CKHA POLICY

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BACKGROUND

Chatham-Kent Health Alliance (CKHA) embraces the philosophy of Patient and Family Centered Care; the values and beliefs of which enable and support partnerships of patients, families, and their healthcare providers. The goal is to provide quality, safe care for patients and families in a respectful and trusted environment for all partners.

CKHA nursing staff are responsible and accountable for their role in ensuring patient safety and quality of care.

This policy defines the expectations of nursing care that all patients will receive at CKHA. In addition to the professional practice expectations outlined in this policy, each unit specific professional practice expectations for patient care are articulated in the appendices of this document.

COMPETENCIES

This policy pertains to CKHA employees with the following designations:

- Registered Nurse (RN)
- Registered Practical Nurse (RPN)

POLICY

Nurses will practice in accordance with the College of Nurses of Ontario (CNO) Standards, Ontario Public Hospitals Act, legislative requirements, and the policies and procedures of CKHA.

Infection Prevention and Control (IPAC)

- Nurses are expected to understand and apply evidence-based measures to prevent and control transmission of micro-organisms that are likely to cause infection relating to vascular access, inserted /indwelling devices, wounds, and patient accommodation.
- All nurses will comply with IPAC policies.
- All admitted patients will be asked screening questions and if applicable, the necessary swabs sent within 24 hours.
- Isolation precautions will be adhered to by all CKHA staff and the necessary Personal Protective Equipment (PPE) to be worn when the patient's condition warrants.
- Hand Hygiene must be performed during the '4 Moments of Hand Hygiene' with alcohol-based hand rub (ABHR) or soap and water 1. before initial patient/patient environment contact, 2. before aseptic procedure, 3. after body fluid exposure risk, and 4. after patient/patient environment contact. Refer to INF-1-014: Hand Hygiene.

Professionalism

- All nurses will treat each other with compassion, respect, and professionalism.
- All nurses will work collaboratively with patients, visitors, and other health care professionals.
- All nurses will adhere to the CKHA Code of Conduct. Refer to PEO-1-030: Code of Conduct.
- All nurses will adhere to the CNO Code of Conduct Code of Conduct for Nurses (cno.org)

Credentialing

- **All nurses will maintain a current Basic Life Support (BLS) certification.**
- Additional mandatory certifications will be completed and maintained based on the unit(s) of hire and unit specific standards.
- All nurses will maintain lab certifications (glucometer/venipuncture) as required.
- All nurses will complete assigned e-learnings within the prescribed timing.
- All new hires will complete assigned learning modules based on unit specific standards within the prescribed timing.

Medical and Patient Care Orders

- Two kinds of orders may be given by a physician or a Registered Nurse in the Extended Class (RN(EC) or NP) (referred to as Provider in rest of this document) for the treatment of patients;
    - direct orders and/or
    - medical directives
- A **direct order** is patient, procedure, and/or treatment specific. With a direct order, a prescription for a procedure or treatment is given for a particular patient with detailed administration instructions. A direct order may be written or verbal (oral).
- A **medical directive** is a prescription for a treatment or procedure that may be performed for a range of patients who meet certain conditions. A directive is an order for an activity or series of activities that may be implemented for a number of clients when specific conditions are met and specific circumstances exist.
    - If a patient leaves Against Medical Advice (AMA) after having a medical directive completed, the primary nurse is responsible to ensure the attending physician reviews the results.
- **All orders associated with the patient shall be reviewed at regular intervals to ensure timely completion of treatments and interventions.**

Direct Order

The Provider will:

- Enter the order into the Electronic Medical Record (EMR) ***or***
- Faxed/paper provider orders will be accepted for patient care purposes (i.e. from office/outpatient clinics). Both the paper orders and the "Fax Transmission Form/Cover Sheet" will be retained for the chart and scanned into the EMR.

Telephone Order

- Providers may dictate a telephone order and sign for it in the EMR on their next visit to the hospital. Any member of a Regulated Health Profession (RHP) who is authorized to take telephone orders will enter the order into Cerner, identify it as a "telephone order" and **confirm** the order by **repeating/reading the order back** to the ordering practitioner in full.

Verbal Order

- Verbal orders **are not acceptable** except in cases of emergency or when the prescriber is unable to document the order i.e. while performing a procedure in the operating room. A verbal order is an order for treatment, dictated verbally by a provider who is physically present on the unit. Any member of the RHP classification who is authorized to take verbal orders will enter the order into Cerner, identify it as a "verbal order" and read it back to the provider in full. The provider will sign for the order as soon as possible within the next 24 hours. Refer to PRO-1-002: Medical Orders/Medical Directives.

Disagreeing with Plan of Care

- When disagreeing with a plan of care, a collaborative approach will occur to discuss such disagreement in a timely manner, and in accordance with policy. Refer to PTS-3-003: Disagreeing or Concern with Plan of Care.

Communication

- Patients, families, and substitute decision makers (SDMs) are to be included in direct patient care as appropriate and at their level of comfort and with consent of the patient. Documentation of clinically related communication and interactions with patient, family, and/or SDMs must be documented in the patient's electronic medical record (EMR).
- Call bells are provided and placed within patient/caregiver's reach for use to alert nurses of a patient's need.
- Shift report is to occur at the bedside, to allow the patient and family or SDM the opportunity to participate in the process. If the patient or SDM decline participation, it will be documented in the chart and on the wipe board (if applicable).

Consent

- Immediately prior to any procedure for which a written, informed consent is required, high risk verification will occur as per required organizational practice. Refer to COM-1-004: Consent and Capacity.
- A pause will be declared by the verbal announcement of "Time Out." Nursing will lead the "Time Out" communication that verifies:
    - Patient identity,
    - Informed consent has been obtained,
    - Procedure including any unilateral site location,
    - Allergies and specific patient alerts related to the procedure, and
    - Prior to transfusion of blood or blood products, the validated Blood Consent is reviewed and documented as being present in the BRIDGE Transfusion application **or** in the Blood Product Transfusion band in CERNER. Transfusions occurring in the Operating Room are excluded from BRIDGE application and managed by the anaesthesiologist.

Restraints

- CKHA embraces the philosophy of least restraint.

- All nurses will be knowledgeable and practice according to CKHA's least restraint policy.
- All patients requiring restraints (physical, chemical, environmental) to protect their safety, the safety of the health care team, and/or the public, will be restrained as **minimally as is safe** and for a **minimal duration**.
- Assessments and checks of restraints will be completed and documented according to PTS-1-012: Least Restraint Policy.

Documentation

- Nurses are expected to document in accordance with College of Nurses of Ontario Professional Standards, CNO Documentation Standards, Ontario Public Hospital's Act, and as per HTI-1-003: Clinical Documentation.
- Nurses will document all assessments, interventions, medications and evaluations of outcomes and/or the patient's/caregiver response to interventions.
- Documentation of events/actions/assessments is accurate, true, and honest.
- Duplication of another professional's events/actions/assessments is **NOT** acceptable practice.
- Value judgments or labeling are avoided by using objective data and client statements to describe behaviour.
- Charting by exception is **NOT** acceptable practice. Findings of all assessments/interventions/outcomes must be clearly documented.
- Late or forgotten entries are entered at the appropriate time of task or event completion, in the EMR.
- Documentation is completed as soon after the event as possible and is written by the person who saw or performed the action except for code/trauma situations where there is a recorder.
- Do not use abbreviations.

Patient Identification

- Nurses will verify patient identification using 2 unique identifiers on every occasion the patient receives medication, a treatment, a diagnostic test, or an invasive procedure and every time a patient is being transferred to another unit/area/facility for care.
- Unique patient identifiers include:
    - Date of birth
    - Medical Record Number (MRN)
    - Financial Indication Number (FIN)
    - Health Card Number
    - Government Issued photo identification or verified photo
- All medications, lab specimens and blood administration **MUST** include bar code scanning of both the patient arm band and the product/item retrieved or administered
- Expected scanning rates are to always be **above 90%** including both armband and medication/specimen**. Overriding is not supported by the organization and will be reviewed with individuals on a case-by-case basis.**
- Issues with scanning or the inability to scan require notification of the transform Regional Service Desk at extension 7771.

- Armbands must be placed on the patient at the time of registration and worn at all times. Any damaged or missing armbands must be replaced prior to treatment.

Most Responsible Nursing Assessment (MRN) Expectations

- A standardized physical assessment and full set of vital signs including pain scale will be completed at the beginning of every shift for the admitted patient, and as patient condition warrants.
- Findings of the complete assessment must be documented each shift.
- Pain will be reassessed on a regular basis (Q4h or more frequently) according to the type and intensity of pain and the treatment plan.
- Additional assessments and the implementation of interventions will be documented each shift, as per specific hospital policy. This includes, but is not limited to:
    - Morse Falls Scale or Edmonson Falls Risk Assessment (Inpatient Mental Health only). Refer to PTS-1-050: Falls Prevention.
    - Braden Pressure Injury Risk Assessment. Refer to PTC-1-030: Pressure Injury Risk Assessment, Prevention and Management.
    - National Early Warning Score (NEWS). Refer to PTC-1-033: National Early Warning Scoring System (NEWS)
    - Confusion Assessment Method (CAM).
- Wound assessments and treatments. Refer to Pressure Injury Identification and Management Poster in the Professional Practice section on the intranet.
- When the care of a patient is transferred between nurses/members of the health care team, assessment details shall be documented within the **handoff tool and flowsheet** to ensure the continuation of individualized patient care needs. Refer to PTS-1-051: Transfer of Accountability (TOA).
- Nurses should maintain a high index of suspicion of delirium, dementia and depression in the older adult and seek urgent treatment as needed.

Patient Rounding/Reassessments

- The nurse checks each patient a minimum of **every two hours**, and as the patient's condition warrants. This includes a "critical look" of the patient which is accomplished through observing and/or interacting with the patient. This check and any interventions provided during checks will be documented in the EMR (i.e. Purposeful Rounds).
- Documentation will describe the following:
    - Patient appearance;
    - Significant patient issues/concerns;
    - All interventions performed and related outcomes;
    - All medications administered including time, dose, route, and patient outcome;
    - Pre and post vital signs, with the administration of medication that may alter the respiratory and hemodynamic status of the patient;
    - Initiation of standard orders/protocols/guidelines/medical directives;
    - Reports of abnormal findings to physicians;
    - Referrals to specialists;

    - Reasons for delays from the expected and explanations to patients and significant others; and
    - Patients will be assessed for pain using a recognized pain scale.
- End of shift summary will be documented in certain care areas (Inpatient Mental Health and Addictions and Neonatal Intensive Care).

Safe Mobility

- Nurses will follow outlined recommendations on the Falls Risk assessment and apply appropriate risk reduction strategies.
- "Falls Risk" Patients are identified with an orange armband and signage at the head of the bed.
- Mobilization of the patient will occur at a minimum, two to three times per day. Depending on the patient's mobility level and capabilities, mobility will include sitting at edge of bed or in a chair, transfers, ambulating with or without a gait aid, and the use of progressive, scaled mobilization. It is the expectation that all healthcare providers will participate in this mobilizations (i.e. Personal Support Workers, externs, Allied Health professionals).
- Mobility moments, method, duration, and tolerance will be captured in documentation.

Monitoring

- All nurses perform patient monitoring and ongoing assessments for their assigned patients and intervene on significant findings promptly. Variances and follow up are to be reported and documented in the EMR.
- The nurse is responsible to ensure timely communication of significant findings to the appropriate health care provider.
- As part of a shift assessment of a patient, equipment being used to monitor and support that patient care includes:
    - Verifying and documenting alarms that are in use (i.e. cardiac monitor, IV, bed or chair alarm) are turned on and functional.

Equipment

- All nurses will maintain the proper functioning of all equipment including oxygen and wall suction.
- Nurses will utilize the smart pump drug library for all intravenous infusions.
- All nurses will follow up on malfunctioning equipment by notifying Biomed, and the nurse manager with problematic equipment.

Lab / Diagnostic tests

- Nurses will complete a review of the patient's lab and diagnostic tests each shift to ensure accountability for these elements.
- Critical test results from the Laboratory and Diagnostic Imaging departments must be received directly by nursing personnel (RN, RPN, and NP) and communicated accurately to the MRP within 30 minutes.

Transfer of Accountability (TOA)

- Every nurse is responsible to ensure information is exchanged at every point of transfer of care. Refer to PTS-1-051: Transfer of Accountability (TOA).
- Patient safety checks and detailed handoff documentation will occur at every nurse-to-nurse handover to reflect the **sending nurse,** and the **receiving nurse** involved. Shift to shift report will occur at the bedside.
- Telephone report will occur to the receiving inpatient unit.
- Face to face report will occur for critical patients.
- All patients transferred to ICU/PCU must be in the care of an RN/RPN and on a cardiac monitor if accessible. Critical intravenous infusions must be on a pump, recent vital signs in EMR and intake and output completed.
- Nursing documentation in EMR will include the time transfer of care was provided and the time the patient left the department. Use of the standardized tools to document information at time of transfer is required. This would include but not be limited to the Handoff tool and the pre-procedure surgical checklist in Cerner.
- Both the sending and receiving nurse will review the "Nurse View" Handoff Mpage or equivalent when transferring care via phone. The following information must be communicated as determined pertinent for the continuation of patient care:
    - Demographic data (patient's name, age, gender, room number, language spoken).
    - Allergies.
    - Name of MRP and acceptance of responsibility.
    - Reason for admission to hospital and diagnosis if known
    - Infection control precautions.
    - Current or desired consultants and if they have been notified.
    - Any planned surgical interventions.
    - Level of consciousness, orientation, and/or changes in status.
    - Physical assessment findings, by system, if significant.
    - Pertinent patient history and medical/physical limitations.
    - Most recent vital signs.
    - Cardiac rhythm if patient is monitored.
    - Tests/treatments performed highlighting abnormal results and actions taken to address.
    - Medication received within the last 12 hours (routine, PRN, and STAT).
    - Highlight medications due in the next 4 hours.
    - Intravenous (IV), Central Venous Access Device (CVAD) status, tubes/drains, dressings (quality and quantity of drainage).
    - Disposition of clothing, valuables, sensory aids, prosthesis, mobility aids to include who it was given to or where the items could be located. Refer to PTC-2-056: Valuables and Personal Belongings (Including Medications Brought from Home).
    - Identified social issues or barriers to discharge.
    - Discharge plans if applicable (i.e. Homecare, LTC, Social Work).

Admission

- Prior to patient transfer to the receiving unit, the following assessments/documentation are to be completed:
    - Full nursing physical assessment/reassessment, a **current,** full set of vital signs (T, P, RR, BP, O2 sat, pain scale) within 30 minutes of transfer.
    - Handoff documentation.
    - Verbal and/or face to face report.
- On admission, the following assessments/documentation are expected:
    - A full set of vital signs (TPR, B/P, pain scale, 02 sat) **within the first hour** of arrival to the unit.
    - A complete physical assessment including a skin assessment, measured weight, height, and allergy identification.
    - Goals of Care nursing documentation.
    - Discharge Planning Risk Assessment Screen (Blaylock).
    - Predicting Pressure Injury Risk Assessment (Braden).
    - Falls Risk Assessment (Morse or Edmonson).
    - Violence Assessment Tool (VAT).
    - Delirium screening using the CAM on **ALL** patients 65 years and older
    - Nutrition Screen for malnutrition/dietitian referral needs.
    - Admission history to be done within 12 hours of admission. Refer to HTI-1-003: Clinical Documentation.
- The nurse shares accountability with pharmacy to ensure the best possible medication history (BPMH) is obtained from every patient, family member, and/or substitute decision maker. Medication reconciliation occurs at admission, transfer, and discharge.

Discharge Documentation

Documentation will include:

- Time of discharge.
- Patient condition.
- Interventions prior to discharge.
- Vital signs within 2 hours of discharge.
- Intake and output will be summarized.
- Education/follow up instructions provided will be recorded in the chart.
- Accompaniment and means of discharge will be recorded with time of discharge.
- The discharge summary will be sent with all patients returning or admitted to LTC. A verbal phone report to the LTC home will be given prior to discharge.

Discharge Instructions

- Nurses are expected to provide patient education and discharge instructions according to the patient's diagnosis, to the patient and family or a substitute decision maker, considering patient/family readiness, capacity and ability to understand:
    - Nurses plan, implement, and evaluate the effectiveness of any education provided using teach back technique.

- Nurses document the education ongoing in the patient record and at discharge using the appropriate discharge forms.
- Discharge instructions (not already developed by CKHA) can be found in Lexicomp (multiple languages) or Dynamic Health resources on the intranet. **Every patient should receive written discharge instructions.**

Patient Care

- If patients are unable to perform activities of daily living independently, care should be provided according to the following:
  - Assistance with oral care. Effective oral care includes daily oral assessment and at a minimum, twice-daily oral care consisting of brushing teeth, denture care if the patient has dentures, oral rinses, suctioning if the patient cannot spit, and use of water-based mouth moisturizers, as appropriate.
  - Patients at high-risk for aspiration (i.e., stroke diagnosis, patients identified as having dysphagia, etc.) should receive oral care at a minimum after all meals, snacks and at bedtime, or every four hours if NPO.
  - Bowel and urinary elimination assessed and maintained every 8 hours and as required according to patient condition.
  - Assistance with personal hygiene at least every 24 hours in the in-patient areas and as required for their length of stay in the out-patient settings.
  - Assistance with meals (including hand hygiene before eating).
  - Assistance with ambulation and toileting according to patient's needs.
  - Patients who are bedridden or limited in mobility will have skin care provided, and appropriate interventions according to their Braden score (i.e. repositioning q2h, pressure offloading to boney prominences Q2h or more often etc.).

Intake / Output

- Nurses are responsible for evaluating patient's nutritional intake/output status. If there are concerns, nurses must ensure clinical nutrition support is provided. No order is required for a consultation with dietitians.
- Nurses are expected to monitor and document a patient's intake (IV, tube feeds, etc.) and output (catheter, chest tube, drains, etc.) according to provider orders, Power Plan, or at minimum q6h.

PROCEDURE

Unit Specific Expectations/Standards of Care

To accommodate the unique needs and criteria for different clinical settings and patient populations within CKHA, program specific standards of care have been determined. These expectations/standards are based on CKHA policy/guidelines or provincial/nationally identified standards.

AMBULATORY CARE

- Ambulatory care nurses will maintain standard competencies required to provide care and support services for adult and pediatric patients in the acute ambulatory care setting.
- Assisting with minor surgical procedures and the provision of elective medical treatments will adhere to organizational practice/policy expectations including confirmation of consent, patient identification, time out process, pre and post treatment vital signs, observations, and focal patient assessments as warranted by the patient condition/treatment. Refer to COM-1-004: Consent and Capacity and PTC-1-028 Blood and Blood Product Administration.
- The nurse will provide patient education aimed at preventing negative outcomes and/or assisting patients in managing chronic conditions.

COMPLEX CONTINUING CARE

- The nurse completes the standardized physical assessment including:
    - TPR, BP, SpO_2, pain scale, and NEWS once per shift unless otherwise ordered (i.e. ALC patients, behavioural, palliative).
    - Complete and document weekly measured weights.
    - Morse Fall, Braden Scale, NEWS, and CAM screening will be completed daily on all patients and with a change in patient condition. Prevention interventions must be initiated and clearly documented.
    - The Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.
    - The Oral Health Assessment Tool (OHAT) will be completed on admission to identify baseline oral health status. This assessment will be repeated as warranted with patient condition changes or symptom development.
- Nurses in Complex Continuing Care will provide nursing care to older adult patients according to Canadian Gerontological Nursing Association Standards of Practice. See reference binder on unit.

DAY SURGERY

- The nurse will complete a health assessment of the surgical patient and document in the EMR.
- The Nurse will prepare the surgical patient for the Operating Room. Refer to PTC-2-037: Pre-operative Preparation of the Surgical Patient.
- Post operative care and discharge will be completed according to provider orders, Power Plans, and readiness for discharge criteria.

DIABETES EDUCATION

- Nurses working in the diabetes education program will achieve and maintain designation as a Diabetes Educator through the Canadian Diabetes Educator Certification Board and/or an accredited program. Yearly proof is required to be shown to the manager.

- Individualized diabetes education and treatment plans will be developed and implemented for outpatient adults, pediatrics, and those with gestational diabetes.
- Inpatient diabetes education and treatment plans will be developed based on the referral process.

DIALYSIS

- Nurses in the dialysis program will provide care to patients with end stage renal disease requiring hemodialysis according to the criteria and standards of Care identified by London Health Sciences Centre (LHSC).
- As a satellite to LHSC, CKHA dialysis staff will complete requisite training through the LHSC Dialysis program within the proposed time.
- Care and treatment plans will be directed by members of the LHSC dialysis team. Patient monitoring will include pre and post weight measurements, vital signs monitoring before, during and after dialyzing, lab results monitoring, fluid volume monitoring, medication administration and dialysis machine management.

EMERGENCY DEPARTMENT

- Nurses will maintain current Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS).
- Nurses will work for approximately 2 years prior to completing Canadian Triage Acuity Scale (CTAS) – Provider Course training.
- Only Registered Nurses can be assigned the role of Triage.
- All ED nurses will rotate through all assignments (up to their competency level).
- All patients presenting to the Emergency Department (ED) will be triaged according to the CTAS guidelines. The patient's CTAS level and condition will establish recommended assessment and reassessment times. CTAS guidelines can be found at: http://caep.ca/resources/ctas/implementation-guidelines**.**
- The triage response times are standardized guidelines. The patient's condition can change and may require more frequent assessments than the original assigned triage level indicates. The nurse will complete additional assessments as necessary using critical thinking, judgement, and knowledge.
- All RNs in the offload nurse position will be responsible for triaging EMS patients and minimizing offload time.
- Offload nurses will collaborate with their team to facilitate offload to a bed and when not utilized for offload will seek to help peers.
- The offload nurse will work with the team leader/charge nurse to assign bed allocations in the ED and if needed transfer to and care for up to 4 patients in the hallway area until a bed is available.

Focused Nursing Assessment (inside the department):

- Documentation expectations include a completed Nursing History of Presenting Illness in addition to a focused assessment specific to their chief complaint.
- If the patient presents with unstable vital signs or multiple health complaints, the patient will receive a comprehensive initial secondary assessment (head to toe

assessment) on admission to the ED, inclusive of assessments of the Respiratory, Cardiovascular, and Neurological systems.

- Vital signs will be recorded q15min on unstable critical patients, q1h on stable critical patients, and q2-4h on stable ED patients.
- If the patient is admitted to hospital, the pharmacy technician will complete the home medications list in the patient's EMR and then the physician will complete medication reconciliation.
- If there is evidence of significant findings, the patient will receive a focused assessment at least every 1 hour and PRN.
- The patient will be reassessed and/or observed based on clinical judgment, protocols, and patient acuity.
- Once patients are assessed by a Provider, the nurse completes and documents the appropriate clinical assessments/reassessments at a minimum of every 2 hours. In addition, the nurse will continue to use critical thinking, judgement, and knowledge to identify the need and frequency for additional assessments and reassessments.
- The ED nurse will ensure all supplies necessary for emergency care (resuscitation) are readily available and working appropriately.
- In the event the ED physician assesses and discharges the patient prior to nursing assessment, the nursing documentation will reflect these events.

Rapid Assessment Zone (RAZ) Patients:

- All patients will be assessed as per department standards with documentation to support interventions and assessments.
- If a patient's condition deteriorates, or the patient requires cardiac monitoring, report must be given to the UCL. Handoff documentation will be completed, and TOA will occur.
- At the end of the day, report on any remaining patients in the RAZ area will be given to the UCL. Handoff documentation will be completed, and TOA will occur.

Pediatric Patients:

- All pediatric patients will have an actual weight in kilograms measured at either triage or during the primary assessment. Infants under 3 months of age will have a naked weight completed.
- All pediatric patients will have a full set of vitals completed including blood pressure and capillary refill.

Gynecological Patients:

- Childbearing age is considered from the start of menarche to cessation of menses.
- Last menstrual period will be included in all assessments of female patients.
- Para and gravida are recorded for all female patients presenting with OBS/GYN issues/concerns.

Obstetrical Patients:

- Obstetrical patients will be triaged according to CTAS guidelines.

- For obstetrical patients greater than 20 weeks' gestation with pregnancy related issues the triage nurse will contact the obstetrical triage nurse and direct the patient to OB Triage for assessment.
- For obstetrical patients less than 20 weeks' gestation or non-pregnancy related issues the triage nurse will complete the triage, determine the CTAS score, and ED physician will complete assessment and plan of care.

Renal Patients:

- Hemodialysis patients presenting to the ED often have a Central Venous Catheter (CVC), fistula or graft. This **should NOT** be accessed, and a peripheral IV should be attempted for treatment.
- If the patient has a graft or fistula, **do not** use the limb for any of the following:
    - Blood work
    - IV access
    - Blood pressure

INTENSIVE CARE UNIT/PROGRESSIVE CARE UNIT

- All nurses (RN/RPN) will maintain certification in Advanced Cardiac Life Support (ACLS).
- Patients will be provided care according to the Standards for Critical Care Nursing in Ontario found at Practice Standards for Critical Care Nursing in Ontario.
- Vital signs will be recorded at least q30min on unstable critical patients, q1h on stable critical patients, and q2-4h on stable patients.
- Continuous cardio-respiratory monitoring is required on all unstable and stable critical care patients. Patients awaiting transfer to an acute care unit (e.g. Medicine or Surgery) or off-service patients may be taken off the cardiac monitor based on the clinical judgement of the Most Responsible Provider and/or Most Responsible Nurse.
- The nurse completes and documents the appropriate clinical assessments and reassessments at a minimum of every 2 hours, or sooner based on clinical judgement.
- The Morse Fall, Braden Scale and CAM screening will be completed daily and with a change in patient condition. Prevention interventions must be initiated and clearly documented.
- The Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.
- The Critical Care Information System (CCIS) workload tool shall be completed for each patient q24h.

MENTAL HEALTH

- The nurse completes the standardized physical assessment (head to toe) at the time of admission. This should include a complete set of vital signs, and assessments of the patient’s neurological, respiratory, cardiovascular, gastrointestinal, genitourinary, and integumentary systems. This assessment shall be repeated PRN to meet the individual patient needs (i.e. post-fall).
- The Mental Status Exam (MSE) shall be completed at minimum of q12h, and PRN as condition changes (anxiety, depression, suicidality, psychosis, etc.).

- Vital signs shall be recorded every shift and PRN based on pt. Condition.
- Edmonson, Braden Scale and CAM screening will be completed daily on all patients and with a change in patient condition. Prevention interventions must be initiated and clearly documented.
- The Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.
- The Mental Health Assessment (MHA) shared care plan shall be completed on admission, after weekly rounds, and updated PRN as care plan changes.
- Shift summary shall be completed at the end of each shift. This includes form status, summary of MSE, discharge plans, family meetings, risk factors, and pass information.
- A Patient/Family meeting ad hoc form shall be completed after each family meeting by the MRN.
- Mental health assessment tools shall be completed as per Provider direction.
- Restraint use is in accordance with the Mental Health Act and PTS-1-012: Least Restraint Policy.
- When a patient is placed in seclusion, staff shall complete the restraint documentation section of the EMR.
- Safety precautions of the mental health unit are implemented for all patients, which includes removing dangerous objects from patients' personal belongings. Non-violent crisis intervention techniques are utilized to promote patient and staff safety.

MEDICINE

- Nursing staff will fulfill the standard competencies required for their area of work. Refer to PRO-3-001: Nursing Competencies Required at CKHA.
- A full head-to-toe physical assessment will be performed and documented in detail. This is to occur every 12 hours, at a minimum.
- Ongoing **focused** assessments and documentation will occur at least twice per 12-hour shift. More frequent assessments are to be complete, dependent on patient condition.
- A full set of vital signs will be obtained per provider order, Power Plan or at minimum, twice per 12hour shift (every 6 hours). This includes temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain.
- Prior to administration of some medications, there may be strict parameters with respect to vital signs that need to be followed. Reading orders and understanding restrictions to medication administration are expected. In these cases, vital signs will be obtained and documented in the EMR, prior to medication administration (i.e. blood pressure and cardiac medications).
- Routine pain assessment/interventions will occur every 4 hours or as warranted by the patient condition.
- The Morse Fall, Braden Scale, NEWS and CAM screening will be completed daily on all patients or with a change in patient condition. Prevention interventions must be initiated and clearly documented.
- The Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.

ONCOLOGY

- Oncology nurses will follow the Cancer Care Ontario Standards and Guiding Principles www.cancercareontario.ca .
- Where CKHA policy and/or procedures are not available, the Cancer Care Ontario policies will be utilized to provide direction to patient care as appropriate for the patient and families.
- Based on referring site London Regional Cancer Program and Windsor Regional Cancer Program guidelines will be followed as required.
- It is recommended that all nurses obtain and maintain the Canadian Nurses Association (CNA) – Oncology Certification.
- Nursing staff to maintain current Canadian Vascular Access Association (CVAA) Certification.
- All Nursing staff are to obtain and maintain deSouza Certification and maintain current Chemotherapy and Biotherapy Certification. Proof of these certifications must be provided to the manager.

OPERATING ROOM- PERIOPERATIVE / ENDOSCOPY

- The Perioperative Nurse promotes and continually develops a unique specialized body of knowledge and skills, contributing to continued improvement of safe patient care.
- The Operating Room Nurses Association of Canada (ORNAC) Standards for Perioperative Nursing Practice provides perioperative nurses standards to assess competence in the performance of quality patient care.
- The Perioperative Nurse works in collaboration with the healthcare team and within the guidelines of the CKHA OR Resource Manual's policies and procedures.
- The Perioperative Nurse precepts and mentors inter-professional colleagues.
- The surgical patient in each theatre is under the direct supervision of a nurse who is physically present.
- All members of the operating room team are accountable to ensure the completion of the Surgical Safety Check List (SSCL) occurs and is documented in the EMR.
    - The Circulator of the operating room will complete a TIME OUT- Before skin incision (WHO, 2009).
    - Debriefing is initiated upon completion of the surgical procedure and just prior to transfer to the receiving unit. It may be initiated by the surgeon, anesthesia care provider, or nurse (WHO, 2009).
- Endoscopy practice is based on standards from the Canadian Society of Gastroenterology Nurses & Associates: http://www.cag-acg.org/guidelines

PALLIATIVE/END OF LIFE CARE

- The Palliative Performance Scale (PPS) will be assessed upon admission, every shift, and with any change in the patient's status.
- The Edmonton Symptom Assessment Scale (ESAS) will be completed on admission and q shift for 24 hours after admission and then twice weekly (Monday and Thursday) and PRN.

- The nurse will monitor, assess, and document the patient receiving analgesia via a Patient Controlled Analgesic (PCA) pain pump Q4h and PRN.
- The PCA Pump will be cleared, and doses will be documented in EMR at end of shift and/or prior to discontinuing.
- Nurses providing end of life care must facilitate and nurture spiritual care for both patients and the families.

POST ANAESTHETIC CARE UNIT

- The Peri-Anesthesia nurse provides safe, competent care to patients who will, in the imminent future, or have just been under the influence of sedation or anaesthetic agents. Peri-Anaesthesia nurses follow the Standards of Peri-Anesthesia Nursing Practice (OPANA, 2023) and unit specific policies.

PRE-SURGICAL SCREENING

- The Pre-Surgical screening nurse will fulfill the standard competencies required for their area of work. Refer to PRO-3-001: Nursing Competencies Required at CKHA.
- The pre-surgical nurse provides safe and competent pre-surgical/pre-anaesthesia assessment of the patient inclusive of:
    - Conducting and documentation of a comprehensive health assessment including review of medical history, current medications, allergies, previous and potential medical risk factors.
    - Baseline physiologic measures (for in person visits).
    - Instruction on fasting, medication adjustments, and surgery specific instructions.
    - Coordination of preoperative diagnostics and tests. Refer to PTC-4-010: Medical Directive: Anaesthesia Pre-requisite.
    - Pre-operative patient and family education as it relates to procedure(s) and expectations pre and post op. Refer to PTC-2-037: Guidelines for Pre-Operative Preparation of the Surgical Patient.
    - Collaboration with surgeon and anaesthesia team as it relates to pre-surgical optimization and assessment needs.

REHABILITATION NURSING

- Nurses on the Rehabilitation unit will provide care to patients according to The Ontario Association of Rehabilitation Nurses (OARNA) Standards of Practice. The nurse completes the standardized physical assessment including:
    - TPR, BP, SpO_2, pain scale, and NEWS once per shift unless otherwise ordered (i.e. ALC patients, behavioural).
    - Morse Fall, Braden Scale, NEWS and CAM screening will be completed daily and with a change in patient condition. Prevention interventions must be initiated and clearly documented.
    - Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.
    - Complete and document weekly measured weights as ordered.

- The rehabilitation nurse completes the Functional Independence Measurement (FIM) Instrument within 72 hours of admission and within 72 hours of discharge.

STROKE CARE/INTEGRATED STROKE UNIT

- Patients admitted to the Stroke Unit will be assessed and cared for according to the Power Plan and/or the provider's orders.
- Canadian Neurological Scale (CNS) will be completed based on the frequency as ordered or as patient condition warrants.
- A full physical assessment, vital signs, SpO_2 and pain assessment will be completed and documented accordingly each shift and according to provider orders.
- The Morse Fall, Braden Scale, NEWS and CAM screening will be completed daily on all patients and with a change in patient condition. Interventions will be initiated and clearly documented.
- Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.
- The Oral Health Assessment Tool (OHAT) will be completed on admission to the unit to identify baseline oral health status. This assessment will be repeated as warranted with patient condition changes or symptom development.
- Ongoing focused assessments/documentation on patient problems will occur a minimum of twice per 12-hour shift, and more frequently if the patient condition warrants.
- On admission, the nurse completes and documents a Dysphagia Screen on all stroke patients. If the patient fails the dysphasia screening assessment, the nurse maintains the patient NPO and will notify the MRP for orders related to medication routes and hydration until the Dysphagia Team has assessed the patient.

SURGERY

- Nursing staff will fulfill the standard competencies required for their area of work.
- All nurses will maintain competency in Neuraxial Analgesia, Epidural Morphine and Patient Controlled Analgesia based on nursing designation. Refer to PRO-3-001: Nursing Competencies Required at CKHA.
- Preoperative care will be provided based on MRP and Anaesthesia orders and/or procedure specific phased Power Plans. Refer to PTC-2-037: Pre-Operative Preparation of the Surgical Patient.
- Post-operative care is directed by procedure specific, phased Power Plans and Acute Pain Service (APS) orders as directed by the MRP and Anaesthesia.
- The nurse is required to activate and discontinue these phases of surgical care orders (pre-op, post op) and Acute Pain Service (APS) orders accordingly.
- **Post operative care standards** include the completion of a full set of vital signs. This includes temperature, pulse, respirations, blood pressure and O_2 saturation:
    - on admission to the unit/transfer from PACU:
        - in 30 minutes
        - Q4h X24 hours
        - then twice per 12hr shift or more often as indicated or ordered

        - Assess O_2 saturation levels before discontinuing O_2 to ensure adequate saturation levels (92% or above).
- Neurovascular and musculoskeletal assessment as indicated by the type of surgery (orthopedic/extremity surgery/injury).
- Sedation level, sensory block and motor block assessment as indicated by the type of anaesthetic administered. Refer to PTC-1-103: Epidural/Paravertebral Analgesia & Intra-operative Intrathecal Analgesia.
- Wound, incisional and drainage device assessment will occur Q4h for the first 24 hours then twice per 12-hour shift thereafter as determined by the patient condition.
- Pain assessment and analgesic mode (i.e. continuous epidural, intrathecal epimorph, spinal, patient-controlled analgesia) will be assessed and documented based on the frequency determined by policy. Interventions and outcomes will be monitored and documented at minimum Q4h. Refer to Refer to PTC-1-103: Epidural/Paravertebral Analgesia & Intra-operative Intrathecal Analgesia.
- Mobilization of the patient will be coordinated by the nurse and interdisciplinary team, with the aim of achieving return to pre surgery status.
- The Morse Fall, Braden Scale, NEWS and CAM screening will be completed daily and with a change in patient condition. Prevention interventions must be initiated and clearly documented.
- The Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.
- For patients assessed through Pre-Surgical Screening, additional patient information may be added to the admission history throughout the patient's stay as needed.

WITHDRAWAL MANAGEMENT SERVICES (WMS)

- The WMS Pre-Arrival Screening ad hoc form shall be completed prior to patient arrival. This may be completed by either WMS or RAAM staff.
- Upon patient arrival, staff shall complete the following:
    - The "Client Risk Assessment on Arrival" ad hoc form.
    - "Valuables/Belongings" ad hoc form.
    - Best Possible Medication History.
    - Any appropriate withdrawal scales (e.g. COWS, CIWA).
- Once admission documentation is complete, further charting shall be captured utilizing the "Mental Health Outpatient" ad hoc form.
- Pt monitoring shall occur based on the patient's condition and shall be recorded in the Safety and Attendance section of the EMR:
    - Intoxicated/acute withdrawal: q15min x4 hrs. Reassess at 4hrs for continued need for q15min checks (e.g. risk of seizure, vomiting, etc.) and adjust according to pt. condition.
    - Moderate withdrawal: q1h
    - Mild withdrawal: q2h
- Vital signs (including temperature) and withdrawal scales shall be recorded based on the patient's condition:
    - Intoxicated/acute withdrawal: q1h

- Moderate withdrawal: q2h
- Mild withdrawal: q4h

WOMEN AND CHILDREN'S UNIT

- All nurses (RN/RPN) working on the Women and Children's Unit will cross train to the distinct areas within the department. Cross training will be based on nursing designation and corresponding scope of practice.
- Morse Fall, Braden Scale and NEWS will be completed daily on all adult patients and with a change in patient condition. Prevention interventions must be initiated and clearly documented.
- The Humpty Dumpty Fall Scale will be completed on all paediatric patients daily, and with any change in patient's condition
- The Post Fall Assessment Documentation Guide will be followed. Refer to PST-1-050: Falls Prevention.

Maternal (Labour and Delivery and Post-Partum)

- Nursing staff will fulfill the standard competencies required for their area(s) of work.
- Refer to PRO-3-001: Nursing Competencies Required at CKHA.
- All nurses will maintain current certification in Neonatal Resuscitation (NRP) and Fetal Health Surveillance based on designation.
- All nurses (RN/RPN) will train to OR scrub position for cesarean section cases.
- All nurses will stay current with More OB readings and participate in educational Opportunities offered.
- All staff will attend the 20-hour Breastfeeding Education course and offer support to meet the therapeutic and individual needs of the patient.
- For admitted post-partum patients with no other risk factors, the nurse will complete the standardized physical assessment at a minimum of every 12 hours and as required to meet the individual patient's needs. Refer to WCD-1-087: Postpartum Care.
- For all well -newborns rooming in with parents, the nurse will complete a system assessment at 1 hour, and 6 hours of age, and at minimum every 6 hours thereafter to meet the infant's needs. Refer to WCD-1-087: Well Baby Care.

Obstetrical Triage

- Registered Nurses will provide obstetrical care in OB Triage for patients at 20 weeks gestation or greater, guided by Triage guidelines and medical directives. Refer to WCD-1-096: Triage Guidelines (obstetrical) - Including Cervical Ripening, and the OTAS learning package.
- Review medical directives guide OB Triage. Refer to WCD-1-065: Group B Streptococcus (GBS) prophylaxis; WCD-1-065: Tests and Interventions for Patients at Risk for Gestational Hypertension; and WCD-1-061: Urinary Tract Infections- Tests and Interventions.

Intrapartum

- Registered Nurses will provide 1:1 patient care during this phase of labour. Refer to

WCD-1-039: Fetal Health Surveillance in Labour.

- Requisite competency in Nitronox administrations and vaginal examination required. Refer to WCD-1-074: Nitrous Oxide-self Administration and WCD-1-101: Vaginal Examination-digital.

Neonatal Intensive Care Unit (NICU) - Level 2

- All newborns will receive a complete physical assessment on admission to the Level II NICU; infants will then receive at minimum vitals and personal care every 3 hours. Infant care will be based on the condition of the infant and interventions provided please refer to specific care policy.
- All nurses will maintain a certification in Neonatal Resuscitation Program (NRP) and recertify every two years.
- All staff will complete Breastmilk Bridge Training in Cerner – Guidelines on handling, storing and administration of Donor Milk. Refer to WCD-1-008: Administration of Pasteurized Donor Milk in the Special Care Nursery.

Paediatrics

- All pediatric patients will receive a complete physical assessment on admission and every 6 hours or more frequently as dictated by the patient's condition. Refer to specific provider Power Plans for the frequency of vital signs and requisite patient assessments.
- All nurses (RN/RPN) will be assigned to work in Paediatric Day Surgery area.

LINKS

INF-1-014: Hand Hygiene
PEO-1-030: Code of Conduct
PRO-1-002: Medical Orders/Medical Directives
PTS-3-003: Disagreeing or Concern with the Plan of Care
PTC-1-030: Pressure Injury Risk Assessment, Prevention and Management.
PTS-1-012: Least Restraint
HTI-1-003: Clinical Documentation
PTS-1-051: Transfer of Accountability (TOA)
PTC-2-056: Valuables and Personal Belongings (Including Medications Brought from Home)
PTC-2-037: Pre-operative Preparation of the Surgical Patient
PRO-3-001: Nursing Competencies Required at CKHA
PTC-1-033: National Early Warning Scoring System (NEWS)
PTS-1-050: Falls Prevention
PTS-2-046: Patient Identification
PTC-1-103: Epidural/Paravertebral Analgesia & Intra-operative Intrathecal Analgesia

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