I. ETHICS:

“The emergency nurse provides care based on philosophical and ethical concepts. These concepts include: reverence for life; respect for the inherent dignity, worth, autonomy, and individuality of each human being; and an acknowledgement of the diversity of all people.” (ENA, 1999, p. 43).

A. The nurse delivers care in a nonjudgmental and nondiscriminatory manner and preserves/protects patient autonomy, dignity, and rights.

B. The nurse maintains patient confidentiality.

C. The nurse acts as a patient advocate.

D. The nurse acts in accord with the DHMC Code of Conduct.

II. ASSESSMENT:

“The emergency nurse initiates accurate and ongoing assessment of physical and psychosocial concerns of patients within the emergency care system.” (ENA, 1999, p. 10).

A. Triage:

“The emergency nurse triages each patient and determines the priority of care based on physical, developmental, and psychosocial needs, as well as factors influencing access to health care and patient flow through the emergency care system.” (ENA, 1999, p. 23).

1. See E.D. Triage policy.

2. Prehospital agency triage
   a. The person receiving the radio or interhospital report will complete an EMS Radio Report and give it to the receiving RN for inclusion in the patient's medical record.
   b. Direct admit patients who deteriorate en route to DHMC will be routed through the E.D. for a brief assessment of stability and the appropriateness of inpatient bed assignment. If the patient is unstable or the bed assignment is inappropriate, the patient should be signed into the E.D. and the admitting service notified.
   c. The charge nurse may assign stable patients to sign in through the triage desk.
d. The assigned RN (or any available RN) will accept the patient from the prehospital agency as quickly as possible. Documentation will include a brief summary of prehospital information.

3. Patients who are triaged to a DHMC clinic will have a brief assessment note with data to support the triage decision. A copy of the assessment note will be sent with the patient to the clinic.

B. Subjective/Objective Assessment

1. The assessment will be completed as indicated by the patient's complaint. Documentation will reflect this assessment and the following information:

   a. Patient name (use Unknown Male or Female if necessary)
   b. Presenting symptoms/brief history
   c. Medications and allergies on the nurses notes. If the patient presents an extensive medication or allergy list, it may be photocopied or printed from CIS. In this case, the nurses note will say "see printout or hard copy of list" under medications and/or allergies. The copy or CIS printout must have the following statement and information to ensure that it is retained as part of the patient’s medical record: “Permanent part of record. Photocopy, original not available. Date, Patient Name and A #.”
   d. Tetanus immunization status for patients with impaired skin integrity or corneal injuries.
   e. Immunization status for all children (15 y.o. and younger)
   f. Last menstrual period in all females of childbearing age (12-55 y.o.)
   g. Complete vital signs are taken for all patients with the following exceptions / additions:
      i. Temperatures are not required for patients with single-system, minor trauma. All other patients must have their temperature taken.
      ii. Include fetal heart tones (FHTs) for pregnant patients (greater than 12 weeks gestation). Initial validation of FHTs by an obstetric physician or nurse is encouraged.
      iii. Blood pressures maybe omitted on children 5 y.o. and younger who are Triage Level 4 or 5.
      iv. Vital signs are not necessary for employees seen only for blood/body fluid exposure or patients seeking a legal blood draw.
   h. Weight (in kilograms) for pediatric patients less than 15 y.o. Head circumference and height/length will be measured upon physician request. Head circumference, if requested, is measured at the greatest circumference (across the top of the eyebrows and pinna of the ear to the occipital prominence of the skull.)
   i. Visual acuity will be obtained on patients with ocular or periorbital injuries/complaints

2. Patients will be undressed to the degree their exam requires. Patients with major illness or injury and those requiring a neurologic or abdominal exam will be totally undressed. Refer to the “Risk for Harm” policy for specific information on undressing and searching psychiatric patients.

3. A neurologic assessment consisting of a Glasgow Coma Scale and pupil size and reaction will be assessed on all head injury patients and Trauma Alert/Trauma 9 patients.

4. ECG and pulse oximetry monitoring may be initiated based on the nurse's clinical
judgment and assessment of the patient.

5. Assess peak flow on any patient 5 y.o. and older with symptoms related to reactive airway disease. Repeat peak flow determination after inhalation therapy.

6. Assessment of physical pain will be included in the initial assessment of all patients. If pain is present, intensity (using a 0-10 scale), location, quality, aggravating/alleviating factors, duration and frequency will be assessed. The Preverbal Pain Behavior Scale will be used for children 2 y.o. and younger and the Faces Rating Scale will be used for Children ages 3-7 y.o. The Behavioral Pain Assessment Scale will be used for non-verbal or confused adults. Patients will be educated about their rights regarding pain management during initial assessment.

7. Whenever possible, patients will be screened for domestic violence. Refer to ED Domestic Violence Screening Guidelines and the DHMC Domestic Violence Protocol.

III. PLANNING:

“The emergency nurse formulates a plan of care with the emergency patient and/or family based on assessment; nursing diagnoses; collaborative problems; identified outcomes; and/or medical diagnosis, within the nurse’s legal scope of practice.” (ENA, 1999, p. 16).

A. The plan for care is based on patient safety. Priorities are always airway, breathing, circulation, and in trauma patients, immobilization of the spine. Pain management, both pharmacologic and non-pharmacologic will be included in the plan as appropriate. A brief initial nursing plan of care will be documented with the exception of Trauma Alert/Trauma Nine patients (because the initial plan for those patients is well understood to be standard trauma assessment & intervention per the Trauma Nursing Core Course).

B. The plan will be verbally discussed among the physicians, nurses, and other members of the health care team to facilitate collaboration among disciplines.

C. Documentation will reflect the ongoing plan of care as appropriate.

IV. IMPLEMENTATION:


A. Documentation will include:

1. Serial vital signs and/or assessments
   a. Patient contact and documentation of patient re-assessment will occur minimally every two hours. An update will be given to patients advising them of their status.
   b. Vital signs will be repeated based on clinical status and interventions (i.e. fluid administration, narcotic/sedative administration, etc).
   c. Patients with abnormal vital signs on admission to the ED will have vital signs repeated prior to being discharged, admitted or transferred.
   d. Trauma Alert / Trauma Nine patients will have vital signs (BP, pulse, respirations, SpO2) documented every 15 minutes for the first hour and then hourly.
e. Neurologic re-assessment:
   i. Trauma Alert/ Trauma 9: Glasgow Coma Scale, motor strength, and pupil reactivity documented every 15 minutes for the first hour and then hourly.
   ii. Head injury with Glasgow Coma Scale less than 14: Use the DHMC Neurological Assessment flow sheet to document a neurologic assessment every 30 minutes until Glasgow Coma Scale is 15.

e. A hard copy of the baseline ECG snapshot will be placed on the chart for any patient with ECG monitoring. The interpretation of the rhythm will also be documented. Subsequent ECG print outs are placed in the medical record at regular intervals or for any change in rhythm.

3. Procedures, medications, and interventions with patient's response.

4. Pain, if present at a level of 4 or greater, will be reassessed at intervals appropriate for the patient’s condition and interventions performed. Pharmacologic and non-pharmacologic interventions will be documented with the patient’s response to them.

5. Fluid monitoring as indicated and for any patient with a running IV.

6. Times the patient leaves and returns to the ED for any procedure and condition upon return to the ED. (Note that the ED x-ray room and CT room are considered part of the ED.)

C. Oxygen may be initiated based on the nurse's clinical judgment and assessment of the patient.

D. Intravenous access will be initiated on patients exhibiting chest pain of suspected cardiac origin, potentially life threatening dysrhythmias, hemodynamic instability, potential systemic illness, acute respiratory distress, altered mental status, acute poisoning with potentially lethal sequelae, abdominal pain, or significant pain, blunt or penetrating trauma with actual or potential significant injury, or for any patient where medication administration is anticipated.

   1. A T-piece (short extension) is used on all IVs.

   2. Pediatric patients (younger than 10 y.o.) requiring IV fluid administration will have an infusion pump.

E. RNs may administer medications without a direct physician order as outlined in the policy “Standing Medication Orders.” Administer Tetanus Diphtheria Toxoid as outlined in the Tetanus Immunization Policy. Tetanus immunization should be documented on the "Immunization Administration Record" in the patient’s medical record.

F. Radiographic studies may be ordered per "RN X-ray Ordering Guidelines." The nurse should discuss the case with the physician if there are questions regarding appropriate radiographic testing.

G. Laboratory specimens may be ordered as outlined "RN Laboratory Ordering Guidelines." The nurse should discuss the case with the physician if there are questions regarding appropriate laboratory testing or if the patient is a child.

H. Specific interventions will be completed in accordance with the ED procedure manual and DHMC policies & procedures.

I. Psychosocial support is provided as well as consultations to other appropriate resources such as social service, chaplain or psychiatric services. These consultations should be documented in the medical record. Patients with domestic violence concerns will be referred
to W.I.S.E. (refer to the ED Domestic Violence Screening Guidelines).

J. Patients and families will be informed and updated of the patient's status and plan of care. Be aware of patient flow; expedite laboratory, radiographic and other patient care procedures. Follow-up on delays with appropriate departments. Alert the Charge Nurse of significant delays in care or changes in patient condition.

K. Side rails will be up and stretchers in the lowest position for patients with altered mental status (including all patients given narcotics or sedatives).

L. Patient care information will be communicated between nurses during change of shift and when the nurse will not be available to ensure continuity of care.

   1. Report will include at a minimum:
      a. Patient name as well as medical record number or date of birth
      b. Physician name
      c. Pertinent medical history, including:
         ▪ Diagnosis
         ▪ Current condition
         ▪ Anticipated changes in condition or treatment
         ▪ What to watch for in the next interval of care
         ▪ Code status
      d. Opportunity to ask and respond to questions

   2. Documentation will include the time of report and the RN receiving report.

M. If a patient is leaving the ED temporarily for a procedure:

   1. The primary RN will be notified before the patient leaves the ED.

   2. If the patient will be receiving nursing care in the receiving unit (Interventional Radiology, Dialysis, Endoscopy, etc.), a verbal nurse-to-nurse report will be given and the ED nurses' notes will be printed out and sent with the patient.

N. With each change of caregiver, it will be verified by the oncoming nurse that all necessary alarms are on and that the limits and volume of audible alarms are appropriate. This will be documented in the nurse’s notes.

O. All documentation will be signed, electronically or on hard copy as applicable, by the appropriate caregiver(s).

V. EVALUATION:

"The emergency nurse evaluates and modifies the plan of care based on observable patient responses and attainment of expected outcomes." (ENA, 1999, p. 21).

A. Responses to interventions will be documented where a response is expected to be observable during the E.D. stay.

B. Evaluation of patient's progress will occur among members of the health care team including nurses, physicians, consulting physicians and services. Revisions to the plan of care are instituted if indicated. The nurse assures open and timely communication with emergency patients, their significant others, and team members (as allowed by HIPPA).
VI. **DISPOSITION:**

Emergency nurses will integrate patient information from time of ED admission throughout the ED to assist in the appropriate discharge plan based on the patient's severity of illness or injury, ability of care for self and available support mechanism.

A. Refer to E.D. policies on Admission.

B. Patients admitted to inpatient areas:

1. Admission orders will be implemented as appropriate while the patient is in the ED.

2. Report to the receiving unit will include:

   a. Patient's name and medical record number or birth date
   b. Admitting clinical diagnosis or problem
   c. Admitting physician / service
   d. Brief overview of ED course to include patient's initial presentation, patient's response to procedures and interventions
   e. Current patient assessment and vital signs including pain status
   f. IV status, medications given, oxygen, cardiac monitoring, I & O
   g. Pertinent laboratory or radiology reports
   h. Anticipated changes in condition or treatment
   i. What to watch for in the next interval of care
   j. Code status
   k. Information regarding psychosocial issues, family/support mechanisms or other concerns
   l. An opportunity to ask and respond to questions
   m. Time and name of nurse receiving report; name and phone number of sending nurse.

3. Transferring paperwork will include:

   a. Face sheet
   b. All non-computerized nursing documentation (hard copy paper forms)
   c. 12-lead ECG
   d. Advance directives, consents
   e. Prehospital trip report (when available)
   f. Admitting orders (when available)
   g. Physician history and physical
   h. Addressograph card
   i. ED order sheet
   j. Ambulance report (patch) form (when available)
   k. Snapshot of rhythms and vital signs sheets as indicated

4. Patient transport:

   a. Critical care/telemetry admits will have at least one ACLS verified person on the transport team. The patient will be transported with a cardiac monitor/defibrillator.
   b. Floor admits may be transported by a Patient Care Unit Technician or a Transportation Orderly.
   c. Patients transported to surgery will be handled as a critical care or floor admit depending on their clinical status.
   d. The emergency department staff is responsible for care until the patient is physically on another patient care unit and report has been given to the receiving caregiver.

C. Patients transferred to another facility (Refer to Transfer Policy)
D. Expired patients (Refer to Death in the ED, DOA, & Post-Mortem Care Policy)

E. Patients discharged to home.

1. Refer to policy: Discharge of Patients from E.D.

2. Assure patient is able to care for self or sufficient support mechanisms are in place.

3. Patients will receive written discharge instructions to include:
   a. Name of attending emergency physician/resident/nurse.
   b. Diagnosis
   c. Instructions for home care and prescriptions including pain management (pharmacologic and non-pharmacologic).
   d. Instructions and indications for follow-up care (including reasons to return for emergency care).

4. The patient chart will have documentation reflecting time of discharge/transfer out of the ED and that aftercare instructions have been provided to patients discharged to home. The patient's (or significant other's) signature on the Receipt of Instructions form will signify that the patient (or significant other) verbalized understanding of instructions or return demonstrated discharge skills (e.g. crutchwalking).