QUINTE HEALTHCARE CORPORATION

Nursing – Service Standards of Care

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Approved By:	**Nursing Practice Committee**		

1. POLICY

The Service Standards of Care define the **minimum** expectations that all patients in Quinte Health Care Corporation (QHC) can expect to receive from nursing staff. In addition to the corporate service standards outlined in this policy, each clinical area has additional standards specific to the needs of the patients in these areas. Nurses will provide the service standard of care reflective of QHC values to every patient, every shift. Documentation and communication is required if nursing staff are unable to meet any aspect of the standards of care.

2. PURPOSE and SCOPE

The purpose of the service standards of care is to incorporate evidence based practice and define excellence in nursing care at QHC. Each nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships. All nurses must continue to use clinical judgment, knowledge and critical thinking to ensure patient needs are met and optimal care is provided (CNO, 2018).

These standards of care are required of Personal Support Workers (PSW) according to the PSW scope of practice as defined by QHC (Appendix A); for example, meeting patients' nutrition and elimination needs and the PSW participation in hourly rounding.

This policy applies to all inpatients, surgical outpatients, and emergency room patients at Quinte Health Care.

3. DEFINITIONS

Shift –A health care professional's scheduled hours of work on a unit

4. PROCEDURE

a. Nurses practice in accordance with the College of Nurses of Ontario (CNO) standards of practice, and policies and procedures of QHC. These include, but are not limited to scope of practice, medication, consent, confidentiality, documentation, ethics and professional standards.
   i. Nurses must practice within one's competencies related to knowledge, skill, and judgment to deliver care to assigned patients.
   ii. Nurses are accountable for their own actions, to seek guidance where appropriate and work in collaboration with other health care providers to deliver optimal care to patients.

b. Patient and family involvement is supported and encouraged for the development of a comprehensive care plan and discharge arrangements throughout the hospital experience. The patient defines family. Family includes any person identified by the patient (or substitute decision maker) as important in their life. Nurses optimize communication with the patient and family by providing on-going support as appropriate during the hospital stay.

c. Every nurse is responsible to ensure information is exchanged at every point of transfer of care. This includes patient transfers within QHC, discharge to another facility or site, shift reports, and when care is being transferred to another provider.

d. The nurse shares accountability with pharmacy to ensure the best possible medication history is obtained from every patient, families and/or substitute decision makers.

e. The nurse will identify the need for infection prevention and control precautions and will practice in accordance with QHC standards and protocols to reduce potential exposure to bodily fluids and the spread of infection.

f. Rounding on patients occurs every hour or more frequently as the patient's condition warrants. This includes a "critical look" of the patient (airway, breathing, and circulation) and responding to any emotional/physical needs. Rounding is accomplished by observing and /or interacting with the patient while assessing safety needs and interventions that are in place.

g. The nurse will monitor the patient by completing assessments and responding to significant findings
appropriately. The nurse will document all significant findings in the health record and communicate
these significant findings to the appropriate health care professional.

h. Nursing staff will follow professional and QHC documentation standards (Policy 3.6.1 Documentation – Clinical Standards) when recording all assessments, treatments, medications and evaluations of outcomes including the patient/family response.

i. The nurse will complete assessments of peripheral venous access device(s) (PVAD) and/or central venous access device(s) (CVAD) Q1H for tenderness, discolouration, inflammation or infiltration.

Documentation will occur with rate change, solution change, and clearing of the infusion pump. The infusion will be cleared at end of each shift. Pressure per square inch (PSI) will be documented each shift.

j. Any patient with an IV infusing at greater than 30 mL per hour requires monitoring and documentation of intake and output at a minimum of every shift or more often as required.

k. Patient (and family) education and discharge instructions are provided according to the patient and family needs, considering readiness and capacity. Nurses will evaluate and document the effectiveness of education provided, accommodating teaching methods and adjusting the learning plan as required.

l. If not performing activities of daily living independently, patients will receive:
    - Oral hygiene at least every 8 hours
    - Assistance with personal hygiene at least every 24 hours
    - Assistance with meals including but not limited to hand hygiene and set up
    - Assistance with ambulation according to patient needs
    - The opportunity for toileting every 2 hours
    - Skin care and be turned and repositioned every 2 hours

m. All patients will have an admission and physical assessment completed and documented within 4 hours of patient arrival to the unit.

n. All patients will have vital signs assessed on admission and then according to unit specific standards and/or physician orders. Vital signs include temperature, heart rate, respiratory rate, blood pressure and oxygen saturation.

o. All patients will be assessed for pain as part of hourly rounding and formally at a minimum of every shift utilizing the appropriate pain scale. Documentation will include the assessment, intervention and outcome.

p. Actual measured height and weight will be obtained on admission. If unable to obtain an actual height and weight, documentation should reflect why these were unable to be obtained.

q. All patients will have the following safety measures in place:
    - Application of legible identification armbands and if applicable an allergy band
    - Ability to call for assistance
    - Clutter free environment
    - Bed in lowest position appropriate for patient
    - Brakes engaged on all equipment (if applicable)

r. Falls assessments and documentation will be completed according to Policy 3.18.8 Patient – Fall Prevention and Post Fall Management.

s. Braden Scale will be completed at admission for all patients, and repeated each shift. With the exception of newborns, and on Mental Health where it is done on admission, and PRN as required for patient's condition and/or change in status.

t. The nurse shall initiate accurate and ongoing assessment of physical, psychosocial and spiritual needs of patients.

u. In addition to the preceding standards, recognizing the unique needs and criteria for different clinical settings within QHC, the following minimum standards of care will be provided to all patients in the specified practice settings.

Unit Specific Standards of Care

Emergency Department

Time frames for nursing assessments are based on the CTAS level assigned to the patient and includes:

Assessment/Procedure	Directions
CTAS level 1	Nursing assessment occurs immediately and nursing reassessment is continuous until initial physician assessment is completed.
CTAS level 2	Nursing assessment occurs immediately and nursing reassessment is every 15 minutes until initial physician assessment is completed.
CTAS level 3	Nursing assessment occurs within 30 minutes of triage and nursing reassessment is every 30 minutes until initial physician assessment is completed.
CTAS level 4	Nursing assessment occurs within 60 minutes and nursing reassessment is every 60 minutes until initial physician assessment is completed.
CTAS level 5	Nursing assessment occurs at 120 minutes and nursing reassessment is every 120 minutes until initial physician assessment is completed.
Triage assessment nurses are required to screen patients as per domestic and sexual assault program (DVSARP) screening protocols.	
Initial Assessment in Patient Assigned Room	Initial assessment shall include systematic and pertinent collection of information based on the chief complaint. The nurse obtains initial focused subjective and objective information through history taking (inclusive of patient/family/EMS and other care providers), physical assessment and review of records.
Ongoing Reassessments including Vital Signs	Once assessed by the physician, the nurse will perform ongoing patient assessment, including vital signs, at a minimum of every four hours and more frequently as patient condition requires. Reassessment will be done regardless of location.
Electrocardiograms (ECG)	Completed ECGs are to be shown to a physician at completion and documented.

Intensive Care Unit (ICU)

Assessment/Procedure	Directions
Physical Assessment	On admission. At a minimum of q4 hours and as required by patient condition.
Vital signs	On admission. At a minimum of q4 hours and as required by patient condition and/or physician's order.
Transfer out of ICU	When a patient is awaiting transfer from the Intensive Care Unit to another inpatient unit, the standards specific to the receiving unit, including intervention sets, will be implemented by the critical care nurse. (The standards of the receiving unit are described in this policy).

Maternal/Child and Paediatric Program

Maternal/Child (Antepartum)

Assessment/Procedure	Directions
Antepartum Assessment and Vital Signs	Antepartum assessment and vital signs will be completed every 12 hours and as required. The fetal heart will be assessed every 12 hours at a minimum and as required. Fetal heart assessments will be interpreted using standardized terminology as outlined in Policy 3.10.8 Maternal Child - Fetal Health Surveillance.
Physical Assessment	Will be completed on admission and at a minimum of every 12 hours.

Maternal/Child (Intrapartum)

Assessment/Procedure	Directions
Vital Signs	T, HR, RR and BP on admission. HR, RR and BP q4h in the latent stage of labour. HR, RR, BP q1h in the active first stage and the second stage of labour. Maternal HR q15min in active second stage of labour. T q3 – 4 h if membranes intact, q2h if membranes ruptured and T q1h if temp greater than $37^{5\circ}$ C. Recovery (Fourth Stage of Labour). HR, RR, BP q15 minutes X 4, and then q30 minutes until transfer to the Mother Baby Unit (MBU). T x 1, repeat in one hour if greater than $38^{5\circ}$C.

Fetal Health Surveillance	Fetal heath assessments will be completed and documented using standardized terminology as outlined in Policy 3.10.8 Maternal Child - Fetal Health Surveillance.

Maternal/Child (Postpartum)

Assessment/Procedure	Directions
Postpartum Assessment and Vital Signs	T, HR, RR, BP SpO_2, pain, sedation scores and postpartum assessment as follows: Vaginal delivery - On admission to mother baby unit (MBU), q30min x 2, q8h x 24h then q12h and PRN. Caesarean delivery – On admission to MBU, q2h x 3, q4h x 4, q24h x 24h then qshift and PRN.
Physical Assessment	For patients that have delivered via cesarean section or assisted vaginal delivery or patients with pre-existing medical or pregnancy complications a physical assessment will be completed at a minimum of every 12 hours and as required. For uncomplicated spontaneous vaginal deliveries, a physical assessment will be done as required to meet individual patient needs.

Maternal/Child (Newborn)

Assessment/Procedure	Directions
Newborn Assessment and Vital Signs	Apgars will be completed at a minimum of one and five minutes of age. **Newborn MBU:** HR, RR and colour will be assessed at 30 minutes of age. Vital signs (T, HR, RR) and newborn assessment will be completed at 1 hour, 2 hours and 4 hours of age then every shift and as required. **Newborn SCN:** Vital signs (T,HR, RR and BP) and newborn assessment will be completed q 30 – 60 minutes until stable then vital signs (T, HR, RR) and newborn assessment q3h and as required; BP as ordered.
Measured actual weights & Measurements	Birth weight, head circumference, chest circumference and length will be completed on admission. Measured actual weights will be done daily. Head circumference will be completed weekly.
Intravenous	An infusion pump will be used for all IV infusions. Infusions will be programmed to a maximum of a two hour volume limit. Neonates with an IV infusing will have the IV assessed and documented on at a minimum of every hour. IV infusion pumps will be cleared and volumes documented hourly.

Falls Assessment	A falls assessment will not be completed on newborns as they are all considered high risk. Falls precautions will be used for all newborns.

Paediatrics

Assessment/Procedure	Directions
Vital Signs	Temperature, heart rate and respiratory rate will be completed at a minimum of every four hours and blood pressure at a minimum of every 12 hours.
Measured actual weights	For patients less than one year of age measured actual weights will be obtained daily.
Physical assessment	To be completed at a minimum of every 12 hours.
Intravenous	All infusions will be run on pumps. A Buretrol shall be used on all patients weighing less than or equal to 20 kg. The Buretrol will be filled to a maximum of a two hour volume limit. Pumps will be cleared and the volume documented hourly. PSI will be documented hourly.

Obstetrical Assessment Clinic

Patients waiting initial physician assessments, either in the waiting room or treatment area, are assessed based on the Obstetrical Triage Acuity Scale (OTAS, 2015). If a patient is moved from the waiting room to the treatment area of the Obstetric Assessment Clinic (OAC), the nurse assigned to the patient resumes the assessments from triage and continues with the associated reassessment times for the patient's priority level until a physician assesses the patient. The nurse will follow the OAC assessment parameters and the associated documentation standards.Time frames for nursing assessments are provided by the OTAS (2015).

Assessment/Procedure	Directions
Level 1 (Resuscitative)	Nursing assessment occurs immediately following triage and nursing reassessment is ongoing or patient is admitted.
Level 2 (Emergent)	Nursing assessment occurs immediately following triage and nursing reassessment every 15 minutes.
Level 3 (Urgent)	Nursing assessment occurs within 5-10 minutes of triage and nursing reassessment every 15 minutes.
Level 4 (Less Urgent)	Nursing assessment occurs within 5-10 minutes of triage and nursing reassessment every 30 minutes.
Level 5 (Non-Urgent)	Nursing assessment occurs within 5-10 minutes of triage and nursing reassessment every 60 minutes.
The time responses are ideal; patients' conditions may change and require more frequent assessments than the patient's original triage level indicates. The OTAS acuity modifiers (2015) may be used to confirm or increase the acuity of the patient.	
Once a physician assesses the patient, the nurse completes the appropriate clinical assessments, with the associated documentation at a minimum of every 4 hours.	

Surgical Services

Preadmission Clinic

Assessment/Procedure	Directions
Pre Admission – the nurse's focus is on the patient education to prepare the patient both physically and psychologically for their surgical/anaesthetic experience. Actual or potential problems that may result are identified using interviewing and assessment techniques.	
Verification of pertinent medical history and allergies	Upon initial telephone or in person assessment.
Schedule medication reconciliation consult with pharmacy	As required for same day admission patients.
Medication Review	Upon initial telephone or in person assessment.
Anaesthetic Questionnaire Review	Upon initial telephone or in person assessment.
Patient teaching	As scheduled.

Same Day Surgery

Assessment/Procedure	Directions
Validate information and compliance to pre procedural instructions	On admission.
Baseline vital signs to be completed, which include: temperature, heart rate (HR), blood pressure (BP), SpO_2	On admission.
Completion of the pre-op assessment and pre-procedure checklist	On admission.

Nursing care is appropriate to meet the patient's needs in the pre-anaesthesia phases as per the most recent edition of the Ontario Perianesthesia Nurses Association (OPANA).

Operating Room- Perioperative

Assessment/Procedure	Direction
Pre-op Checklist	On admission.
Integumentary	On admission, PRN and discharge from O.R.
Surgical Safety Checklist	Prior to induction, prior to incision and prior to patient leaving the operating room.
Surgical Count	As defined by the surgical procedure.

The perioperative nursing role includes those of scrub and circulating nurse. With additional education and training the perioperative RN is skilled to perform the role of Registered Nurse First Assistant (RNFA).

The scope of practice of the perioperative nurse encompasses the immediate preoperative, intraoperative and immediate postoperative phases of the surgical experience.

Preoperatively the nurse will collaborate with the anaesthetic care provider to ensure all the necessary supplies and equipment is in the OR and functioning.

Preoperatively the nurse will ensure availability of surgical equipment, supplies and instruments prior to admission of the patient to the OR.

Perioperative nurses will follow the most recently published Operating Room Nurses Association of Canada (ORNAC) Standards for Perioperative Registered Nursing Practice for each phase of peri-operative patient care.

Phase I Recovery (PACU - Post Anaesthetic Care Unit)

Assessment/Procedure	**Directions**
Airway Assessment	Immediately upon admission to the PACU. When the patient is unconscious, airway assessments are continuous. Documentation every 15 minutes, unless significant findings, then as required by patient condition.
Respiratory Assessment	Phase 1 - On admission to the PACU. Continuous monitoring of respiratory status along with airway assessment is documented every 15 minutes and as required by patient condition.
Cardiac Assessment - Cardiac rhythm interpretation and recognition	Phase 1- Continuous monitoring of heart rate, blood pressure, SpO2, and cardiac rhythm with documentation every 15 minutes and as required by patient condition until patient meets PACU discharge criteria.
Vital signs monitoring includes: Temperature, heart rate, blood pressure, SpO^2, level of consciousness, level of sedation, pain score	Vital signs are assessed against the patients' preoperative baselines. Assessment and documentation of vital signs are done on admission to PACU, every 5 minutes until conscious, then every 15 minutes until patient meets PACU discharge criteria.
Input and output	Assessed and documented on admission and every hour until patient meets PACU discharge criteria.
Dressing and Drains	Assessed and documented on admission and q15 minutes until patient meets PACU discharge criteria.
Limb assessment includes CSM, temperature and pulse of operative and non-operative limb	Performed for limb surgeries: Assessed and documented on admission and q15 minutes until patient meets PACU discharge criteria.
Modified Aldrete Score	Assessed and documented on admission and q15 minutes until patient meets PACU discharge criteria.
Bromage Scale/Motor Scale (for Neuraxial and Regional Anaesthesia)	Assessed and documented on admission and q15 minutes until patient meets PACU discharge criteria.
Sensory Level Landmarks (for Neuraxial and Regional Anaesthesia)	Assessed and documented on admission and q15 minutes until patient meets PACU discharge criteria.

Phase II - Recovery

Assessment/Procedure	Directions
Respiratory Assessment	Phase 2 – on admission and q30 minutes or meets Post-Anaesthetic Discharge Scoring System (PADSS) discharge criteria.
Vital signs monitoring includes: temperature, heart rate, blood pressure, SpO^2, level of consciousness, level of sedation, pain score	The frequency of vital signs is dependent on the patient's level of consciousness and stability and current vital signs are assessed against the patients' preoperative baselines. Phase II - on admission and q30 minutes until PADSS discharge criteria met. Phase III - If stable and still in Phase II PACU, progress to post-operative vital sign frequency.
Dressing and Drains	On admission and q30 minutes until discharge.
Limb assessment for limb surgery, includes CSM, temperature and pulse of operative and non-operative limb	On admission and q30 minutes until discharge.
Bromage Scale/Motor Scale (for Neuraxial and Regional Anaesthesia)	On admission and q30 minutes until discharge criteria met when applicable.
Sensory Level Landmarks (for Neuraxial and Regional Anaesthesia)	On admission and q15 minutes until discharge criteria met when applicable.

Perianaesthesia nurses will follow the most recently published edition of the National Perianesthesia Nurses Association (NAPAN) Standards.

Surgical Inpatient Unit

Assessment/Procedure	Directions
Physical assessment	On admission and completed a minimum of every 12 hours and to meet individual patient needs.
Vital signs	On admission, then q4h x 24 hours, then QID x 24 hours, and then BID when stable and as required to meet individual patient needs. **Phase III** Post-operative patients: Temp, HR, RR, BP, SpO_2, level of consciousness, level of sedation, and pain score on admission to unit, then q2h x3, then q4h x4, then every 4h for next 24 hrs., then every shift and as required to meet individual patient needs. For orthopaedic patients only: Temp, HR, RR, BP, SpO_2, level of consciousness, level of sedation, CSM assessment (circulation, sensation and movement), pedal pulses and pain score on admission to unit, q2h x 3, then q4h x 4, then q4h for next 24 hrs., then q shift and PRN (Notify MD if temperature greater than 38^5 C).

Post-operative assessment (including Bromage Scale/Motor Scale and Sensory Level Landmarks for Neuraxial and Regional Anaesthesia)	Completed in conjunction with vital signs as above.

Surgical Short-Stay Unit

Assessment/Procedure	Directions
Physical assessment	On admission and completed a minimum of every 12 hours and to meet individual patient needs.
Vital signs	On admission, then q4h x 24 hours, then QID x 24 hours, and then BID when stable and as required to meet individual patient needs. **Phase III** Post-operative patients: Temp, HR, RR, BP, SpO_2, level of consciousness, level of sedation, and pain score on admission to unit, then q2h x3, then q4h x4, then every 4h for next 24 hrs., then every shift and as required to meet individual patient needs. For orthopaedic patients only: Temp, HR, RR, BP, SpO_2, level of consciousness, level of sedation, CSM assessment (circulation, sensation and movement), pedal pulses and pain score on admission to unit, q2h x 3, then q4h x 4, then q4h for next 24 hrs., then q shift and PRN (Notify MD if temperature greater than 38^5 C).
Post-operative assessment	Completed in conjunction with vital signs as above.

Endoscopy

Pre-procedure:
Nursing care is appropriate to meet the patient's needs in the pre anaesthesia phase as per the most recently published edition of Ontario Standards of Perianesthesia Nursing Association (OPANA), the Canadian Society of Gastroenterology Nurses and Associates (CSGNA).

Assessment/Procedure	Directions
The nurse's focus is on validation of information and compliance to pre procedural instructions and implementation of pre-procedural orders	On admission.
Baseline Vital signs to be completed, which include: temperature, heart rate (HR), blood pressure (BP), SpO_2	On admission.
Completion of pre-procedure checklist	On admission.

Intra Procedure:

Assessment/Procedure	Directions
Airway Assessment	Continuously throughout the procedure.
Level of Pain	q3 minutes.
Level of Consciousness	q3 minutes.
Vital signs to be completed, which include: temperature, heart rate (HR), blood pressure (BP), SpO_2	q3 minutes.

Post Procedure:

Assessment/Procedure	Directions
Airway Assessment	Immediately upon admission to the Endoscopy Recovery area. When the patient is unconscious airway checks are done continuously until patient can manage own airway. When the patient is fully conscious airway checks are done every15 minutes.
Vital signs to be completed, which include: temperature, heart rate (HR), blood pressure (BP), SpO_2	On admission, every15 minutes and every 30 minutes post procedure until meets discharge criteria.
Discharge Instructions	On discharge.

Phase II- The nurse in Phase II endoscopy recovery continues with critical evaluation of patients following procedures under anaesthesia or sedation, assisting them with returning to a condition which approximates the pre-anaesthesia condition as much as possible. This includes return to pre-anaesthesia ambulatory status, normal bodily functions and without regression to their status in phase I recovery.

Extended Observation-The nurse performs ongoing assessment of the patients continued return of normal functioning based on ongoing assessment without regression to their status in either of the previous phases of recovery (OPANA, 2014).

Patients must meet the requirements of the PADSS score to be discharged from Phase II recovery.

Mental Health - Psychiatry Inpatient and Intensive Treatment Area (ITA)

Assessment/Procedure	Directions
Physical assessment	At time of admission and then repeated a minimum every 7 days, or more frequently as required
Vital signs	ITA patients require vitals TID and as required to meet individual patient needs. General Ward patients require vitals on admission and are repeated every 7days or more frequently as required
Mental Status Exam	Will be completed a minimum of every 12 hours and updated accordingly throughout the shift as status changes
Columbia Suicide Severity Rating Scale (C-SSRS)- admission Columbia Suicide Severity Rating Scale (C-SSRS) frequent screener Columbia Suicide Severity Rating Scale (C-SSRS) discharge screener	C-SSRS (long version) on admission Frequent screener is completed: whenever there is a significant change in clinical status related to suicide risk; prior to increasing privileges and/or decreasing observation levels; prior to patient going out on extended pass e.g. overnight pass Discharge screener is completed prior to discharging patient home
Violence Risk Assessment-DASA	Completed at time of admission Completed at any time during the patient's admission when new behavior exhibited meets risk of harm criteria Reassessment is completed every 24hrs when there is a positive DASA score Behavioral Alert Flag is initiated on identified at risk patients with a positive DASA score 2 or greater Individual Behavioral Care plans are completed for patients who have a DASA score of 4 or greater See policy 3.26 Behavioural Alert Flagging: Managing Violent, Aggressive or Responsive Behaviours for more information on assessment, flagging and care planning procedures
RAI –MH	Initial assessment will be completed within 72 hours of admission Discharge assessment is completed before the patient is discharged from hospital Patients who have extended length of stay require reassessments every three months Significant unexpected change in clinical status requires re-assessment
Rights-Mental Health Act	Patients are informed of their rights under the Mental Health Act. Additional information in QHC policy 2.12.1 Delegation of Officer in Charge Responsibility under the Mental Health Act
Crisis Intervention Training	Staff receives Non Violent Crisis Intervention training. Recertification is provided yearly to maintain skill and

	competency
Restraints	Restraint use is in accordance with the Mental Health Act and QHC Policy 3.16.6 Nursing – Restraint Minimization.
Environmental Safety	Precautions applicable to all patients include removing dangerous objects from personal belongings at time of admission, upon return from extended passes, or when there is a significant clinical change that warrants further investigation. Room checks are to be done daily. Please see QHC policy # 3.16.1Management of Dangerous, Illegal Substances and Articles
Observation and Engagement	As per QHC policy # 3.18.11 Patient- Enhanced Levels of Observation and use of sitters ITA patients will be monitored by closed circuit television (CCTV) with frequent face to face assessment as per above policy Patients on the general ward require purposeful rounding at a minimum of every hour, or more frequently as indicated by clinical presentation Form one patients on the general ward require purposeful rounding at a minimum of every 30 minutes, or more frequently as indicated by clinical presentation
Patient Passes	Patients must be monitored and assessed for autonomy and safety prior to going out and upon return from passes Where possible, upon return from extended pass assessment of the patient will include consultation with patients and/or families to determine if there were any concerns Patients belongings must be checked upon return from extended pass, as well at any time there is a concern related to safety

Medicine

Assessment/Procedure	**Directions**
Physical Assessment	On admission and at a minimum of every 12 hours and to meet individual patient needs.
Cardiac monitoring (telemetry)	As per QHC Policy 3.25 Telemetry Monitoring.
Vital signs	On admission, then every 4h x 24 hours, then QID x 24 hours, and then BID when stable and as required to meet individual patient needs.
Alternative level of care (ALC)	When a physician has ordered alternative level of care on a patient, the nurse will follow the Complex Continuing Care standards described in this policy, excluding the RAI-MDS.

Complex Continuing Care

Assessment/Procedure	Directions
Physical Assessment	On admission and once weekly, and as required to meet the individual patient needs.
Vital Signs	On admission and once weekly, and as required to meet the individual patient needs.
Integumentary System Assessment	Completed every shift.
RAI-MDS	Completed on admission, discharge and every 3 months.

Rehabilitation

Assessment/Procedure	Directions
Physical Assessment	On admission and once weekly, and as required to meet the individual patient needs.
Vital Signs	On admission and once weekly, and as required to meet the individual patient needs.
Integumentary System Assessment	Completed every shift.
National Rehabilitation Reporting System (NRS) assessment	Completed on admission and discharge.

Behavioural Support Transition Unit (BSTU)

Assessment/Procedure	Directions
Physical Assessment	On admission and once monthly, and as required to meet the individual patient needs
Vital Signs	On admission and once monthly, and as required to meet the individual patient needs.
Integumentary System Assessment	Completed every shift.
National Rehabilitation Reporting System (NRS) assessment	Completed on admission and discharge
Cohen-Mansfield Agitation Inventory	Completed on admission and discharge and as needed
Dementia Observation System (DOS)	Completed on admission for 5 days and as needed.
PAIN-AD	Completed a minimum of every 12 hours and to meet individual patient needs.
Cornell Depression Inventory	Initiated at the time of admission and completed within the first 7 days. Updated whenever there is a change in mental status warranting further assessment
Confusion Assessment Method	Completed on admission and whenever there is an abrupt change in mental status and/or behavior warranting further assessment

Comprehensive Behavioural Assessment	PIECES assessment to be completed on admission and updated as needed
Behavioural Crisis Assessment Tool (BCAT)	Completed weekly in order to measure fluctuations in a patients risk for aggression
Behavioural Care Planning	Updated weekly during Interprofessional rounds
Observation and Engagement	Patients require purposeful rounding at a minimum of every 30 minutes, or more frequently as indicated by clinical presentation

APPENDICES AND REFERENCES

Appendix A: PSW Scope of Practice and Limitations

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