical condition and ambulation safety criteria If unable to void by 6 hrs post-delivery or after urinary catheter removal, scan bladder If residual is greater than 150 mls, notify MRP and insert foley catheter After initial voiding, and when satisfactory bladder function has been established, assess **q 4 hr** while awake. **NOTE:** It is common for women to have a rapid diuresis following birth and a full bladder is the most common cause of preventable post-partum hemorrhage (PPH) in the 4th stage of labour Assess intravenous infusions and medications according to IV monitoring guidelines and as ordered Assess and manage Foley catheter, as ordered **<u>Fluid Balance:</u>** Assess intake and output while patient is receiving parenteral fluids in the post-partum period **<u>Breasts:</u>** Perform ongoing assessments for bruising, cracks in nipple integrity, engorgement, and lumps at a minimum **q 8 hrs.** Observe and assess a minimum of 2 Breast feeds or pumping sessions in 12 hours Utilize LATCH score parameters as per Infant Feeding Policy
Clinical Situation	**Acute Care Childbirth Services Admission to Post-Partum Care Unit**

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	NOTE: More frequent assessments and/or a Lactation consultation may be required during the hospital stay. **LATCH SCORES:** less than 7: Initiate contact with primary health care provider and/or Lactation Consultant if NB older than 24 hrs of age greater than or equal to 7: Evaluate breastfeeding mother's learning needs and assist mother through health teaching and support with area of concern **For bottle-feeding women,** assess for level of comfort and engorgement **q8hrs.** Encourage comfort measures i.e. promote comfort and supportive bra, cold compresses, shower, analgesia, etc. **Deep Vein Thrombosis (DVT):** If patient is at risk of developing a DVT, assess for calf tenderness, reddened/warm areas and /or peripheral edema, **q 8h** (risk factors may include prolonged bed rest or immobility, Obesity, surgical intervention and previous DVT). Assess and document "Homan's sign" Assess for shortness of breath and chest pain. Report to MRP for further orders. Refer to preprinted orders, if indicated, for VTE prophylaxis **<u>Bowels:</u>** Assess bowel function q 8 hrs and prior to discharge. If no bowel movement reinforce health teaching related to diet, fluids, stool softener, activity and effects of analgesia with codeine. **<u>Bonding / Attachment:</u>** Assess for signs that birth person is bonding with her infant with each nursing interaction. Initiate social work referral as indicated if patient concerns identified. Identify birth person or family history of mental health issues, medication use or substance abuse **<u>Psychosocial:</u>** Assess for warning signs indicating family violence or abuse Assess patient/families understanding of expected course of stay, goals, concerns and satisfaction with their birthing experience/care. Review and sign off on LBPP plan prior to discharge
Clinical Situation	**Acute Care Childbirth Services Admission to Post-Partum Care Unit**

	Sexual health: Encourage patient and partner to speak to their provider regarding contraception and when to resume sexual activity **Other assessments:** Review maternal needs for Rubella vaccination or Rhogam as ordered
Patient Education	**Learning Needs** • Check that "Discharge folder" has been provided to birth person and partner. Review all required education in preparation for discharge. Provide initial and continue to re-inforce all self and newborn health teaching, as identified, based on ongoing assessment of learning needs including, but not limited to: o Newborn and self-care; early ambulation, adjusting to parenthood; coping at home; available community resources and Oak Valley health videos, website content & handouts as required. For C/S- splinting incision with ambulation. • **For vaginal birth only**: o Review SAM program. Discuss importance of understanding chosen pain management options and potential impact on newborn i.e. narcotic use and possible impact on newborn health. Review in detail all handouts provided e.g. "Options for post-partum pain management", jaundice and dehydration etc. • **For C/S birth:** o SAM program is not indicated if patient is on PCA. Provide specific education on use of PCA pump and use of bolus doses • Discuss chosen method of newborn feeding • Required follow-up appointments for self & baby. **Note**: Infants to be assessed by a Health Care Professional within 48hrs if discharged at less than 48 hrs of age. If discharged greater than 48hrs of age, follow provider orders. Mother to be assessed at 6 weeks by primary provider • To facilitate Public Health follow-up, ensure Healthy Baby/Healthy Children consent has been obtained, process Initiated in hospital and entered into BORN database for electronic submission. Remind patient of self-referral option **Note**: Refer to health teaching videos (available on the website and accessed using QR code provided) and available handouts while providing and reinforcing all health teaching for self and

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	baby care.
Clinical Situation	**Acute Care Childbirth Services** **Admission to Post-Partum Care Unit**

Discharge	**<u>**Refer to appropriate policy for patient-specific (SVD or C/S) discharge expectations</u>** • **Document all assessments and interventions in BOTH paper and electronic health record according to the identified frequency and standards listed here.** • **Ensure a focus note is written when indicated.** • **Follow downtime process as indicated** **Note: Refer to maternal discharge criteria: expected outcomes vaginal delivery & caesarean section, for detailed guidance** • Complete medication reconciliation • Ensure all necessary health teaching has been provided • Complete discharge plan and checklist • Complete discharge focus note
Discharge to Another Facility	• Ensure medication reconciliation is completed • Document a focus note related to transfer • Complete all required transfer forms
Clinical Situation	**Acute Care Childbirth Services** **Healthy Term Newborn (greater than or equal to 37 weeks gestation)**
IMMEDIATE CARE AT BIRTH **L&D + ongoing NB assessment**	**The Labour & Birth nurse will:** • Implement initial steps of "Neonatal resuscitation provider (NRP)" guidelines as indicated • At birth, complete Apgar score at 1 & 5 mins (10 mins if indicated), **see reference on Infant warmer** • Maintain a neutro-thermal NB environment. If newborn conditions allows, encourage uninterrupted and safe skin to skin contact as indicated in LBPP plan. Close NB monitoring is required during skin to skin contact • Newborn rooms-in with mother unless maternal or newborn condition requires separation
Clinical Situation	**Acute Care Childbirth Services** **Healthy Term Newborn (greater than or equal to 37 weeks gestation)**

	• Apply identification bands as per policy • Apply Erythromycin ointment and Vitamin K as indicated by each medical directive check medical directive for delay for skin to skin. **Follow "Newborn Routine Orders" for specific screening, monitoring and prophylaxis procedures i.e. Hepatitis protocol as ordered** • Birth parent/partner/family are included in decision making processes and partner in care planning during the hospital stay • Newborn care teaching is provided in presence of parents to optimize maternal/family involvement **Assess NB for the following signs of hypothermia:** • Axillary temperature less than 36.5^{O}C • Tachycardia (heart rate greater than 160 beats/min) • Chest retractions, nasal flaring • Bradycardia (heart rate less than 100 beats/min) • Decreased muscle tone Treat hypothermia by placing the newborn skin to skin with parent and put warm blanket over newborn. Reassess temperature after 30 mins. If temp not increasing, place newborn under radiant warmer with skin probe between umbilicus and xiphoid process, on "skin mode". Newborn must be clearly visible to access transfer of heat. Do not cover neonate with blanket. Re-check temp within 1 hour. If temp remains below 36.5, notify MRP. Blood glucose testing may be ordered **Assess NB for signs of respiratory distress:** • Tachypnea • Nasal flaring • Chest retractions • Expiratory grunting If any of above signs is present, assess preductal oxygen saturation. Place neonate under radiant warmer with skin probe and notify MRP for further orders Perform initial weight within 1-2 hrs. of birth, prioritizing uninterrupted skin to skin contact and initial breastfeed as indicated by baby's condition.
Clinical Situation	**Acute Care Childbirth Services Healthy Term Newborn (greater than or equal to 37 weeks gestation)**

	An initial breastfeeding attempt within 1-2 hrs. of birth Assess and document a comprehensive "Initial head to toe assessment" within 1-2 hrs. of birth, or as soon as condition allows. This includes initial measurement of head circumference and length **Assess NB for risks of bacterial sepsis:** • Mother's Group B strep status is "positive, unknown or has not had adequate intra-partum prophylaxis", regardless of gestation. **See Newborn PPO** • Prolonged ROM 18 hrs. or greater, prior to birth • Maternal temp. of 38C or greater • Suspected maternal Chorioamnionitis • Gestation of 37 wks. or less Notify neonatologist, Paeds on call, or most responsible NB provider for further management orders
No risk factors for infection at birth and ongoing assessments and prior to discharge home	**On transfer to post-partum care, the L&D nurse and post-partum nurse will:** • Review relevant maternal history during TOA at bedside and identify complications that may impact ongoing newborn monitoring and care (i.e. maternal diabetes, Hep B/GBS status, intra-partum fever) • Review the newborn orders together and verify Vitamin K and Erythromycin prophylaxis was given and recorded on orders • All birth history documentation (paper and electronic) is communicated and documented (i.e. Apgars, weight, etc.) **NEWBORN MONITORING** Includes temperature, respiratory rate and effort, circulation (capillary refill), heart rate, colour, tone and pain assessment. Follow frequency guidelines according to newborn status and **"Newborn Routine Orders" for specific screening , monitoring and treatment ordered** At the beginning of each shift, nurse will check that newborn has 2 correct and secure ID bands and security tag, as consented.
Clinical Situation	**Acute Care Childbirth Services** **Healthy Term Newborn (greater than or equal to 37 weeks gestation)**

	The routine nursing assessment and documentation for healthy, clinically stable, newborns will include: • Vital signs as listed above • Weight as ordered • A comprehensive head to toe assessment **q8 hrs (or per shift) until discharge** • Feeding and elimination every 3-4 hrs Ongoing assessment of newborns at-risks, i.e. • Axillary temp less than 36.5^{o}C • Any symptoms of respiratory distress (indrawing, grunting, high respiratory rate, nasal flaring • Colour pale, cyanosis, dusky • Decreased tone • Feeding difficulties • Low blood sugar (follow medical directive) • No meconium or urine in first 24 hrs of life • Repeat head circumference measurements may be required if head assessment concerns identified. Contact MRP for specific frequency of assessment Assess and document head circumference, presence of fluctuant mass, increase in size of fluctuant mass, increase in bogginess/swelling/tension of scalp since birth, Q2h until 12 hour and then as ordered. On a daily basis identify and assess for risk factors for: • Jaundice **Follow clinical pathway for the management of hyperbilirubinemia in term and late pre-term infants (greater than or equal to 35 weeks)** for detailed NB management and follow-up with TSB result • Hypoglycemia • Infection or sepsis Notify MRP of concerns and follow ongoing orders for treatment With acute or worsening signs of distress, notify Paeds on call, transfer newborn to NICU and/or call Code Pink as per NRP guidelines All assessments and interventions will be recorded in the patient chart before end of shift and TOA **<u>Intake:</u>**

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Clinical Situation	Acute Care Childbirth Services Healthy Term Newborn (greater than or equal to 37 weeks gestation)
	Breastfeeding: • Follow breastfeeding assessment guidelines as per "Breastfeeding the healthy term newborn policy "Infant feeding policy- check name • Avoid bathing NB, <u>unless Hep B concerns,</u> before first feeding attempt • Document **<u>all feeds</u>** using LATCH score. A minimum of 2 LATCH scores will be observed in 12hrs • At least 2 breastfeeding/pumping sessions will be documented q 12 hrs. Manual expression is recommended if NB is unable to attempt breastfeed. Breastfeeding newborns should be breastfeeding on demand approximately 8-12 times/24 hrs **Bottle feeding:** • Ensure parents are aware of risks and benefits of formula versus breastfeeding and verbal consent is obtained. • Provide health teaching and support as required in the Infant feeding policy • Observe newborn's first formula feed • document all feeds amount and type of formula until discharge **<u>Output:</u>** • Record each void and stool visualized or reported by parents • Assess amount and colour of urine & stool q 3-4 hrs in conjunction with feeds **Weight:** • Weigh as indicated on NB Routine orders. Notify MD/MW if weight loss is greater than or equal to <u>8 % at 24 hours of age.</u> • <u>Notify MD/MW if weight loss is greater than or equal to 8% at time of discharge</u> • Document all weights as required for discharge expectations **Umbilical stump:** • Cleanse around umbilical cord with wet washcloth if required Expose cord stump to air • Assess for inflammation, foul odour or discharge from umbilicus, in conjunction with feeds and diaper changes. Notify MRP if
Clinical Situation	Acute Care Childbirth Services Healthy Term Newborn (greater than or equal to 37 weeks gestation)

	swab is indicated for culture and sensitivity • Remove cord clamp when dry. Provide parents health teaching for ongoing umbilical stump assessment and care **Skin Care:** • Daily baths are not necessary • Wash newborn's face with warm water daily and as needed • Check diaper area with each diaper change and wash after each stool or voiding with wet washcloth or wipes and dry • Observe and document skin condition **Safety & Positioning:** • Position newborn on a firm, flat surface and on their back • Reassure parents that healthy newborns have ability and reflexes to manage mucous or spit up when lying on their backs by turning their head • Inform parents that "tummy time" is recommended for developmental reasons when newborn awake • Ensure 2 I.D. bands, with correct information, are present on NB at every assessment as per NB security policy • Transport newborn in a crib or incubator for travel between units and for off unit testing/procedures **MD/MW Initial examination:** • Ensure MD/MW assessment is performed within 24 hrs of birth **Diagnostics:** • Review arterial & venous cord gas results and notify NB MD/MW with abnormal findings. Ensure 24 hr TSB & newborn screen is drawn prior to discharge or plan is developed for completion
Clinical Situation	**Acute Care Childbirth Services Healthy Term Newborn (greater than or equal to 37 weeks gestation)**

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Discharge	**Newborn Screening:** Parents have the right to refuse screening tests. In this case the MRP will be notified to enable an informed discussion with the MRP. Documentation of refusal for treatment is required All newborns will have: • Newborn screen & TSB after 24 hrs of age, as indicated. • CCHD screen, as indicated prior to discharge • Hearing screen if available • Healthy Baby Healthy Children screen A follow-up plan will be made with parents and documented, if discharge occurs prior to screening **Refer to newborn discharge criteria: "Expected Outcomes Healthy Term Newborn for detailed requirements.** **Document all assessments and interventions in BOTH paper and electronic health record according to the identified frequency and standards listed here. Ensure a focus note is written when indicated. Follow downtime process as indicated**
Readmission of newborns	Newborn monitoring and care will be guided by specific readmission orders based on clinical condition

Appendix E: Acute Care – NICU

Clinical Situation	Acute Care – NICU
Admission	**<u>Within 12 hours of birth/admission:</u>** MRSA/VRE swabs for any admission from the community or if transferred from another hospital **<u>Within 1 hours of birth/admission:</u>** • Complete admission history & assessment **<u>Within 24 hours of birth/admission:</u>** • Document allergies within the MEDITECH allergy routine • Write admission focus note Complete Best Possible Medication History and document in MEDITECH home medication routine
Room Set-up and Equipment checks	**Limit the quantity of supplies brought into the room to avoid potential contamination / wastage ** **All Emergency Cart/Kits are checked as indicated on unit-specific checklists** Wipe down monitor, computer, equipment cart with cavicide wipes at beginning of every shift. **Infant Bed Space:** Oxygen flowmeter on blender, flow inflating bag and all suction equipment is to be present, checked and functional at the beginning of each shift and after use. • Rinse used suction equipment (tubing) with sterile water after use and the suction equipment is to be changed (soft red liner/tubing/) q 24 hours. • Suction catheters are to be thrown out after every use – these are SINGLE USE ONLY. **Ensure all bedside monitor alarms are set appropriately on each shift** **Change isolette every 7 days and ensure date of change is visible.**
Clinical Situation	**Acute Care – NICU**

	Resuscitation Room: all resuscitation equipment on infant radiant warmer such as T-Piece resuscitator, flow inflating bag, Alternate Airway box, suction equipment, IV pole/pump (Large volume channel and syringe pumps) is to be set-up/present, checked and functional at the beginning of each shift and after use. 2 UVC trays are stocked and available. Resuscitation room equipment carts checked and stocked. Neonatal crash cart : • Daily check and to ensure drawers are locked and external content is present. • Monthly check is to open drawers and check expiry dates Transport Isolette: • Daily ensure that the unit is plugged in • Weekly - complete check of all components (see check list)
Delivery (Baby)	• Complete *Birth Summary* after attending any "at-risk" delivery
Head to Toe Assessment	• Assess and document *Initial head to toe assessment* within 1-2 hours of birth, or as soon as condition allows • Assess and document a full systems assessment at the beginning of every shift • When significant findings identified, complete that assessment <u>at a minimum</u> of every four hours and PRN • Write focus note when significant findings identified **<u>Exception:</u>** • A focus note is not required if all system assessment parameters are met except for the presence of a documented longstanding health condition(s)
Breastfeeding Mothers	• Assess and document feeding readiness cues and implement an individualized feeding plan in collaboration with parents of infant • Complete LATCH assessment a minimum of 2 breastfeeds/pumping sessions every 12 hours • Document minutes of breastfeeding and signs of effective latch in the preterm population • Provide ongoing feeding support and teaching • Obtain informed consent for formula supplementation
Clinical Situation	**Acute Care – NICU**

Bottle-feeding Mothers /Enteral	• Assess and document infant feeding readiness cues and implement an individualized feeding plan in collaboration with parents of infant • Provide feeding support and teaching as indicated • Document enteral feeding volumes throughout shift and residuals • Obtain informed consent for formula supplementation
Blood & Blood Products	• Document relevant blood product(s) in the "IV Fluid Volume" assessment • Complete the Laboratory Transfusion Record (paper document) • Complete IVIG assessment parameters included on preprinted order for NICU • Write a focus note
Parenteral Fluid/Fluid Status Monitoring	• Document IV fluid intake a minimum of every 12 hours in the "IV Fluid Volumes" assessment at the end of each assigned nurse's shift • Assess fluid balance (intake and output totals) every 8 hours (0700, 1500 and 2300) • Assess and document patency of IV site every hour • UVC/PICC lines assess placement marking every handling and document
Voiding History & Bowel Function	• Assess and document newborn elimination (urine and stool output) throughout shift • Weigh diapers when on IV fluids or ordered for strict I/O
Vital Signs	**A vital signs assessment includes:** • Respirations • Temperature • Heart rate/pulse • Blood pressure • Oxygen Saturation • Pain • Capillary refill **Complete and document vital signs in the following circumstances:** • On admission • A minimum of every 4 hours or as ordered • (NOTE: blood pressure measurement is not required while patient is sleeping provided other vital sign parameters are within normal range (no evidence of sustained tachycardia, colour change, cap refill 3 seconds or greater) or unless ordered
Clinical Situation	**Acute Care – NICU**

	• Every hour if the patient is receiving non-invasive or invasive respiratory support • Before, during and after the administration of medications or application of therapies that affect cardiovascular, respiratory or temperature-control functions • Before, during and after a transfusion of any type of blood products • When patient's general physical condition changes (change in level of consciousness) • Before, during and after a surgical or invasive diagnostic procedure
Respiratory support	• Document every hour the mode and associated parameters with the type of respiratory support
Weight/Length	**Obtain patient weight on approved medical grade scale PANDA weigh scale or infant tray scale)** • On admission • Daily • Plot weight • Perform length and head circumference weekly or as per order
Shift Summary	• Document that unit standards –NICU have been met for every nursing shift • Document a focus note if standards not met • Document and perform TOA with every shift handover • All assessments and interventions will be recorded in the patient chart before end of shift and TOA
Change in Condition/unexpected occurrence or Critical Event	• Document detailed assessment of relevant system(s) • Write a focus note • Complete any relevant paper-based forms as indicated (e.g. Neonatal Resuscitation Record) • Increase frequency of vital sign monitoring for close observation
Transfer to Another Unit/Department/ Level of care	• Write a focus note • Ensure Medication reconciliation completed by the sending unit if not completed by sending unit then the receiving unit will complete within 12 hours of transfer • Complete the Situation, Background, Assessment, Recommendations Documentation (SBARD) prior to transfer
Transfer to another Facility	• Ensure Medication reconciliation is completed • Write a focus note • Complete transfer forms as required as outlined by receiving facility
Clinical Situation	**Acute Care – NICU**

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Discharge	• Ensure Medication Reconciliation completed • Complete Discharge / health teaching screen as required • Write a focus note that includes births weight, discharge weight, last bilirubin level and follow up appointments • Complete receipt of Infant form • Complete Healthy Babies Healthy Children form • Provide mother with copy of NICU discharge summary • Complete Phototherapy Predictive Graph signed by parent and give copy to parent for NB greater than 35 wks. • Complete NICU discharge teaching and document assessment, have parent sign printed copy • Give hearing screen result to parent or provide parent with instructions for booking an appointment in the community • Complete and document screening result for Critical Congenital Heart Disease (in MEDITECH and on Newborn Screening Ontario card) • Obtain consent for public health follow-up in the community • Complete BORN

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Appendix F: Acute Care – Paediatrics

Clinical Situation	Acute Care - Paediatrics
Admission	**<u>Within 2 hours of admission:</u>** • Complete admission history & full system assessment including vitals **<u>Within 12 hours of birth/admission:</u>** • Complete antibiotic Resistant Organism Assessment • Document allergies within the MEDITECH allergy routine • Write admission focus note • Complete Best Possible Medication History and document in MEDITECH home medication routine • Assess and document falls risk using the Humpty Dumpty Falls Risk Assessment
Room Set-up and Equipment checks	*Limit the quantity of supplies brought into the room to avoid potential contamination / wastage * **All Emergency Cart/Kits are checked as indicated on unit-specific checklists** ****Ensure bed/crib/isolette is ALWAYS situated in front of the headwall where the emergency equipment is located **** **Paediatric Room**: Ensure oxygen flowmeter, and all suction equipment is to be present, checked and functional at the beginning of each shift and after use. Ensure the age appropriate self-inflating bag with mask (neonatal, paediatric or adult) and non-re-breather mask is present in room. **Ensure bedside monitor alarms are set appropriately on each shift** **Suction:** • Rinse used suction equipment (tubing/yankauer) using sterile water after use and the suction equipment is to be changed (soft red liner/tubing/Yankauer) q 24 hours. • Ensure you place the “changed date” on the outside of the yankauer package. • Suction catheters are to be thrown out after every use – these are SINGLE USE ONLY. • After use, the yankauer will be placed inside the original package and secured so that it will not fall onto the ground. If it falls onto the ground it MUST be thrown out and a new Yankauer is obtained. • Sterile water bottle that is used for suctioning needs to be labeled

	"suction only" and must be poured into a cup. The cup is dated and changed q24 hours
Clinical Situation	**Acute Care - Paediatrics**
Head to Toe Assessment	• Assess and document initial head to toe assessment within 2 hours of admission, or as soon as condition allows • Assess and document a full systems assessment at the beginning of every shift including vitals • When significant findings identified, complete that assessment <u>at a minimum</u> of every four hours and PRN • Write focus note when significant findings identified **<u>Exception:</u>** • A focus note is not required if all system assessment parameters are met except for the presence of a documented longstanding health condition(s)
Breastfeeding Mothers	• Complete LATCH assessment within first 2 h, and at least 2 breastfeeds/pumping sessions every 12 hours • Obtain informed consent if supplementation initiated. • Write focus note required

Blood & Blood Products	• Document relevant blood product(s) in the "IV Fluid Volume" assessment • Complete the Laboratory Transfusion Record (paper document) • Write a focus note • Complete IVIG assessment parameters included on preprinted order for pediatrics and NICU
Parenteral Fluid/Fluid Status Monitoring	• Document IV fluid intake a minimum of every 12 hours in the "IV Fluid Volumes" assessment at the end of each assigned nurse's shift • Assess fluid balance (intake and output totals) every 8 hours (0700, 1500 and 2300) • Assess and document patency of IV site every hour
Voiding History & Bowel Function	• Assess and document paediatric elimination (urine and stool output) throughout shift • Weigh diapers if infant on IV fluids or strict I/O ordered
Vital Signs	**A vital signs assessment includes:** Bedside Paediatric Early Warning Score (BPEWS) 7 clinical indicators: • Heart rate/Pulse • Respiratory rate • Blood pressure • Cap refill • SpO2 • Type/mode of oxygen • Respiratory effort **Plus:** • Temperature • Pain
Clinical Situation	**Acute Care - Paediatrics**

	Complete and document vital signs and BPEWS in the following circumstances: • On admission • A minimum of every 4 hours and as indicated by the BPEWS recommendations • (NOTE: blood pressure measurement is not required while patient is sleeping provided other vital sign parameters are within normal range (no evidence of sustained tachycardia, colour change, cap refill 3 seconds or greater etc.) or if ordered • Before, during and after the administration of medications or application of therapies that affect cardiovascular, respiratory or temperature-control functions • Before, during and after a transfusion of any type of blood products • Before, during, and after nursing intervention influencing a vital sign (e.g. before and after patient previously on bed rest ambulates, before and after he or she performs range-of-motion exercises • When patient reports specific symptoms of physical distress (e.g. feeling "funny" or "different") • When patient's general physical condition changes (e.g. loss of consciousness, increase intensity of pain) • Before, during and after a surgical or invasive diagnostic procedure • Postoperatively every 1 hour x 3, then every 4 hours x 24 and then every 8 hours or as ordered • Follow BPEWS recommended actions after every set of vital signs is measured
Weight	**Obtain patient weight on approved medical grade scale:** • On admission • And as ordered
Falls Risk Assessment	**Complete and document falls risk assessment:** • On admission • On transfer • Daily • Post fall • With any significant change in cognitive or mobility status
Clinical Situation	**Acute Care - Paediatrics**
Mobility, ADLs &Nutrition	• Ambulate patient as tolerated and document • Assess and document meal intake

Shift Summary	- Document that the unit standards of basic care – Paediatrics have been met Document a focus note if standards not met - Document on SBARD and perform TOA with every shift handover and place in chart - All assessments and interventions will be recorded in the patient chart before end of shift and TOA
Transfer to Another Unit/Department/ Level of care	- Write a focus note - Ensure Medication reconciliation is completed by the sending unit if not completed by sending unit then receiving unit will complete within 12 hours of transfer - Complete the Situation, Background, Assessment, Recommendations Documentation (SBARD) prior to transfer
Transfer to another Facility	- Ensure Medication reconciliation is completed - Write a focus note - Complete transfer forms as required as outlined by receiving facility
Discharge	- Ensure medication reconciliation completed - Complete discharge plan & checklist - Complete Discharge / health teaching screen as required - Write a discharge focus note that includes any follow up appointments - Complete Healthy Babies Healthy Children form if applicable - Provide parents with a copy of the discharge summary

Appendix G: Non Acute Care (LTLD, Rehab, ALC, Palliative, CCC) and Mental Health

Clinical Situation	Non Acute Care (LTLD, Rehab, ALC, Palliative, CCC) and Mental Health
Admission	**<u>Within 12 hours:</u>** • Complete antibiotic Resistant Organism Assessment (**Exception**; Mental Health) **<u>Within 24 hours:</u>** • Complete admission history & assessment • Document allergies within the EMR allergy routine • Complete nicotine assessment/management • Write admission focus note • Complete Best Possible Medication History and document in EMR home medication routine • Review advance care directives orders and document in EMR (**Exception**; Mental Health) • Adult patients are screened for nutritional risk on admission. This includes obtaining the patient's weight and assessing the patient's weight history. Any patients deemed at nutritional risk will have a dietitian referral entered. • Initiate the MH-RAI for Mental Health Patients only **<u>Exceptions: Markham Stouffville Hospital</u>** • Complete the "Med/Surg Admission In-house Transfer" assessment for patients admitted to Rehab or Complex Continuing Care from within MSH **<u>Exception: Uxbridge Hospital</u>** • Complete the "Designation Change Admit Same Unit" assessment and appropriate system assessment for patients transferred (discharged and readmitted) on same unit **<u>Within 72 hours for Rehabilitation</u>** • Complete FIM assessment **<u>Within 72 hours for Mental Health:</u>** • Complete MH-RAI assessment **<u>For CCC:</u>** **<u>For CCC:</u>** • On admission complete the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) Admission Background_Assessment • On day 14 after admission, complete the RAI-MDS Admission Assessment • Every 92 days after admission complete the RAI-MDS Quarterly Assessment

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	• 1 year after admission complete the RAI-MDS Annual Assessment • If length of stay is less than 14 days complete the RAI-MDS Discharge Prior to Completing Initial AssessmentAssessment
Clinical Situation	**Non Acute Care (LTLD, Rehab, ALC, Palliative, CCC) and Mental Health**

<table>
<tr><td>Room Set-up and Equipment checks</td><td>*Limit the quantity of supplies brought into the room to avoid potential contamination / wastage *

All Emergency Cart/Kits are checked as indicated on unit-specific checklists

All areas excluding Mental Health:
• Ensure oxygen flowmeter and all suction equipment is present, checked and functional at the beginning of each shift and after each use
o Rinse used suction equipment (tubing/Yankauer) with sterile water after each use
o Suction equipment changed (soft liner/tubing/Yankauer) every 24 hours, and “changed date” placed on outside of yankauer package
o Suction catheters are to be thrown out after every use – they are SINGLE USE ONLY.
o Yankauer after use to be will be placed inside the original package and secured so that it will not fall onto the ground. If it falls onto the ground it MUST be thrown out and a new Yankauer is obtained.
o Sterile water bottle used for suctioning to be labelled “Suction only”. Pour sterile water into a cup first, labeled with date and change cup every 24 hours.
• For patient with a tracheostomy, ensure following is available at bedside:
1. Emergency Trach Bin – containing a tracheostomy tube of the same size, one size smaller and a cuffed tracheostomy tube. Provided by Registered Respiratory Therapist.
2. Multiple spare inner cannulas (change every shift and PRN)
3. Obturator
4. Complete suction setup with Yankauer
5. Spare suction catheters (12F or 14 F)
a. Resuscitation bag</td></tr>
<tr><td>On transfer to the Transitional Care Unit</td><td><u>Within 24 hours:</u>
• Complete the “GEN Med/Surg Admit In-House Transfer as part of the “ALC Transfer” intervention set</td></tr>
<tr><td>Clinical Situation</td><td>Non Acute Care (LTLD, Rehab, ALC, Palliative, CCC) and Mental Health</td></tr>
</table>

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Head to Toe Assessment	• System assessments completed BID with the following exceptions: **Exceptions ALC:** • Complete system assessment weekly at minimum, increase assessments if patient condition warrants **Exception Mental Health:** • Complete system assessment as required as per patient clinical presentation
Assessment parameters not met/Significant findings	**When "Significant Findings" is identified:** • Complete a full system assessment • Document a focus note **Exception:** A focus note is not required if all system assessment parameters are met except for the presence of a documented longstanding health condition(s)
Additional Assessments/ Interventions	• Additional assessments may be required, but not limited to the following, Reproductive, Psychosocial, Ice Application, Epidural, PCA, Sleep Apnea Monitoring, Patient Education, Isolation Precautions, Intrathecal Single Dose, Pain, Wound Pressure Ulcer, CADD Pump, CIWA Alcohol Withdrawal, Education Ostomy, Drain, central lines, Neuro Scale, and tracheostomy The frequency of these assessments are completed based on orders, specific related policies/procedures/pathways and Clinician assessment • If patient admitted with an infusion or dressing or any type of intervention not started in hospital, an order must be obtained for continuation or discontinuation, refer to appropriate relevant policies (i.e. insulin pump) This must be documented in a focus note and the correct assessments added and completed Note: medications are not left at bedside for self-administration
Blood and blood products	• Document relevant blood product(s) in the "IV Fluid Volume" assessment • Complete the Laboratory Transfusion Record • Write a focus note • Ensure consent has been obtained (unless in emergency situation) • Monitor for transfusion reaction as per policy

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Parenteral Fluid/Fluid Status Monitoring	• Documents Intake and output from all sources (including enteral feeds) throughout the shift on “Intake and Output” screen • Document Intravenous (IV) fluid intake q8h on the “IV Fluid Volumes” screen (between 0630-0730, 1430-1530, and 2230-2330) • Complete vascular access (i.e. Peripherally Inserted Central Catheter (PICC), IV peripheral) assessment • Document Enteral Feeding q8h (between 0630-0730, 1430-1530, and 2230-2330) • Document Continuous Bladder Irrigation q8h on the “Genitourinary” screen (between 0630-0730, 1430-1530, and 2230-2330) • Document Hypodermoclysis in the “Hypodermoclysis” screen every shift
Voiding History & Bowel Function	• Assess and document every 8 hrs.
Vital Signs	A vital signs assessment includes: • Respiration rate • Temperature • Heart rate • Blood pressure • SpO2 • Pain Complete and document vital signs every 8 hours and in the following circumstances: • On admission • Before, during and after the administration of medications or application of therapies that affect cardiovascular, respiratory or temperature-control functions • Before, during and after a transfusion of any type of blood products • When patient reports specific symptoms of physical distress (e.g. feeling “funny” or “different” • When patient’s general physical condition changes (e.g. loss of consciousness, increase intensity of pain • Before, during and after a surgical or invasive diagnostic procedure • Postoperatively every 1 hour x 3, then every 4 hours x 24 and then every 8 hours or as ordered Exception Rehab/Restorative and Rehabilitation • Vital signs are completed in the above circumstances and daily Exception Mental Health: • Vital signs are completed in the above circumstances and PRN Exception ALC:

	• Vital signs are completed in the above circumstances and weekly • Assess and document pain daily
Neuro Vitals	• Complete and document as required as per protocol
Weight	**Obtain patient weight on approved medical grade scale:** • On admission • Every 30 days **Exception Mental Health:** • On admission and as required
Falls Risk Assessment	**Complete and document falls risk assessment:** • On admission • On transfer • Daily • Post fall • With any significant change in cognitive or mobility status
Mobility, ADLs &Nutrition	• Assess and document ADL every shift • Assess and document food/enteral intake every shift • Assess and document mobility level and mobility attained every shift
Skin Assessment	• Complete and document skin condition BID (Days & evenings) in the Integumentary assessment • Complete and document Wound/Dressing assessment every 12 hours or prn or as per orders Exception ALC: • Complete and document skin condition daily in the Integumentary assessment Exception Mental Health: • Complete and document skin condition as required in the Integumentary assessment

Braden Scale	**Complete and document Braden scale:**
	• Within 24 hours of admission
	• Every 2 days
	• Upon transfer
	• With any change in patient condition
	
	Exception ALC:
	• The Braden assessment will be completed:
	  o Within 24 hours of admission
	  o Weekly
	  o Upon transfer
	  o With any change in patient condition
	  o If patient has skin integrity concerns or change in health status document q48h
	
	Exception Mental Health:
	• Braden assessment will be completed as required (if patient has skin integrity concerns)

Mental Status Examination/Mental Status	• Complete the Confusion Assessment Method (CAM) and document daily between 1500h and 1900h (exception Mental Health) For **Mental Health only**; • Complete and document the mental status examination once per shift while patient awake and with any change in patient's condition • Write a focus note detailing significant changes in clinical presentation, safety issues, restraint use, interventions, and evaluation of care at least once per shift and as needed For patients under intensive observation write a focus note at least every 2 hours detailing changes in clinical presentation, safety issues, restraint use, interventions, and evaluation of care
Goals List	For **Mental Health only:** • Review and document the goals list once per shift
Shift Summary	• Document shift summary at the end of every shift • Verify that the unit standards of basic care have been met • Document a focus note if standards not met
Clinical Situation	**Non Acute Care (LTLD, Rehab, ALC, Palliative, CCC) and Mental Health**
Interprofessional Kardex	• Review/update each shift and with any change in plan of care or new orders received For **Mental Health only**; • Ensure observation and privilege level is updated as needed

Restraint use	• Complete the Restraint Minimization Assessment when patient displays behaviours harmful to self or others • If restraints have been implemented, document the Restraint Monitoring Record per policy
Change in Condition/unexpected occurrence or Critical Event	• Document detailed assessment of relevant system(s) • Write a focus note • Complete any relevant paper-based forms as indicated (e.g. cardiac arrest record)
Transfer to Another Unit/Department/ Level of care	• Write a focus note • Ensure Medication reconciliation (completed by the receiving unit) within 12 hours of transfer • Complete the Situation, Background, Assessment, Recommendations Documentation (SBARD) prior to transfer
Transfer to another Facility	• Ensure Medication reconciliation is completed • Write a focus note • Complete transfer forms as required as outlined by receiving facility • Provide telephone report to receiving facility using SBARD if not accompanying patient • If accompanying patient ensure all medication given prior to departure and/or obtain medications as ordered for transfer

Discharge	• Ensure Medication reconciliation completed
	• Complete discharge plan & checklist
	• Complete Discharge / health teaching screen as required
	• Write a focus note to include:
	    o time of discharge
	    o health teaching
	    o valuables returned
	
	Exception for Mental Health:
	The following assessment will also be completed:
	• MH-RAI discharge assessment

Death	• Refer to the death policy

Appendix H: Inpatient Allied Health – Clinical Dietetics

Clinical Situation	Clinical Dietitian
Prioritization Guidelines	The Markham Stouffville Hospital Standards of Care in Clinical Dietetics include the criteria for classification of three stages of nutrition risk: 1) **High Nutrition Risk** 2) **Moderate Nutrition Risk , and** 3) **Low Nutrition Risk** The classification of patients into the most appropriate stage of nutrition risk will provide direction for nutrition interventions including: • measurable, outcome based goals • follow-up frequency • chart audit evaluations Every Clinical Dietitian employed by Markham Stouffville Hospital will: • use the following descriptions in determining the appropriate stage of nutritional risk for their respective patient population • use the provided Criteria For Determining Nutrition Risk (as well as drawn upon their clinical experience) to categorize patient nutrition risk and prioritize their patient caseload Clinical Dietitans retain the flexibility to deviate from the clinical prioritization system where it is required in order to prioritize patient needs within the context of an interprofessional team and/or in exceptional circumstances. **Initiation of Clinical Dietetics Service:** ***High risk patients – Tier 1 (seen within 1 business day)*** • Patients with new enteral or parenteral tube feeds ***High risk patients – Tier 2 (seen within 1-2 business days)*** • All other patient types listed in the high nutritional risk section in Table 1 (Criteria For Determining Nutrition Risk Staging in Adults) **Moderate risk patients (Priority 2)**: To be seen for assessment/intervention within 2 business days of

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	identification (i.e. time of referral order entry). **Low risk patients (Priority 3):** To be seen by PRN referral only or as determined necessary by the dietitian.
Clinical Situation	**Clinical Dietitian**

	Please refer to Table 1 for Criteria For Determining Nutrition Risk Staging in Adults and examples for each level of nutrition risk. **<u>High Nutrition Risk (Priority 1)</u>** This patient population includes patients for whom nutrition plays a <u>critical role</u> in their rapidly changing medical situation and in the outcome of their medical condition. **<u>General Goals of Nutrition Intervention</u>** The general goals of nutrition intervention for patients who are deemed to be high risk are patient <u>specific</u> and <u>measurable</u>. The goals encompass the following: • to provide nutrition therapy appropriate to the circumstances • to augment and optimize nutrition status • to positively influence patient survival **<u>Objectives of the Standards</u>** 1. To assist in the development of nutrition care plans that will promote optimal nutritional status in high-risk patients for whom nutrition and/or nutrition related issues have immediate impact on their survival, medical condition and/or medical management. 2. To assist in the delivery of equitable care to patients 3. To assist in the evaluation of the impact of nutrition intervention.
Clinical Situation	**Clinical Dietitian**

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	Moderate Nutrition Risk (Priority 2) This patient population depends on nutrition interventions to decrease the progression and/or prevent the reoccurrence of their medical problem. In these patients, maintenance or improvement of their nutrition status will have a direct impact on their recovery and risk for issue reoccurrence. **General Goals of Nutrition Intervention** The general goals of nutrition intervention for moderate risk patients receiving oral nutrition are patient specific and measurable. The goals might encompass the following: • to positively influence the decreased recurrence/progression of condition • to provide nutrition therapy appropriate to the circumstances • to optimize nutrition status **Objectives of the Standards** 1. To assist in the development of nutrition care plans that will promote optimal nutritional status in patients for whom nutrition and/or nutrition related issues have immediate impact on the recurrence/progression of condition. 2. To assist in the delivery of equitable care to patients receiving oral nutrition and are defined as moderate nutrition risk. 3. To assist in the evaluation of the impact of nutrition intervention. **Low Nutrition Risk (Priority 3)** Nutrition interventions in this patient population focus on maintenance of a stable condition and/or maintenance/cultivation of good nutrition status. Disease prevention and palliative care patients fall into this classification. **General Goals of Nutrition Intervention** The general goals of nutrition intervention for low risk patients receiving oral nutrition are patient specific and measurable. The goals might encompass the following: • to positively influence the palliation of condition • to positively influence the prevention of disease • to maintain nutrition adequate/good nutrition status • to maintain stable condition
Clinical Situation	**Clinical Dietitian**

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	Objectives of the Standards 1. To assist in the development of nutrition care plans that will promote palliation of condition and/or good nutritional health and disease. 2. To assist in the delivery of equitable care to patients receiving oral nutrition and are defined as low nutrition risk. 3. To assist in the evaluation of the impact of nutrition intervention

Receipt of Referral	• Screens new referrals for stage of nutrition risk
	  o If order is for food preference determination, forward referral information to food services and cancel dietitian order
	  o If reason for order is unknown, discuss with ordering provider to determine if referral is required
	• Completes a chart review for the patient, including review of:
	  • History of present illness,
	  • Past medical history,
	  • Baseline nutrition status,
	  • Review of relevant vitals, labs, reports, etc., and
	  • Current nutrition status
	• Discusses patient status with interprofessional team, where appropriate (e.g. nursing, allied team)
	• Accepts new referrals in the electronic medical record

Assessment	• Completes a discipline-specific assessment for appropriate, referred patients • Documents full assessment findings in the electronic medical record • Identifies and documents significant findings, interpretation, actions taken, and plan of care with respect to the significant findings. • Communicates relevant assessment results with relevant interprofessional team members
Consent	• Obtains informed consent for clinical nutrition assessment, the nutrition plan of care, and each patient visit (see Health Care Consent Policy #270.914.914.030 for additional information) • Documents consent obtained

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Monitoring/Follow-Up	• Monitors patient status regularly while on clinical dietetics caseload
	• Monitoring can include:
	    • Reviewing the patient chart
	    • Discussing patient status with interprofessional team members
	    • Discussing patient status with patient and/or substitute decision maker
	• Adjusts nutrition care plan as needed if significant findings are identified
	• Communicates relevant findings and changes in the plan of care with relevant inteprofessional team members

Interprofessional Kardex	• Reviews and updates the kardex with relevant changes as needed
Change in Condition / Unexpected Occurrence / Critical Event	• Documents a detailed focus note • Completes relevant forms as needed (e.g. i-Report) • Liaises with relevant interprofessional team members, including the primary nurse and/or most-responsible provider
Transfer of Accountability	• Provides pertinent patient information to an oncoming clinical dietitian following the department Inpatient Allied Health Transfer of Accountability Process for Registered Dietitians document
Discharge	• Completes discharge plan and/or checklist (where appropriate) • Ensures patient has been provided with all relevant discipline-specific information and education required for a safe discharge • Ensures relevant, nutrition related community referrals have been completed • Documents a discharge summary where appropriate (e.g. patient being discharged to long term care)
Workload	• Documents associated workload for each patient visit in accordance with MIS guidelines
Clinician Accountability	All clinicians are responsible to ensure that they maintain competency in their areas of expertise as set out by the College of Dietitians of Ontario

TABLE 1: CRITERIA FOR DETERMINING NUTRITION RISK STAGING IN ADULT PATIENTS

The purpose of Criteria for Determining Nutrition Risk Staging is to optimize the prioritization of patients to be triaged and assessed by the Clinical Dietitian. It is not designed, nor is it meant, to suggest that all patients can or will be seen. The time parameters for assessment and follow-up are based, in part; on national and professional recommendations (1, 2). Nutrition risk, caseload and cross-coverage will determine the Clinical Dietitian's decision making process.

NUTRITION CARE LEVEL	PRIORITY 1	PRIORITY 2	PRIORITY 3
Nutritional Risk	High	Moderate	Low
Patient profile & disease activity	• Acute or active chronic disease/increased metabolic needs. • Nutrient losses (vomiting/ diarrhea) • Malnutrition • Needs close monitoring of intake or tolerance to diet and nutrition support. • Discharge pending nutrition education	• Acuity resolved, degree/risk of malnutrition stabilized. • Stable patient receiving therapeutic diet requiring: • nutrition education for discharge plans; and/or • b) referral for follow-up care.	• No known acute or active nutrition-related problems. • Patient receiving appropriate diet that is well tolerated and is able to meet nutritional needs.
Diet Texture or Feeding Modality	PN/EN NPO/Clear Fluids ≥ 3 days Full fluids ≥ 5 days	Pureed thickened diet Minced diet PN/EN < 1 month Thickened Fluids Multiple concurrent therapeutic diets	**Diet:** Regular, Soft, NAS, Low Fat /Cholesterol Weight Reduction Therapeutic supplements PN/EN > 2 months and stable
NUTRITION CARE LEVEL	**PRIORITY 1**	**PRIORITY 2**	**PRIORITY 3**
Nutritional Risk	High	Moderate	Low

Role of nutrition	Nutrition intervention plays a critical role in the patient's medical situation - central treatment and will influence the outcome (recovery and survival) of their medical problem.	Nutrition intervention aims to decrease progression and or prevent the reoccurrence of their medical problem. Maintenance or improvement of their nutritional status will have a direct impact on their recovery.	Nutrition intervention focuses on: • maintenance of a stable condition; • maintenance/cultivation of good nutritional status/quality of life; and/or • primary and secondary disease prevention.
Weight status	< 80% IBW or > 200% IBW ≤74% UBW Weight change (unintentional): >2% in 1 week >5% in 1 month >7.5% in 3 months >10% in 6 months ≥20% unlimited time	80-90% IBW 75-84%UBW Weight change (unintentional): 1-2% in 1 week 2-5% in 1 month 5-7.5% in 3 months 7.5-10% in 6 months 10-20% unlimited time	> 90% IBW 85-95% UBW
Subjective Global Assessment	C	B	A
Malnutrition screening tool	High malnutrition risk	Moderate malnutrition risk	Low malnutrition risk
Time parameters for	Assessment/intervention within 1-2 business days from identification (consult or through	Assessment/intervention within 2 business days from identification (consult or through	Assessment/intervention by PRN referral only Monitor q72hours*** or as deemed required
NUTRITION CARE LEVEL	**PRIORITY 1**	**PRIORITY 2**	**PRIORITY 3**
Nutritional Risk	High	Moderate	Low

assessment/intervention, monitoring and follow-up frequency:	screening) Patients admitted over a weekend will be seen within 2 business days AND Follow-up q24hours*** X 2, and then as deemed necessary (f/u minimum q5d)	screening) Patients admitted over a weekend will be seen within 2 business days AND Follow-up q48hours*** x 2, and then as deemed necessary until discharged from RD care (f/u minimum q5d)	
Examples	• Food intake less than 50% of meal tray • Poor intake < 25% of needs ≥ 3 days • Abnormal nutrition-related labs or Refeeding Syndrome • Newly initiated EN or PN support • Newly initiated insulin therapy (Type 1 or 2 or steroid-induced), or frequent or severe	• Poor intake < 50% needs ≥ 3-5 days • Existing texture-modified diet • Post-op diet teaching (ileostomy, myotomy, GI stent) • Monitoring existing EN or PN support • Stable CKD • Stable IBD • Commencing	• Adequate intake • Regular texture diet & fluids • Previous abdominal surgery with no changes in intake • Food preferences • HIV without malnutrition • Dyslipidemia [need some kind of cut off] • Weight management • Pre-existing chronic
NUTRITION CARE LEVEL	**PRIORITY 1**	**PRIORITY 2**	**PRIORITY 3**
Nutritional Risk	High	Moderate	Low

	hypoglycemia. • ARF/AKI, initiation of dialysis • Acute/flare IBD • Discharge pending nutrition education	texture modified foods or fluids.	medical conditions (e.g. DM, CHF, CAD) with therapeutic diet teaching in the past

***follow up timelines indicate regular working hours, as scheduled.

Appendix I: Allied Health – Occupational Therapy

<table>
<tr><th>Clinical Situation</th><th>Occupational Therapy</th></tr>
<tr><td>Prioritization Guidelines</td><td>All inpatients referred for Occupational Therapy (OT) will receive assessment and/or treatment services based on a clinical prioritization system. The prioritization of patients is based on set criteria and will ensure that patients are prioritized according to clinical need and patient safety.

The clinical prioritization system will facilitate daily caseload management and ensure the needs of patients with the highest clinical requirements are met first.

The clinical prioritization system is based on the following guiding principles:
• Improving patient safety and health status,
• Admission avoidance, and
• Decreasing patient length of stay.

Occupational Therapists retain the flexibility to deviate from the clinical prioritization system where it is required in order to prioritize patient needs within the context of an interprofessional team and/or in exceptional circumstances.

<u>High Risk Patients</u>
Rationale: Anticipating discharge within 24 hours: home alone or home with limited support. Immediate action required to prevent deterioration or exacerbation of a medical condition.
1. Discharge planning and equipment recommendations.
2. Safety assessments e.g., cognitive/perceptual.
3. Seating/positioning required for safety, skin issues and mobilization.

<u>Moderate Risk Patients</u>
Rationale: Anticipating discharge within 2-3 days or discharge to a supportive environment e.g. home with caregiver, rehab, retirement home, or convalescence or anticipating changes in discharge destination.
1. Discharge planning.
Providing recommendation and or positioning devices to prevent musculoskeletal injuries.</td></tr>
<tr><th>Clinical Situation</th><th>Occupational Therapy</th></tr>
</table>

	3. Treatment for patients with potential to upgrade discharge destination and/or to optimize function prior to discharge. **<u>Low Risk Patients</u>** Rationale: OT unlikely to affect immediate change or have immediate impact on the overall care/safety of the patient. 1. Patient is unable to participate in OT e.g., medically unstable, significant cognitive or behavioral issues. 2. Needs can be met in another setting. 3. Needs can be met through the inter-professional team e.g., ADL handout for surgical procedures. 4. Needs have been met through pre-operative teaching. 5. Patient conditions are long-standing and are not expected to change in the acute care setting. 6. Reassessment and/or progression of treatment plans for patients with set discharge plans. 7. Other splinting e.g., for chronic conditions. **<u>Note:</u>** Splinting for post-surgical plastic conditions will be referred to Outpatient OT and if they are not available the Unit can call a Hospital Orthopaedic Technologist.
Receipt of Referral	• Screen new referrals for appropriateness o If inappropriate, discuss with ordering provider to determine if referral can be cancelled • Complete a chart review for the patient, including review of: • History of present illness, • Past medical history, • Baseline functional status, • Social history, • Current functional status, and • Review of relevant vitals, labs, reports, etc. • Discuss patient status with interprofessional team (e.g. nursing, allied team) • Accept new referrals in the electronic medical record

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Assessment	• Complete a discipline-specific assessment for appropriate, referred patients • Document full assessment findings in the electronic medical record • Where significant findings are identified, an additional focus note may be documented to describe the findings, actions taken to address the findings, and the ongoing plan of care related to the significant findings • Communicate relevant assessment results with relevant interprofessional team members
Other Standardized Assessments	Complete as required based on patient coding/unit. Assessments may include: • Minimum Data Set (MDS) assessments/reassessments. Completed according to CCRS guidelines (e.g. Complex Continuing Care patients). • Functional Independence Measure (FIM) assessments. Completed according to NRS guidelines (e.g. Rehabilitation patients). • AlphaFIM assessments. Completed according to ministry guidelines (e.g. stroke patients). • The Barthel Index. Completed according to Reactivation Care Centre (RCC) guidelines (e.g. RCC patients). • Resource Matching & Referral assessments. Completed as needed based on discharge location.
Room / Equipment Set-Up	• Check all equipment for safety & ensure it is in good working order prior to providing to a patient for use (e.g. wheelchairs, therapy equipment) • Tag broken equipment & remove from patient care area. Notify relevant parties of the need for repair per usual protocol (e.g. allied health clinical leader, maintenance, biomedical services) • Ensure all equipment provided to a patient is clean. If unsure, clean and/or request that an environmental service attendant clean per IPAC protocols • Dedicate equipment to one patient only wherever possible o When equipment must be shared between patients, ensure it is thoroughly cleaned per IPAC protocols between patients
Consent	• Obtain informed consent for assessment, the OT plan of care, and each patient visit (see Health Care Consent Policy #270.914.914.030 for additional information) • Document consent obtained

Monitoring	- Monitor patient status regularly while on OT caseload - Monitoring can include: - Reviewing the patient chart - Discussing patient status at team rounds - Discussing patient status with interprofessional team members - Initiate a re-assessment and/or follow-up with the patient if significant findings are noted, and/or as per the treatment plan. Communicate findings with the inteprofessional team, including any relevant changes in the plan of care (e.g. documentation, update plan of care, team rounds)
Vital Signs	- Monitor vital signs before, during, and/or after assessment and treatment per clinical judgment, and within scope of practice - Vital signs monitored could include: - Heart rate - Blood pressure - Respirations - SpO2 - Pain - Document vital signs as per specific orders OR based on assessment findings, AND in the following circumstances: - When the patient reports specific findings of physical distress (e.g. patient is feeling “funny” or “different”) - When the patient’s general physical condition changes (e.g. loss of consciousness, increased intensity of pain)
Change in Condition / Unexpected Occurrence / Critical Event	- Document an appropriate focus note. Include relevant details if/when OT was involved or witnessed a critical event. - Complete relevant forms as needed (e.g. i-Report) - Liaise with relevant interprofessional team members, including the primary nurse and/or most-responsible provider
Transfer of Accountability	Provide pertinent patient information to an oncoming OT following the department Inpatient Allied Health Transfer of Accountability Process for Occupational Therapy document
Discharge	- Complete discharge plan and/or checklist (where appropriate) - Ensure patient has been provided with all relevant discipline-specific information and education required for a safe discharge

	• Ensure any community referrals within scope of OT to refer have been completed • Document a discharge summary
Workload	• Document associated workload for each patient visit in accordance with MIS guidelines
Clinician Accountability	All clinicians are responsible to ensure that they maintain competency in their areas of expertise as set out by the College of Occupational Therapists of Ontario

Appendix J: Allied Health – Physiotherapy

Clinical Situation	Physiotherapy

Assessment	All inpatients referred for Physiotherapy (PT) will receive assessment and/or treatment services based on a clinical prioritization system. The prioritization of patients is based on set criteria and will ensure that patients are prioritized according to clinical need and patient safety.
	
	The clinical prioritization system will facilitate daily caseload management and ensure the needs of patients with the highest clinical requirements are met first.
	
	The clinical prioritization system is based on the following guiding principles:
	• Improving patient safety and health status,
	• Admission avoidance
	• Decreasing patient length of stay, and
	• Prioritization of clients at risk of deterioration without physiotherapy intervention
	
	Physiotherapists retain the flexibility to deviate from the clinical prioritization system where it is required in order to prioritize patient needs within the context of an interprofessional team and/or in exceptional circumstances.
	
	<u>Priority One:</u>
	• Clients who may be discharged within 24hrs from hospital after PT assessment (new or current clients)
	• PT assessment that may prevent an admission (non-admitted ED client) with the following exclusion criteria:
	  o Clients who are bedbound or who use a mechanical lift transfer at baseline
	  o Clients who are mobilizing independently where the referral is for mobility exclusively
	  o Clients who will be returning to an institution with the capacity to provide PT service for assessment/intervention there. This includes long term care facilities (LTCF), complex care and rehabilitation
	• Acute cardiorespiratory clients with the following exclusion criteria:
	  o Chronic respiratory conditions without an acute flare

Clinical Situation	**Physiotherapy**

	o Conditions where PT intervention will not affect a change i.e. Pulmonary edema, pleural effusion, tuberculosis, consolidated pneumonia o Clients with a clear, dry cough o Clients who only require suctioning (please refer to nurse) o Clients coughing up secretions independently **Priority Two:** - Stroke new referrals - Falls risk/safety assessment - Orthopedic new referrals Ongoing caseload requiring active discharge planning **Priority Three:** - All other new referrals - Ongoing orthopedic patients (not for discharge within 24hours) and stroke rehab patients **Priority Four:** - Second visits to total joints and hip fractures - ongoing physiotherapy caseload
Other Standardized Assessments	Complete as required based on patient coding/unit. Assessments may include: • Minimum Data Set (MDS) assessments/reassessments. Completed according to CCRS guidelines (e.g. Complex Continuing Care patients). • Functional Independence Measure (FIM) assessments. Completed according to NRS guidelines (e.g. Rehabilitation patients). • AlphaFIM assessments. Completed according to ministry guidelines (e.g. stroke patients). • Resource Matching & Referral assessments. Completed as needed based on discharge location.
Workload	Every patient visit and the associated workload will be electronically documented in accordance with MIS Guidelines

Appendix K: Allied Health – Speech-Language Pathology

<table>
<tr><th>Clinical Situation</th><th>Speech-Language Pathology</th></tr>
<tr><td>Prioritization Guidelines</td><td>SLPs will retain the flexibility to deviate from the clinical prioritization system where it is required in order to prioritize patient needs within the context of an interprofessional team, patient readiness for SLP involvement, and/or in any exceptional circumstances. SLPs are also encouraged to utilize their buddy system as needed to manage caseload and priority demands.

1. High priority patients: Will ideally be seen for assessment/intervention within 1 business day from time of identified need.
Note: If a high priority patient is unable to be seen within the suggested timefame, the patient's priority level may move to the top of the high priority list.

2. Moderate priority patients: Will ideally be seen for assessment/intervention within 2-3 business days from time of identified need.
Note: If a moderate priority patient cannot be seen within this suggested timeframe, the patient's priority level may move to the top of the moderate priority list.

3. Low priority patients: Will be seen as determined necessary by the SLP, generally within 4-5 business days from time of referral or date of last SLP visit.
Note: If a low priority patient cannot be seen within this suggested timeframe, the patient's priority level may change to moderate.

<u>High Priority Classification</u>

This patient population includes patients who require urgent assessment/intervention to ensure immediate patient safety and/or to facilitate discharge.

The following are examples of patient populations that fall within this classification and are in order of priority:

1. Imminent discharges and work supporting immediate patient flow
2. Communication initial assessment – confirmed stroke, passed Stroke Dysphagia Screen (SDS), <u>for likely or possible imminent discharge</u>
3. Dysphagia assessment/re-assessment – new NPO, with no alternatives
4. Dysphagia assessment/re-assessment – on diet, with safety concerns (both known/unknown safety concerns)
5. Inpatient VFSS analysis</td></tr>
</table>

6. Dysphagia assessment/re-assessment – new NPO (up to 3 days), with alternatives
7. Communication facilitation to support decision-making regarding goals of care (if no SDM/POA)

Moderate Priority Classification

This patient population includes patients who require non-urgent assessment/intervention to ensure patient safety and/or optimize patient outcomes.

The following are examples of patient populations that fall within this classification and are in order of priority:

1. MODERATE priority patients – passed “see by date”
2. Communication initial assessment / comprehensive assessment
3. Dysphagia re-assessment – on diet, with nutrition/hydration concerns
4. Dysphagia assessment/re-assessment – longstanding NPO, with alternatives
5. Dysphagia assessment/re-assessment – other
6. Non-imminent discharge planning
7. LOW priority patients who have passed “see by” date (except low priority 3, 6, 7, and 8)

Low Priority Classification

This patient population includes patients whose assessment/intervention is focused on maintenance and/or optimizing patient outcomes.

The following are examples of patient populations that fall within this classification and are in order of priority:

1. Dysphagia therapy
2. Communication therapy – stroke rehab
3. Low priority 6, 7, or 8 patients who have passed “see by” date
4. Dysphagia re-assessment – long standing NPO, with alternatives
5. Dysphagia re-assessment – on diet, with no safety concerns, to see for texture upgrades, removal of strategies, medication administration
6. Dysphagia re-assessment – other
7. Communication therapy – other
8. Communication partner training / Communication facilitation – other

Note: These high, medium, and low priority classifications do not include every possible patient and clinical scenario. In such circumstances, SLPs will use their

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	professional and clinical judgment around prioritization, keeping in mind the above guiding principles.

Receipt of Referral	• Screen new referrals for appropriateness
	  ○ If inappropriate, discuss with ordering provider and/or the interprofessional team to determine if referral can be cancelled
	• Complete a chart review for the patient, including review of:
	  • Reason for referral
	  • History of present illness,
	  • Relevant past medical history,
	  • Activity limitations and/or participation restrictions
	  • Baseline functional status,
	  • Social history,
	  • Current functional status, and

	• Review of relevant vitals, labs, reports, etc. • Discuss patient status with interprofessional team as needed (e.g. nursing, allied team) • Accept new referrals in the electronic medical record
Assessment	• Complete a discipline-specific assessment for appropriate, referred patients • Document full assessment findings in the electronic medical record • Where significant findings are identified, findings, the actions taken to address them, and the ongoing plan of care related to the significant findings will be documented • Communicate relevant assessment results with relevant interprofessional team members
Other Standardized Assessments	Complete as required based on patient coding/unit. Assessments may include: • Functional Independence Measure (FIM) assessments. Completed according to NRS guidelines (e.g. Rehabilitation patients). • Resources Matching & Referral assessments. Completed as needed based on discharge location
Videofluoroscopic Swallowing Studies	• Inpatient videofluoroscopic swallowing studies (VFSS) will be completed by trained Speech-Language Pathologists per their clinical judgment about patient care needs
Room / Equipment Set-Up	• Only supplies that are needed for a particular S-LP assessment/intervention will be brought into a patient room (e.g. swallowing assessment supplies) • When supplies must be removed from the patient room, ensure they are thoroughly cleaned per IPAC principles upon removal
Consent	• Obtain informed consent for assessment, the S-LP plan of care, and each patient visit (see Health Care Consent Policy #270.914.914.030 for additional information) • Document consent obtained

Monitoring	• Monitor patient status regularly while on S-LP caseload
	• Monitoring can include:
	  • Reviewing the patient chart
	  • Discussing patient status at team rounds
	  • Discussing patient status with interprofessional team members
	• Initiate a re-assessment and/or follow-up with the patient if significant findings are noted, and/or as per treatment plan. Communicate findings with the inteprofessional team, including any changes in the plan of care (e.g. documentation, update plan of care, team rounds)

Vital Signs	• Monitor vital signs before, during, and/or after assessment and treatment per clinical judgment, and within scope of practice • Vital signs monitored could include:

	• Respirations • SpO2 • Document vital signs based on assessment findings, AND if found to be abnormal • Communicate relevant vital sign findings with relevant interprofessional team members
Interprofessional Kardex	• Review and update relevant sections of the kardex with any change in the recommended plan of care (e.g. strategies for swallowing safety, medication administration recommendations) •
Change in Condition / Unexpected Occurrence / Critical Event	• Document a detailed focus note • Complete relevant forms as needed (e.g. i-Report) • Liaise with relevant interprofessional team members, including the primary nurse and/or most-responsible provider
Transfer of Accountability	• Provide pertinent patient information to an oncoming S-LP following the department Inpatient Allied Health Transfer of Accountability Process for Speech Language Pathology document
Discharge	• Complete discharge plan and/or checklist (where appropriate) • Ensure patient has been provided with all relevant discipline-specific information and education required for a safe discharge • Ensure any community referrals within scope of S-LP to refer have been completed • Document a discharge summary
Workload	• Document associated workload for each patient visit in accordance with MIS guidelines
Clinician Accountability	• All clinicians are responsible to ensure that they maintain competency in their areas of expertise as set out by the College of Audiologists and Speech-Language Pathologists of Ontario

Appendix L: Allied Health – Social Work

<table>
<tr><th>Clinical Situation</th><th>Social Work</th></tr>
<tr><td>Prioritization Guidelines</td><td>
All inpatients referred for Social Work (SW) will receive assessment and/or treatment services based on a clinical prioritization system. The prioritization of patients is based on set criteria and will ensure that patients are prioritized according to clinical need and patient safety.
The clinical prioritization system will facilitate daily caseload management and ensure the needs of patients with the highest clinical requirements are met first.
The clinical prioritization system is based on the following guiding principles:

Improving patient safety and health status,
Admission avoidance, and
Decreasing patient length of stay.

Social Workers retain the flexibility to deviate from the clinical prioritization system where it is required in order to prioritize patient needs within the context of an interprofessional team and/or in exceptional circumstances.
<u>High Priority</u>

Clients with urgent safety risks including, but not limited to:

Child safety issues and/or involvement of Children’s Aid Society
Elder abuse or neglect
Domestic violence
Suicidality/low-mood

Clients who will be discharged within 24 hours and require SW intervention to support discharge planning for palliative care or urgent resources
Grief/bereavement due to sudden loss
Clients experiencing Code Blue/Pink
Clients experiencing OBS alerts
Identification of legal decision makers (Substitute Decision Maker’s, Guardian’s and Powers of Attorney, Public Guardian and Trustee, Consent and Capacity Board, Treatment Decision Unit and location of next of kin)
Wills and Powers of Attorney for clients with terminal prognosis
Unclaimed bodies
Client without identification (i.e. Jane/John Doe’s)
No fixed address clients requiring emergency shelter placement
Clients requiring linking to addiction Detox Centre’s and residential treatment programs

</td></tr>
</table>

	• Team consultation specific to ethical dilemmas
Clinical Situation	**Social Work**

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<table>
<tr><td></td><td>
<u>Moderate Priority</u>

Clients in family conflict
Non-insured clients (no OHIP, Interim Federal Health Refugee program, non-residents)
Clients who require assistance with finances/financial management
Clients who require assistance with housing (group homes, domiciliary hostels etc.)
Clients requiring support at end of life (goals of care, MAID, community palliative care services)
Clients requiring assistance with legal documentation for surrogacy/adoption
Counselling for clients struggling with anxiety, depression, difficulty coping with health status
Clients with consent/capacity concerns
Clients requiring addiction resources and counselling
Clients requiring support to cope/adjust with illness (i.e. new diagnosis, prognosis)
Screening tools to be completed in accordance with Clinical Pathway guidelines (i.e. PHQ-9, Depression Screening tools
Clients requiring support, education, and linkages to community partners

<u>Low Priority</u>

Clients requiring support, education, and linkages to community partners (non-urgent)
Assistance in completing forms
Transportation assistance
Request for letters

Out Patient referrals and follow up will be triaged according to the prioritization guidelines and acuity.

Weekend coverage will follow the prioritization guidelines with priority given to the following areas: ICU, ED, CCS (Childbirth and Children’s Services), Palliative Care patients
</td></tr>
<tr><th>Clinical Situation</th><th>Social Work</th></tr>
<tr><td>Receipt of Referral</td><td>

Screen new referrals for appropriateness
If inappropriate, discuss with ordering provider to determine if referral can be cancelled
Complete a chart review for the patient, including review of:

History of present illness,
Past medical history,
Social history,
Review of relevant reports, etc.

</td></tr>
</table>

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	• Discuss patient status with interprofessional team (e.g. nursing, allied team) • Accept new referrals in the electronic medical record
Assessment	• Complete a discipline-specific assessment for appropriate, referred patients • Document full assessment findings in the electronic medical record • Where significant findings are identified, actions taken to address the findings, and the ongoing plan of care related to the significant findings will be documented • Communicate relevant assessment results with relevant interprofessional team members
Other Standardized Assessments	Complete as required based on patient coding/unit. Assessments may include: • Resources Matching & Referral assessments. Completed as needed. • Edinburg Postnatal Depression Screening (EPDS). Completed with postpartum patients as needed based on clinical judgment Patient Health Questionnaire – 9 or Stroke Aphasic Depression assessments. Completed as per stroke clinical pathway(s).
Consent	• Obtain informed consent for assessment, the SW plan of care, and each patient visit (see Health Care Consent Policy #270.914.914.030 for additional information) • Document consent obtained

Monitoring	• Monitor patient status regularly while on SW caseload
	• Monitoring can include:
	    • Reviewing the patient chart
	    • Discussing patient status at team rounds
	    • Discussing patient status with interprofessional team members
	• Initiate a re-assessment and/or follow-up with the patient if significant findings are noted, and/or as per the treatment plan. Communicate findings with the inteprofessional team, including any changes in the plan of care (e.g. documentation, update plan of care, team rounds)

Interprofessional Kardex	• Review and update as needed
Change in Condition / Unexpected Occurrence / Critical Event	• Document a detailed focus note • Complete relevant forms as needed (e.g. i-Report) • Liaise with relevant interprofessional team members, including

	the primary nurse and/or most-responsible provider
Transfer of Accountability	• Provide pertinent patient information to an oncoming SW following the department Inpatient Allied Health Transfer of Accountability Process for Social Work document
Discharge	• Complete discharge plan and/or checklist (where appropriate) • Ensure patient has been provided with all relevant discipline-specific information and education required for a safe discharge • Ensure any community referrals within scope of SW to refer have been completed • Document a discharge summary
Workload	• Document associated workload for each patient visit in accordance with MIS guidelines
Clinician Accountability	All clinicians are responsible to ensure that they maintain competency in their areas of expertise as set out by the Ontario College of Social Workers and Social Service Workers

Appendix M: Allied Health – Therapeutic Recreation

Clinical Situation	Therapeutic Recreation

Prioritization Guidelines	All inpatients referred for Therapeutic Recreation (TR) will receive assessment and/or treatment services based on a clinical prioritization system. The prioritization of patients is based on set criteria and will ensure that patients are prioritized according to clinical need and patient safety. The clinical prioritization system will facilitate daily caseload management and ensure the needs of patients with the highest clinical requirements are met first. The clinical prioritization system is based on the following guiding principles: • Improving patient safety and health status, • Admission avoidance, and • Decreasing patient length of stay. Therapeutic Recreation Specialists retain the flexibility to deviate from the clinical prioritization system where it is required in order to prioritize patient needs within the context of an interprofessional team and/or in exceptional circumstances. **High Priority** • Patients who require support, education, & linkages to community partners • Patients with limited social/family support and therefore limited recreational participation in hospital • Patients exhibiting acute behaviours (including restlessness, physically protective behaviours, verbally protective behaviours, delirium, sun downing, etc.) • Patients who have not been seen as per TR Treatment Plan frequency **Moderate Priority** • Patients with a slight change in rehab/ALC status (e.g. low hemoglobin, low blood sugar, low oxygen saturation, high blood pressure) • Patients whose rehab status has stabilized (patient has plateaued) and is now being seen for maintenance • Patients whose status has been changed to ALC due to inability to meet rehab goals
Clinical Situation	**Therapeutic Recreation**

<table>
<tr><td></td><td><u>Low Priority</u>
Medically unstable patients
Patients who are unable to participate due to cognitive impairment
Patients who are unable to participate due to inability to follow verbal instruction/visual cues</td></tr>
<tr><td>Receipt of Referral</td><td>Screen new referrals for appropriateness
If inappropriate, discuss with ordering provider to determine if referral can be cancelled
Complete a chart review for the patient, including review of:
History of present illness,
Past medical history,
Social history,
Leisure interests and participation history,
Baseline and current functional status, and
Review of relevant vitals, labs, reports, etc.
Discuss patient status with interprofessional team (e.g. nursing, allied team)
Accept new referrals in the electronic medical record</td></tr>
<tr><td>Assessment</td><td>Complete a discipline-specific assessment for appropriate, referred patients
Document full assessment findings in the electronic medical record
Where significant findings are identified, an additional focus note may be documented to describe the findings, actions taken to address the findings, and the ongoing plan of care related to the significant findings
Communicate relevant assessment results with relevant interprofessional team members</td></tr>
<tr><td>Other Standardized Assessments</td><td>Complete as required based on patient coding/unit. Assessments may include:
Minimum Data Set (MDS) assessments/reassessments. Completed according to CCRS guidelines (e.g. Complex Continuing Care patients).</td></tr>
<tr><td>Room / Equipment Set-Up</td><td>Check all equipment for safety & ensure it is in good working order prior to providing to a patient for use (e.g. wheelchairs, therapy equipment)
Tag broken equipment & remove from patient care area. Notify relevant parties of the need for repair per usual protocol (e.g. allied health/unit clinical leader, maintenance, biomedical services)
Ensure all equipment provided to a patient is clean. If unsure, clean and/or request that an environmental service attendant clean per IPAC protocols</td></tr>
</table>

	• Dedicate equipment to one patient only wherever possible o When equipment must be shared between patients, ensure it is thoroughly cleaned per IPAC protocols between patients
Consent	• Obtain informed consent for assessment, the TR plan of care, and each patient visit (see Health Care Consent Policy #270.914.914.030 for additional information) • Document consent obtained
Monitoring	• Monitor patient status regularly while on TR caseload • Monitoring can include: • Reviewing the patient chart • Discussing patient status at team rounds • Discussing patient status with interprofessional team members • Initiate a re-assessment and/or follow-up with the patient if significant findings are noted, and/or as per the treatment plan. Communicate findings with the inteprofessional team, including any changes in the plan of care (e.g. documentation, update plan of care, team rounds)
Interprofessional Kardex	• Review and update after with any change in the recommended plan of care
Change in Condition / Unexpected Occurrence / Critical Event	• Document a detailed focus note • Complete relevant forms as needed (e.g. i-Report) • Liaise with relevant interprofessional team members, including the primary nurse and/or most-responsible provider
Transfer of Accountability	• Provide pertinent patient information to an oncoming TR following the department Inpatient Allied Health Transfer of Accountability Process for Therapeutic Recreation document
Discharge	• Complete discharge plan and/or checklist (where appropriate) • Ensure patient has been provided with all relevant discipline-specific information and education required for a safe discharge • Ensure any community referrals within scope of TR to refer have been completed • Document a discharge summary
Workload	• Document associated workload for each patient visit in accordance with MIS Guidelines
Clinician Accountability	All clinicians are responsible to ensure that they maintain competency in their areas of expertise as set out by Therapeutic Recreation Ontario