Title: Cognitively Complex Standards of Care	
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Performed by: Nursing Staff	**Revised by:** Jody/Anastasia
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PURPOSE:

The standard of care for admission to Bluewater Health (BWH) is the delivery of quality patient care in alignment with our strategic priorities as outlined in our mission statement. BWH is committed to providing patient and family centered care. All patients admitted into the cognitively complex care (CCC) ward will be assessed and managed in a timely manner with every effort to admit within 2 hours when a bed is available. The standards identified in this document define minimum expectations all patients can expect to receive from our interprofessional staff. If a patient's condition warrants an increased level of care, interventions will be customized to reflect this and the most responsible health care provider (MRP) will be notified.

Accountability:

- All nurses are professionally accountable to ensure they maintain competency as stated by the College of Nurses of Ontario (CNO) (Professional Standards, 2015)
- All nurses consistently demonstrate professional conduct in accordance with CNO standards for nursing practice and ethics; primary duty to ensure safe, competent, ethical nursing care to the patient
- All nurses are accountable and self directed to complete assigned BWH e-learning modules
- All nurses will work collaboratively with other members of the health care team
- All nurses are responsible to inform the most responsible physician of a change in patient status, follow through with orders and document the assessments, interventions, and response
- All nurses demonstrate Compassion, Accountability, Respect, and Excellence (CARE) while caring for patients and their families as stated by BWH mission and values.
- All nurses will introduce themselves by name and designation to patients and families; wear and display their hospital ID badges
- Plans of care will be explained to the patient and families in a collaborative effort from the interdisciplinary team
- All nurses should recognize and ensure competency in caring for the patient by maintaining:
    - Basic Cardiac Life Support (BCLS)
- All nurses will target to complete and maintain certification in the following courses within 1 year of hire:
    - Gentle Persuasive Approaches
    - Non-crisis intervention
- All nurses are encouraged to attend educational sessions internally and externally to support professional standards of continuing education in accordance with BWH's strategic plan for Inspired People

Assignments:

- Daily nursing assignments are completed by the charge nurse or based on the competencies of the nurses working to ensure a fair and equitable assignment

Infection Prevention and Control:

- All nurses shall protect themselves and their patients through compliance with Infection Prevention and Control (IPC) standards and policies
- If an acute infection or hazardous drug use has been identified the appropriate sign will be placed outside the patients room
- Isolation precautions will be adhered to by all BWH staff and the required personal protective equipment (PPE) will be worn as per BWH policy
- Nursing will complete hand hygiene according to the 4 moments of hand hygiene
- If a patient FAILS the ARI screen, staff will initiate Droplet/Contact precautions (with curtains pulled, if in semi or ward room). Appropriate signage will be used
- Preferred accommodation for Droplet/Contact Precautions is a single room with a dedicated patient toilet and sink. If single rooms are unavailable, cohorting of those who are confirmed to have the same infectious agent maybe acceptable. If cohorting occurs, privacy curtain must remain drawn between patients
- Patients are required to remain in their room unless required for diagnostic purposes. All therapies should occur in patient room until symptoms have resolved
- If patient must leave their room, they must perform hand hygiene and place a procedure mask over the mouth and nose when tolerated
- MRSA and VRE Screening is completed for patients who; had previous colonization or infection, greater than 12 continuous hours in any health care facility, receive home care with an indwelling medical device, or recent exposure to MRSA/VRE/ESBL
- Patients diagnosed with C.difficile will be kept in Additional Precautions until they are symptom free for 48 hours.
- Nursing must consult with Infection Prevention and Control (Shift Manager on off hours) PRIOR to discontinuing any Additional Precautions on C difficile, MRSA, VRE or ESBL
- Follow Public Health Officer's directives for Community outbreaks via Bluewater Health Infection Prevention and Control Team
- Nursing will communicate any issues with Infection Prevention and Control team daily and throughout the day as issues arise
- Nursing will perform a risk assessment with each patient interaction and will follow Infection Control and Occupational Health & Safety guidelines for procedures and care needs of patients and staff using appropriate Personal Protective Equipment (PPE).
- Nursing will educate family and visitors re: Infection Control procedures and use of PPE when visiting the patients in precautions. Nursing will contact Infection Prevention and Control if additional education required
- Staff will monitor visitation / no visitation during outbreaks
- When a patient is admitted from an Outbreak facility, staff will follow case-specific direction given by Infection Prevention and Control (or Shift Manager), regarding initiation and duration of precautions, etc.

Safety:

- Every effort will be made to ensure a safe environment for patients, staff and volunteers
- All patients will wear an identification bracelet applied at the registration desk
- Staff will ensure use of PPE for interactions with any patients identified as aggressive or presenting with bizarre unpredictable behaviour, or any other presenting complaint that

may present a risk to staff. Refer to the Identification of Aggressive Behaviours Policy for further direction in the care of patients identified
- Positive identification of the patient will include a minimum of two patient identifiers
- Two patient identifiers will be checked prior to any intervention (i.e. Medication administration, blood draw, Diagnostic imaging test) with the patient
- Staff will adhere to patient privacy and confidentiality
- Use restraints only when required to protect the patient, the healthcare workers and others. If restraints are necessary, they should be in the least restrictive form and for the shortest time possible. For further details refer to the Least Restraint (last resort) Program Policy
- Falls risk assessment will be completed on all patients. Refer to the Falls Prevention Policy for further direction in patients identified and interventions
- All nurses will follow up with Biomed regarding malfunctioning equipment by calling Biomed if the need is emergent (i.e.: central station) or by using a yellow tag to flag the equipment as deficient/faulty and remove equipment from the patient care area
- Regular rounding will occur on each patient at a minimum of every hour to ensure quality, safety and efficient care for patients focused on: The 4 P's of Rounding (Pain - Personal Care – Position – Perimeter)

Admission Documentation Assessment:
- The nurse will assess the patient within 15 minutes of admission for level of consciousness, vital signs, intravenous infusions, other tubing, and immediate care needs
- All documentation standards will meet the College of Nursing of Ontario guidelines as stated in the practice standard Documentation, Revised 2008.
- Documentation will reflect all aspects of the nursing process including assessment, planning, intervention, and evaluation
- Documentation will include both objective and subjective data

Admission Clinical History:
- The date/time of the assessment are to be documented
- The applicable care plans will be added/removed in the initial history screen during admission to the unit
- Resuscitation Level will be identified and documented on admission
- Acute Respiratory Illness Screening will be completed on each admission and documented daily
- Focus Note: Admission (Can Text) D: At- (insert time), admitted to Petrolia Bluewater Health, room number, patient admitted from _____, patient accompanied by _____
- The SBAR from the transferring unit must be signed by the receiving nurse to close the loop of communication in the transfer of care

Admission Physical Assessment:
- The nurse must complete the admission assessment documentation within two (2) hours of arrival to the inpatient unit
- All patients will be weighed on admission when possible
- Weight and height are entered into the administrated data screen and updated on the care plan monthly
- The assessment will be completed and documented using the criteria provide in each systems documentation field

- This documentation will be driven by the "Within Defined Limits" (WDL) or "Significant Findings"(SF)
- The following assessments will be completed on admission, once per shift and when required
  - ✓ Neurological
  - ✓ Cardiac
  - ✓ Neurovascular
  - ✓ Respiratory
  - ✓ Gastrointestinal
  - ✓ Genitourinary
  - ✓ Musculoskeletal
  - ✓ Skin, including Braden Risk assessment, Pressure Injury
  - ✓ Pain Assessment
  - ✓ Oral Health
  - ✓ Behaviour
  - ✓ Fall risk (BEEEACH model)
  - ✓ Client Centered Care: Goals and concerns
  - ✓ Confusion/Delirium (CAM)
- Any assessment that results in a SF will be accompanied by either a comment in that screen or focus note that pertains details to these findings
- Issues that have been identified by a SF from the admission history and physical will trigger interventions for the patients care plan
- Any SF requiring further treatment outside of admission orders will be reported to the charge nurse and MRP within 1 hour to facilitate a revision to plan of care

Interventions:

- The care plan will be electronically generated with completion of the initial assessment
- Care plans will be individualized to patient care needs by adding and deleting interventions that are applicable

Vital Signs

- Vital sign measurements will include: temperature, pulse, respirations, blood pressure, oxygen saturation levels and any oxygen therapy
- All vital signs must be documented into the vital sign intervention screen
- Vital signs will be obtained as per the MRP orders (In the absence of a specific order, at a minimum vitals signs are to be measured and documented monthly, and as needed for changes to patient condition
- Vital signs on patients deemed alternative level of care (ALC) are done weekly unless the patient warrants a change in frequency
- The nurse is responsible for reporting any concerns at shift handover
- Early Warning Scoring System (EWSS) triggers a rising acuity (grey) or an alert (red) nurses will follow directions provided in that documentation screen and report findings to nursing liaison and/or the MRP
- Any SF documented must be accompanied by a vital signs altered focus note

Gastrointestinal and Nutrition:

- Each patient will be assessed and the percentage of food, beverages and supplements taken (0%, 25%, 50%, 100%, NPO) will be document in the care plan three times a day at meal times

- If there are any nutritional concerns and/or dehydration suspected, the nurse will consult with the Registered Dietitian

Bladder and Bowel Regime:

- Assessment of bladder and bowel function will be documented each shift and as needed
- Documentation must include the presence of a catheter, urine assessment, and continence
- Lack of BM for three days or greater may require action if this is not consistent with the patient's pre admission pattern

Fluid and Electrolyte Balance (Intake and Output):

- All intravenous (IV) solutions must run on a pump
- All IV infusion sites will be checked hourly
- IV pumps must be reviewed at the beginning of every shift to confirm the pump has been programmed with the correct solution/s and infusion rate/s
- Intake and output (I/O) will be documented at 0500 and 1700
- I/O will contain all intake (oral, nasogastric, intravenous) and all output (catheter, drains)
- Assessment of the 24 hour fluid balance will be made each day to ensure that adequate hydration and elimination is relevant to the patient's condition
- Assess the patency of all drainage tubes every four (4) hours for the first twenty-four (24) hours, then every six (6) hours for the next twenty-four(24)hours then every twelve hours and as needed, unless otherwise indicated

Activities of Daily Living:

- In collaboration with physiotherapy (PT), occupational therapy (OT), and behaviour support the appropriate activity levels will be established and implemented into each patient's care plan
- Assist the patient where appropriate to retain or maintain optimal activity levels
- Cluster activities to assist the patient to obtain rest and sleep
- All immobile patients must be turned and reposition every two (2) hours unless contraindicated

Integumentary:

- If activity is limited or the patient is at a high risk for pressure injury, the skin should be observed at a minimum every two (2) hours and any changes documented in the nursing notes and on the SBAR
- If the patient is at a high risk for pressure injury implement the use of the appropriate devices: therapeutic surfaces, heel protection, pressure reducing cushions
- Integumentary Assessment must be completed on admission and re-evaluated every shift
- Patient will be encouraged to perform basic hygiene to their level of ability, assistance will be provided by staff and or family when required (e.g. shaving and bathing)
- Tub baths or showers are provided weekly on a rotating schedule with personal care daily each morning and as needed throughout the day tailored to the needs of the patient
- If the patient is unable to ambulate to the washroom, hand hygiene will be provided before each meal and after using the bedpan/urinal
- Mouth care will be provided based on the needs of the patient and will done at a minimum twice a day
- All pressure injury areas must be staged using a validated pressure injury tool (Bates-Jensen Wound Assessment Tool) and any injury staged three (3) or greater **MUST** have a wound consult

- All diabetic foot ulcers must have a consult sent to a skin and wound champion/clinical educator
- All wound assessments must be accompanied by a pain assessment

Pain:

- Pain will be assessed at the beginning of each shift and when needed (PRN)
- Patients that require scheduled/as needed pain medication will be provided analgesia prior to any therapy and/or procedures
- Document in a focus note if there is a significant finding including, pain scale, sedation scale and severity of pain and management
- The MRP must be contacted if the pain is not controlled

Fall Risk:

- All patients will be assessed on admission using the Morse Fall Scale to determine the patient's risk for falling. Refer to the Falls Prevention Policy for further direction.
- All fall reassessments are completed q7days or in the event of a fall
- All in-patients scoring greater than 45 points on the Morse Fall Scale will have interventions implemented using the BEEEACH Model
- Complete a post fall huddle to discuss the cause and possible prevention measures
- Document the fall
- All falls must be communicated on the SBAR, to the nursing liaison, MRP and family
- Any patient who has fallen, must have a RL6 completed

Medication:

- Medication administration standards will be in accordance to CNO Medication Practice Standard 2015
- Allergies and food intolerance will be assessed, documented and verified on every patient using the allergy module in Meditech on admission and when a new allergy/intolerance develops
- Any patient with an allergy will have a red patient identifier armband applied
- Allergies must be identified on the physician's order sheet /physician order sets and every medication record sheet
- Allergy should be verified with each 24 hour chart check to ensure that the allergies have populated onto the pharmacy profile sheet that is printed each night
- All medications are to be transcribed using the generic name
- Scan all physician orders to pharmacy
- A ward clerk may transcribe an order to the MAR/cMAR. Transcription of medication orders must be verified by a nurse before the medication is administered. Refer to the medication policy for further direction
- Prior to administration, the nurse must verify all new orders following the ten (10) rights of medications
- Orders must be checked every twenty-four (24) hours
- Medications are to be removed from the bedside and stored in a secure area until they can be taken home by the family or the patient is discharged

Discharge Education and Planning:

- In collaboration with the interprofessional team, discharge planning will commence on admission to the unit and weekly
- Discharge plans will be reviewed weekly with physician and at the interprofessional team rounds

- When the discharge order is received after 1000 patients who can be discharged directly home are encouraged to vacate their room within 2 hours
- All referrals/tests will be arranged and communicated to the patient/family or facility assuming care prior to discharge home
- A complete discharge record will be given to each patient or facility assuming care on discharge, it will include: discharge teaching from all applicable interdisciplinary teams instructions, referrals and follow up tests pending
- Discharge instructions will be provided to all patients or facilities assuming care including medication, changes and new prescriptions, discharge instructions, educational material relative to diagnosis, procedure or follow up
- Upon discharge, documentation should include: disposition, destination, and mode of discharge/transportation
- If patient is transferred to a Retirement Home or Long Term Care facility a telephone/verbal transfer of accountability will occur
- Facilitate transportation options if required (voyageur, taxi, family). Refer to the Guidelines for Ambulance and Non Urgent Patient Transportation for further direction

End of Life Care:

- If a patient has died or prior to death, Trillium Gift of Life will be notified using the Routine Notification Worksheet and the TGLN number is to be documented in Meditech
- Death is documented in a focus note
- A death worksheet is documented in Meditech

Transfer of Accountability (TOA):

- Verbal TOA will occur when patient care is transferred during change of shift
- When a patient is transferred to another unit of care (i. e. CT suite), the paper SBAR tool will be fully completed to the best of the nurse's ability and sent to the receiving unit with a verbal report
- When a patient requires transfer to another acute care facility, the nurse will collaborate with colleagues, charge nurse/ nursing liaison, EMS, and/or Voyageur to facilitate a safe and appropriate transfer based on the needs of the patient and the department

REFERENCES:

"Practice Standards Documentation." www.cno.org College of Nurses of Ontario, 2008. Web. 22, July 2015.

BWH Policies:
CPM-P&PC-A-1407: Medication Reconciliation
CPM-P&PC-A-11.01 Medication administration and documentation
CPM-P&PC-A-14.08: Managing medications brought from home including narcotics
CPM-UM-A-1.17 SBAR Intra-hospital report: communication and documentation
CPM-PtS-A-6.01 Patient Identification:
CPM-PtS-A-1.03 Falls Prevention Program
CPM-PtS-A-8.01 Hazardous Drugs
CPM-PtS-A-7.01 Identification of Aggressive Behaviours Policy
CPM-UM-A-1.16 Guidelines for Ambulance and Non Urgent Patient Transportation
CPM-PPC-A-59.01 Preservation of Forensic Evidence
CPM-P&PC-A-45.06 Cardiac (ECG) Monitoring Policy

CPM-P&PC-A-43.01 Policy Management of Fecal Incontinence with Flexi-seal FMS
CPM-P&PC-A-42.02 Resuscitation
CPM-UM-A-1.14 Bed Management and full hospital protocol
CPM-UM-A-1.09 Discharge policy
CPM-UM-A-1.17 SBAR Intra-hospital report: communication and documentation
CPM-P&PC-A34.01 Skin and wound care
CPM-Pts-A-1.01: Allergic and Adverse Reactions
CPM-PtS-A-4.01) High-Alert Medications
CPM-PtS-A-1.05 Least Restraint (last resort) program