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| **Policy** |
| Developed By: Professional Practice | Approved By: VP Clinical Services/CNE |
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**Policy Statement**

The following document outlines the standards of nursing care for all nurses practicing within Listowel Wingham Hospitals Alliance (LWHA) and adheres to both legislative requirements and regulatory requirements as outlined by the College of Nurses of Ontario (CNO). It serves to inform heath care staff of their accountabilities when providing care to patients and applies to all staff regardless of role, job description, or area of practice. This standard will ensure that patients receive consistent, high quality, and evidence-informed care from nursing staff and other health care disciplines during their stay.

**Definitions**

**Care Team** – The care team is the group of individuals involved in the care of the patient. The patient and patient’s family are always at the center of the care team. Other members of the team may include nurses, physicians, health disciplines, and other unregulated staff. The care team collaborates together to meet the needs of the patient and to achieve the goals set out in the patient’s care team.

**Circle of Care** – The circle of care describes the individuals or groups whom a patient wish to include in their care and decision-making. The patient is always at the center of the circle of care.

**Family** – The group of individuals that the patient defines as being part of their family

**Nurse** – A nurse refers to any registered nursing professional actively practicing at LWHA. This includes both Registered Nurses (RNs) and Registered Practical Nurses (RPNs).

**Shift** – A nurse’s scheduled hours of work on any unit or clinical area

**Substitute decision –maker (SDM) –** A person identified by the HCCA who may make a treatment decision for someone who is incapable of making his/her own decision. The HCCA provides a hierarchy to determine who is eligible to be a substitute decision-maker.

**Health Care Provider –** is a person that provides a health care service to a patient while working within their designated scope of practice. The list of health care providers may include nurses, physicians, health disciplines, and other unregulated staff

**Documentation Standards**

Documentation from Health Care Professional’s (HCPs) is a vital component of professional practice and interprofessional communication that occurs within a patient’s health record. This documentation is essential to promote safe and quality care through meaningful, clear, and concise communication (College of Nurses of Ontario (CNO), 2008).

*(Appendix 1, Appendix 2)*

**Safety**

* Ensure that every patient has an armband on that is registered to the particular visit and ensure that all information on the armband is accurate.
* Protect patients, staff and visitors by adhering to all infection control and prevention practices as outlined by Infection Prevention and Control policies
* Ensure their patients have the ability to call for assistance when needed
* Nurses will orientate the patient and family to their specific room and to the amenities on the unit
* Ensure the patient is comfortable and the room and environment are safe
	+ **Comfort Rounding** is complete and documented every hour or unless there is a change in the condition of the patient and requires more frequent assessment
		- Pain
		- Elimination
		- Environment
		- Positioning
		- Return

**Screening**

Nurses will assess every patient for being at risk of the following:

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| **Type of Screening/Assessment** | **LWHA Patient Care Standard** | **Timing/Frequency** |
| **Delirium, Dementia & Depression Assessment (CAM)** | Nurses will use their area-specific screening tool to deem whether their patient is at risk of delirium, dementia and depression. | * Completed on admission
* Every 7 days for admitted patients
* Upon a change in patient condition
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| Health Care providers will implement appropriate safety precautions and assessments to identify the potential causes. |
| **Falls Risk Assessment (Morse or Humpty Dumpty)** | Nurses will use their area-specific screening tool to deem whether the patient is at risk of falling. | * Completed on admission within 24 hours of arrival to the unit
* Every 7 days for admitted patients
* After any fall or as needed according to nursing judgment
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| Nurses will perform or recommend a more in-depth assessment of patients identified at risk for falls. |
| Nurses will implement appropriate safety precautions to mitigate falls risk using input from the patient, the patient’s family, and members of the care team. |
| Interventions must be documented and communicated to everyone in the circle of care. |
| Health Care providers evaluate and change beside transfer cards to reflect the current needs of the patient. |
| **Behaviour Safety Alert Screening** | Nurses will use their area-specific screening tool to identify whether the patient poses a risk of violence to others. | * Completed upon arrival to the ED (greater than 10 years of age) at triage or upon direct admission
* Inpatient Reassessment of Behaviour Safety Screening is to be completed daily on every patient
* BSA Incident and Interventions PowerForm completed upon an incident of violent behaviour as deemed appropriate.
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| Health care providers will implement appropriate safety precautions to mitigate any risk from patient behaviour. These interventions must be documented and communicated to everyone in the circle of care. |
| **Skin Assessment****(Braden Risk Assessment)** | Nurses will use their area-specific screening tool to assess the patient’s risk for pressure injuries and skin breakdown. | * Screening will be completed for every patient upon admission, when they have a significant change in health status and every 7 days on the admitted patient
* Nurses will perform a more in-depth assessment of patients identified at risk for pressure injury or skin breakdown
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| Nurses will implement appropriate safety precautions to prevent pressure injury and skin breakdown using input from the patient, the patient’s family and members of the care team. These interventions must be documented and communicated to everyone in the circle of care. |
| **Complex Discharge Screening** | Nurses will assess for potential risks impacting the patient’s discharge. A task will be initiated to the LHIN care coordinator for discharge planning based on the needs identified in the tool. | * Completed upon admission
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| **MRSA/VRE Screening** | Nurses will obtain a culture swab of the nares, rectum and any area where there is a break in skin integrity of all patients admitted from nursing homes, retirement homes or who have had an admission to hospital within the previous 12 months. | * Completed on admission
* Upon physician order
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| Nurses will initiate contact isolation precautions on patients who have been admitted from nursing homes or who have had an admission to hospital within the previous 12 months. Patients will remain on contact isolation precautions until they have received a negative result from their screening. |
| **Malnutrition Risk Screening** | Nurses will assess for risk of malnutrition based on the collection of admission history. | * Completed upon the collection of the admission history as needed
* As required based on patient nutritional status
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| Nurses will initiate a task to the dietician based on the collection of admission history by placing an order for a dietician referral. |

**Basic and Universal Care Needs**

* + All Health Care Professionals (HCP) are required to maintain patient confidentiality
	+ All HCP are required to introduce themselves to the patient and patient’s family, identifying their role on the care team and their purpose
	+ Educate patient and families on visiting hours policies and resources
	+ Nurses will incorporate input from the patient and the patient’s family regarding their plan of care and incorporating their home routines. It is an expectation that the patient and the patients’ family be included in their plan of care and wherever possible, incorporating home routines into their care
	+ HCP will advocate for the patient
	+ Patients will be bathed or showered according to unit-specific guidelines
	+ Nurses will ensure the patient has access to hygiene and personal care resources and request a consultation when the patient requires assistive devices to meet their care needs
	+ Nurses, in collaboration with health disciplines, will assess and document each patient’s level of independence upon admission and communicate to the care team areas in which the patient needs assistance. These assessments must be updated as the patient’s condition changes

**Assessments and Reassessments of Interventions**

* + Nurses will monitor each patient by completing and documenting the following assessments as indicated by corporate standards, unit-specific standards, minimum standards and orders placed by providers.
	+ Nurses must adhere to the documentation standards and ensure that any significant findings are shared and communicated with the care team.
	+ Nurses should report significant findings based on clinical judgment to the Most Responsible Physician (MRP), or if after hours, to the on-call emergency physician, unless otherwise indicated by the MRP.
	+ The nurse will provide follow up documentation on any intervention provided to the patient within a reasonable timeframe (Example: after pain medications administered)

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| **Assessment** | **LWHA Patient Care Standard** | **Timing/Frequency** |
| **Health History** | Nurses must ensure that the following elements of a Health History are completed for every patient encounter:* Allergy History consisting of medication, environmental, and food allergies
* Best Possible Medication History (BPMH)
* Admission Histories
 | * Completed at triage and upon admission to an inpatient unit.
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| **Height & Weight** | An actual height will be measured in centimeters (cm).. | * Obtained upon admission and as ordered by physician
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| An actual weight will be measured in Kilograms (kg). | * Obtained upon admission and as ordered by physician
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| Height and weight will be taken using an approved weigh scale that has be properly calibrated.  |  |
| In the rare circumstance that an actual height or weight cannot be obtained, an estimated height and weight may be documented according to policy.  | * An actual height and weight should be taken as soon as possible and updated in the her
 |
| Height and weight should be taken by a registered care professional whenever possible. An unregulated care professional (UCP) may take a height and weight if they have undergone proper training. |  |
| **Pain Assessment** | Documentation of a comprehensive pain assessment should be a part of a nurse’s full systems assessment. | * Upon admission to inpatient unit
* At least once a shift (recommended it occur as close to the beginning of the shift as possible)
* Upon a change in health status or condition
* If they have reported pain, or if a pain intervention has been implemented
 |
| The frequency of pain assessments should reflect pain intensity and stability of the patient’s medical condition. |
| An assessment should be done on each major pain site the patient reports (e.g. the patient may have acute chest pain and also report chronic back pain. The back pain should be reported as an additional pain site). |
| Nurses must use an appropriate pain scale to assess their patients:* Numeric Pain Scale
* FLACC (Face, Legs, Activity, Cry, Consolability Scale)
* Faces Pain Scale
 |
| If a patient reports having pain, nurses must complete a comprehensive pain assessment:* Onset
* Provoking/palliating factors
* Quality
* Region/Radiating
* Severity
* Time
 |
| * Nurses will engage the patient and family, where possible, to effectively manage pain.
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| Nurses will document their comprehensive pain assessment in the EHR and communicate findings with the care team when necessary. |
| Nurses will implement and facilitate appropriate pain management interventions. Nurses will assess for and document outcomes of interventions and re-evaluate the plan of care where needed. |
| **Vital Signs** | Nurses must assess and document the vital signs of their patients. | * Completed upon admission
* According to provider order
* **Acute Care**: Twice daily (morning and evening) *excluding post-operative patients*
* **ICU**: Every 4 hours or as per provider order (*if ordered per protocol*)
* **CCC**: Weekly
* **Rehab**: Twice daily for 1 week from admission then once daily
* **Post-operative**: Complete PACU q15 minute x 1 hour, then q1 hour x 4, then every shift or according to provider order
	+ Transfer of care must include where the inpatient nurse is to continue with vital sign assessment
* **OBS**:
	+ Following vaginal birth: q15 minute x 1 hour, q1 hour x 3, at 8 hours, at 12 hours, then every shift
	+ Following C-section: q 15 min x 4 in PACU, q1 hour x 4, q4 hour x 48 hours, then every shift
	+ For newborn: at 30 minutes, 1 hour, 2 hours, 4 hours, 8 hours, 12 hours, then every shift
* Upon a change in health status or condition
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| The frequency of vital signs monitoring should increase if the patient’s vital signs fall outside the normal range for that patient or have a change in condition or health status. |
| Every patient must receive an initial set of baseline vital signs when being received to a new clinical area unless contraindicated (e.g. a palliative care patient). |
| At minimum, vital signs assessment must include:* Blood pressure
* Heart rate (beats per minute)

*Note that the defaulted documentation in the EHR is a measurement by pulse oximeter. If another method is used, it should be denoted (e.g. auscultation, palpation).** Respiratory rate (respirations per minute)
* Oxygen saturation/pulse oximetry reading (%)

*The nurse must specify if the patient’s oxygen saturation is based on room air. If the patient is receiving oxygen therapy, the nurse must document the oxygen therapy device as well as the flow rate.** Temperature (degrees Celsius) following area-specific standards

*Wherever possible temperature measurement should be obtained in a consistent manner using the same route* |
| **Physical Assessments** | At minimum, a comprehensive physical assessment should occur every shift and include an assessment of the following systems:**Neurological System*** Level of alertness and consciousness
* Level of orientation

**Cardiovascular System*** Assessment of pulse regularity and strength
* Assessment of skin (e.g. colour, warmth, and moisture)

**Respiratory System*** Assessment of airway patency
* Assessment of pattern and rate of breathing
* Auscultation of lung fields anteriorly/posteriorly (both when appropriate) *\*\*Must be completed on all patients unless their admitting diagnosis OR chief complaint AND their past medical history do not pertain to respiratory issues*
* Assessment of any respiratory airways or devices

**Gastrointestinal System*** Abdominal inspection and palpation
* Auscultation for bowel sounds *\*\*Must be completed on all patients unless their admitting diagnosis OR chief complaint AND their past medical history do not pertain to gastrointestinal issues*
* Assessment of last bowel movement
* Eating difficulties

**Genitourinary System*** Difficulties or abnormal signs and symptoms associated with voiding
* Last void

**Integumentary System*** Head-to-toe scan of patient’s skin for: Integrity, colour, wounds, skin breakdown, ulcers, etc.

**Mental Health/Psychosocial*** Affect and mood and Behaviour
 | * A **FULL** physical assessment must occur within 4 hours of the patient’s admission in order to obtain a baseline status
* At minimum, a comprehensive physical assessment should occur every shift (or morning and evening). This must include the minimum assessment standards for each system listed in this policy.
* Upon a change in health status or condition
* Based on provider order
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| **Intake and Output** | Nurses are required to complete accurate intake and output documentation when ordered by the provider.* Patients with increased loss if fluid
* Patients have a device (ie. infusion pump) that records fluid loss
* Patients with decreased intravascular volume related to: Sepsis, Bowel Obstruction, Pancreatitis, Acute Liver Failure, Malnutrition
* Patients on nephrotoxic medications or with renal compromise/failure
* Patients in Acute Heart Failure
 | * Based on provider order for intake and output
* If required, oral intake should be documented after every meal/snack and account for other fluids taken throughout the shift
* If required, output should be documented throughout the shift based on patient output patterns
* Intake from continuous intravenous infusions should be document at the end of each and the shift volumes should be cleared from the infusion pump
 |
| Nurses will document intake and output on any patient with a continuous intravenous infusion. |
| **Vascular Access/Intravenous Administration** | Nurses will assess the condition and document on all vascular access sites for signs of infection, infiltration and phlebitis.*(see Intravenous IV Therapy Guidelines – LWHA policy)* | * *When there are intravenous fluids infusing*:

 - Vascular access site check to occur every 4 hours in adults and every 1 hour in paediatrics  - Any time a medication or fluid is added* *Saline Lock only*

 - Vascular access sites to have a site check every 12 hours. |
| Nurses will flush all vascular access sites with 0.9% sodium chloride (normal saline) 3 ml. | * Vascular access sites should be flushed daily
 |
| Nurse will change primary and secondary intravenous administration sets (and any add-on devices that are part of the administration sets (e.g., stopcocks, extension sets, in-line filters, caps) used to deliver fluids.  | * Continuous intravenous infusion sets changed every 72 hours
* Intermittent intravenous infusion sets changed every 24 hours
 |
| Nurses will follow the guidelines outlined in the Clinical Skills – Mosby’s resource located in the intranet |
| **Subcutaneous Ports** | Nurses will assess the condition and document on all subcutaneous ports for signs of infection, infiltration and phlebitis.*(see Subcutaneous Port and Infusions– LWHA policy)* | * Assess the site condition every time it is used for administrating medications or every 4 hours if rehydrating
 |
| Subcutaneous ports do not require to be flushed after medication administration  | * Do not administer more than 2mls at one time or 10mls/hr if rehydrating
 |
| Nurse will change subcutaneous port and tubing as per policy | * Site to be changed every 7 days or as needed
* Tubing and syringe to be changed every 24 hours or as needed
 |
| Nurses will follow the guidelines outlined in the Clinical Skills – Mosby’s resource located in the intranet |
| **Central Venous Access Devices (CVAD)** | Nurses will assess the condition and document on all CVAD’s for signs of infection, infiltration and phlebitis.*(see Central Venous Access Devices– LWHA policy)* | * When not in use, a site assessment will be documented every 12 hours
 |
| Specially trained nurses will flush all CVAD’s with 0.9% sodium chloride (normal saline) | * *If not being accessed:*

 *-* PICC Line: flush each lumen with 20 mls of NS using the ‘Stop Start’ method once weekly and as needed- - Portacath: flush with 20mls of NS once a month and as needed |
| Nurses will change dressings of CVAD’s as per policy | * Changed 24 hours post insertion then weekly or as needed
 |
| **Cardiac Monitoring Interpretation** | Nurses will print off a cardiac monitor strip, analyze the rhythm and place on the chart. The interpretation of the strip can be documented in the EHR. | * Every 4 hours
* Upon a change in the cardiac rhythm
 |
| **Interventions** | Treatments, medications, and medical device management ordered by providers will be instituted according to policies and procedures | * Completed based on provider order, nursing practice standards, best practice guidelines and clinical judgement
 |
| If any abnormal findings are identified in the assessment, the nurse should ensure that the appropriate action is taken and documented. The intervention should be based upon nursing practice standards, patient orders, best practice guidelines, and clinical judgment. |
| It is expected that nurses will assess, and document outcomes following interventions and adjust the plan of care as needed. |
| Interventions should be based on the principles of patient and family centered care. |

**Plan of Care**

* On admission, explore the patient’s goals of care, the patient’s expected discharge date, and learning needs, and how they want to be involved in care
* HCP’s will ensure that patient and family involvement in care planning is supported and encouraged. The patient defines the family and may include anyone important in the patient’s life
* Nurses will foster the development of a comprehensive care plan that incorporates input from the patient, the family, and all relevant members of the care team
* Care planning should begin as soon as possible in the patient’s journey and should extend to support discharge arrangements and follow-up
* On a shift to shift basis, the plan of care will be updated electronically to reflect changes and the patient’s progress towards their goals

**Education and Discharge Information**

* Patient and family education must be provided throughout the patient’s hospital stay and discharge instructions are provided at every discharge according to unit-specific education guidelines or best practice guidelines
* Nurses will document not just that education was provided, but also what was taught
* All HCP’s must assess and consider patient and family needs, readiness, and capacity
* All HCP’s will assess and document the effectiveness of the education provided and adjust teaching methods or learning plans as needed
* Nurses are required to provide the patient and family with printed discharge instructions
* Medication education and discharge instruction:
	+ Nurses will provide medication specific education to both the patient and relevant family members including dosing, frequency, reason for the medication, and potential side effects
	+ Patients should have complete medication reconciliation before discharge.
	+ Medication education should come from the prescribing physician or Pharmacy approved reference sources

**Transfer of Care/Handoff**

* All nurses must ensure that all pertinent information related to the patient’s care must be communicated at every transitional point of care. These transfer points include:
	+ Shift-to-shift hand off
	+ Transfer to another unit or area
	+ Transfer to another facility
	+ Any other time that care is being transferred to another nurse or member of the care team
* The nurse giving the transfer of care/hand-off report must follow the process outlined by the LWHA Transfer of Accountability Policy and document in the EHR based on this policy

*(Appendix 3)*

**Appendix**

1. LWHA Clinical Documentation Standards (2020) – Located on COPPS
2. LWHA Emergency Department Documentation Standards (2020) – Located on COPPS
3. LWHA Transfer of Accountability (2020) – Located on COPPS

**References**

LHSC Inpatient Practice Standards, 2019
College of Nurses Practice Standards, 2018
Clinical Skills – Mosby’s (Intranet)