Zuckerberg San Francisco General Hospital and Trauma Center
Adult Medical Center

Adult Medical Center
Registered Nurse

Medical Screening and Standardized Procedures Manual
Zuckerberg San Francisco General Hospital and Trauma Center
Adult Medical Center
Registered Nurse
Medical Screening Examination and
Standardized Procedures and Protocols Manual

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Distribution List:
Copy 1: Medical Staff Office
Copy 2: General Medicine Richard H. Fine People's Clinic Center Policy and Procedure Manual
Copy 3: Medical Director
Copy 4: Ward 92 Medical Subspecialties

Commented [351]: Not sure what this should be called – would want to be consistent with other PC sites
The following Registered Nurses have reviewed the standardized procedures and have demonstrated competency as Registered Nurses working in the General MedicineRichard H. Fine People’s Clinic and Ward 92 Specialties Clinic. They are authorized to practice in the General Medicine-Richard H. Fine People’s Clinic and Ward 92 Medical Specialties Clinic under the Standardized Procedures and Protocols contained in this manual:

Bren Turner, RN
Maribel Amodo, RN
Martha Baer, RN
Igor Berman, RN
Stephanie Chew, RN

Hilda Erlenbach, RN
Ellen Davis RN
Robin Grotch, RN
Kathryn Guta, RN
Jung Hee Noh, RN
Emillia Patrick, RN
Igor Berman, RN
Fern Ebeling, RN (complex care Sharon Keyes NM)
Phoebe Rossiter (complex care Sharon Keyes NM)
Nina Caneda, RN
Amellia Bullard, RN
Catherine Cullinane RN (new CDE)

Christine Greene, RN
Vivian Diokno RN
Khern Saelee RN
Sujatha Vasudevan, RN
Bren Turner, RN

Jung Hee Noh, RN
Emillia Patrick, RN
Igor Berman, RN
Fern Ebeling, RN
Christine Greene
Nina Caneda, RN
Amellia Bullard, RN
Christine Greene, RN
Khern Saelee
Rachel Abdel, RN
Maribel Amode, RN
Beverly Bagdorf, RN
Igor Berman, RN
Theresa Cahill, RN
Eva Del Campo
Fern Ebeling, RN
Hilda Erlenbach, RN
Rosalyn Ferrer, RN
Christine Greene, RN
Kathryn Guta, RN
Jessica Lee, RN
Isela Mosteiro, RN
Jung Hee Noh, RN
Sue Trupin, RN
Bren Turner, RN
Sujatha Vasduvean, RN

Alice Chen
Claire Horton, MD, MPH

Medical Director, Adult Richard H. Fine People’s Clinic Medical Center

Rosalyn Ferrer
Stefan Strassfeld
Philippa Doyle, RN, CNS MSN

Nurse Manager, Adult Medical Center

List updated 06/01/2017

Commented [ED4]: Need to update with new names
Commented [u5]: Stefan can you please update the list so that it’s accurate?
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Commented [JS6]: Need to update with all RN names as well as review date
Community Health Network of San Francisco Health Network
Adult Medical Center

Introduction

The following protocols are the policies and guidelines for the care provided to patients at Zuckerberg San Francisco General Hospital and Trauma Center (SFGH) at the Adult Medical Center (AMC) Medical Screening area or Telephone Advice area by a Registered Nurse (RN). Adult Medical Center is comprised of the Richard H. Fine People’s Clinic (formerly General Medicine Clinic) and Ward 92 Medical Subspecialties Clinic. Since it is impossible to anticipate every clinical situation or presenting chief complaint that may arise, it is expected that attending physician consultation may be warranted. The belief is that the RN may refer any patient for physician evaluation in the General Medicine Clinic Richard H. Fine People’s Clinic or Ward 92 using their nursing clinical judgment. In general, the RN shall function within the scope of practice as specified in the State of California Nurse Practice Act. The RN may refer patients for physician provider evaluation or to an appropriate clinic using their nursing clinical judgment.

The Standardized Procedures were developed with assistance from the following:


2. An Explanation of the Scope of RN Practice, State of California Board of Registered Nursing, Department of Consumer Affairs.
Title: STANDARDIZED PROCEDURE ~ REGISTERED NURSE

I. Policy Statement
   A. It is the policy of the Community-San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Registered Nurses, Physicians, Pharmacists and Administrators.
   B. A copy of the signed procedures will be kept in the operational manual in the Telephone Advice Room 1M36 in the General Medicine-Richard H. Fine People’s Clinic, Charge Nurse Office in Ward 92 and on file in the Medical Staff Office.

II. Functions:
The RN provides health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the RN to seek physician consultation.

III. Circumstances under which an RN may perform function
   A. Setting; The RN may perform the following standardized procedure functions in the Adult Medical Center consistent with their experience and training.

   B. Scope of Supervision Required
      1. The RN is responsible and accountable to the Nurse Manager, Medical Director, Charge Nurse and Attending Physician in Charge.
      2. Overlapping functions are to be performed in areas which allow for a consulting physician to be available, at all times, to the RN, by phone or in person including but not limited to the clinical area.
      3. **Physician consultation** is to be specified in the protocols and under the following circumstances:
         - Assessment of acute and episodic illness and injuries
         - General evaluation of health status
         - Emergency conditions requiring prompt medical intervention
         - Upon request of nurse or physician
         - Any patient requiring likely hospitalization

Commented [JK8]: Gabriella Teache-Guerrero asked if RN's consult with other providers? (PA and NPs?)
4. Scope of Practice

Protocol #1
Medical Screening Evaluation \textit{\textbf{Triage of Chief Complaints}}

Protocol #2
Assessment and Management of Chest Pain

Protocol #3
Assessment and Management of Shortness of Breath with Wheezes (Asthma/COPD)

Protocol #4
Assessment and Management of Shortness of Breath without Wheezes

Protocol #5
Assessment and Management of Pregnant Patients

Protocol #6
Assessment and Management of Abdominal Pain

5. Requirements for the Registered Nurse

A. Experience and Education
   1. Possess an unrestricted California license as a Registered Nurse.
   2. Current Basic Life Support Certification from an approved American Heart Association provider.

B. Special Training
   1. Completion of the SFGEH Emergency Medical Treatment Active Labor Act (EMTALA) and Medical Screening Evaluation training
   2. Successful completion of the didactic (1.5 hours) and clinical training \textit{\textbf{Minimum of 40 hour's preceptorship}} requirements

C. Evaluation:
   1. Initial: at the conclusion of the standardized procedure training the Nurse Manager and Medical Director or designated physician will assess the RN's ability to perform the standardized procedure by:
      a. Successful completion of the RN orientation program

\textit{Commented [359]}: No longer required – remove.
b. Successful completion of the medical screening and telephone triage skills checklist.

c. Review of a minimum of 10 patient cases for completeness of documentation by the Nurse Manager or preceptor.

2. Annual: Nurse Manager, Medical Director or designated physician will evaluate the RN’s competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation and no fewer than 3 chart reviews.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, Medical Director or designated physician at appropriate intervals until acceptable skill level is achieved.

IV. Development and Approval of Standardized Procedures

A. Method of Development
   All standardized procedures are developed collaboratively by the Adult Medical Clinic’s Medical Director and Nurse Manager, Registered Nurses and administrators and must conform to the eleven steps on the standardized procedure guideline as specified in Title 16, CCR Section 1474.

B. Approval
   All standardized procedures must be approved by the CIDP, Credentials Committee, Medical Executive Committee and the Joint Conference Committee prior to use.

C. Review
   All standardized procedures will be reviewed every three years, and as practice changes, by the Adult Medical Center’s Medical Director, Nurse Manager and Associate Medical Director for General Medicine Clinic.

D. Revisions
   All changes or additions to the standardized procedures are to be approved by CIDP accompanied by the dated and signed approval sheet.
Protocol #1: Medical Screening Evaluation Triage of Chief Complaints

A. Definition

This protocol covers the medical screening examination (MSE) triage and assessment of patients presenting with a chief complaint performed in the Adult Medical Center. The MSE-triage process is an assessment and examination performed by physicians, Nurse Practitioner, or qualified Registered Nurses, on all patients who present to the Adult Medical Center seeking care.

B. Data Base

1. Subjective Data
   a. Chief complaint
   b. Patient history and symptoms relevant to disease process/injury and organ systems affected
   c. Pain assessment including location and intensity (0-10 scale)
   d. Pertinent past medical history, medications and allergies
   e. Current immunization status for adults with surface trauma
   f. Any treatments used prior to arrival to the clinical area

2. Objective Data
   a. Limited physical exam appropriate to disease process/injury
   b. Level of consciousness
   c. Vital signs
   d. Skin signs
   e. Emotional state
   f. Physical appearance, size and location of injuries, with assessment of circulation, movement and sensation as appropriate
   g. Assessment of ability to ambulate and gait, as appropriate
   h. Assessment of symptoms of pregnancy or possible labor, including Term gestation as appropriate

C. Assessment

1. Consistent with subjective and objective findings
2. Assessment of status of disease process/injury
3. Age appropriate screening and/or diagnostic tests for purposes of Disease identification.
4. Immunization update

D. Plan

1. Treatment
   a. Determination of triage category: emergent, urgent, or non-urgent.
2. Patient conditions requiring attending consultation as determined by triage category (urgent or emergent)
   - Acute decompensation of patient situation
   - Unexplained historical, physical or laboratory findings
   - Upon request of patient, RN or provider

3. Education
   - Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling

4. Follow up
   - As indicated and appropriate to patient health status and diagnosis

E. Record Keeping
   All records relevant to patient care will be recorded in the electronic medical record and EMTALA log. General Medicine Richard H. Fine, People’s Clinic, and or or EMR or medical record Ward 92.
Protocol #2: Assessment and Management of Chest Pain

A. Definition: This protocol covers the initial assessment and management of patients with suspected ischemic chest discomfort seen by Registered Nurses (RN) in the Adult Medical Clinic.

Indications
- Suspected chest discomfort

Exclusions
- Acute chest trauma or suspected musculoskeletal pain
- Fever > 38 ° C (100.4 ° F)

B. Data Base

1. Subjective Data
   a. Review history and signs and symptoms concerning for ischemic causes of chest discomfort.
      - Retrosternal chest discomfort
      - Pain spreading to shoulders, neck, arms, or jaw, or pain in back
      - Associated lightheadedness, fainting, diaphoresis, or nausea
      - Shortness of breath
      - Global feeling of distress, anxiety, or impending doom
   b. Pertinent past medical history, current medications and allergies
   c. Characteristics of pain, i.e. location, quality, duration and intensity (0-10)
   d. Any treatments used prior to arrival and any relief of pain

2. Objective Data
   a. Perform focused physical exam relevant to chest pain/cardiac disease
   b. Level of consciousness
   c. Measure vital signs including assessment of pain >5/10
   d. Place on pulse oximetry and measure SpO₂ <92%
   e. Skin signs: color, temperature, moisture, and capillary refill
   f. Laboratory and imaging evaluation:
   g. 12-lead ECG, show to provider when completed

C. Assessment

1. Consistent with subjective and objective findings
2. **Assessment of status of disease process**

D. **Plan**

1. **All patients complaining of chest pain require attending consultation.**

2. **Treatment**

   a. Administer oxygen via nasal cannula at 2 liters/minute. **Titrate to maintain SpO₂ >94%**

   b. Start saline heparlock IV. Draw full tubes. Send CBC, stat basic metabolic panel, coagulations and Troponins.

   c. Administer Aspirin 325 mg chewed (if no contraindications) for patients in General Medicine Clinic RFPC.

   d. If BP > 90/60 give Nitroglycerine tablets 0.4mg, sublingual and check BP q5 minutes x3 for patients assessed and treated in General Medicine Richard Fine People’s Clinic.

2. **All patients complaining of chest pain require attending consultation.**

   **Patient conditions requiring attending consultation**

   a. HR >120

   b. BP <90/60, RR >28

   c. SpO₂ <92%

   d. Transport to ED for patients in General Medicine Richard Fine People’s Clinic or call 911 to Emergency Department for patients in Ward 92 if indicated under provider’s direction.

3. **Education**

   a. Patient education and counseling appropriate to disease including treatment modalities and lifestyle counseling

4. **Follow-up**

   a. As indicated and appropriate to patient health status and diagnosis

E. **Record Keeping**

   **All records relevant to patient care will be recorded in the electronic medical record**

   All information relevant to patient care will be recorded in the medical record and EMTALA log and or EMR in General Medicine Richard Fine People’s Clinic and EMR or medical record in Ward 92.
Protocol #3: Assessment and Management of Shortness of Breath with Wheezes (Asthma/COPD)

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath with wheezes seen by Registered Nurses (RN) in the Adult Medical Center

   Indications
   • Shortness of breath with confirmed wheezing and history of asthma/COPD

B. Data Base

1. Subjective Data
   a. Review history and signs and symptoms of asthma/COPD
   b. Pertinent past medical history, current medications and allergies
   c. Characteristics of shortness of breath and associated symptoms (cough, fever, chills)
   d. Any treatments used prior to arrival

2. Objective Data
   a. Perform focused physical exam relevant to respiratory disease
      • Auscultate lung sounds bilaterally
      • Note respiratory rate, depth, and work of breathing
      • Stridor or audible wheezing
   b. Measure vital signs every 30 minutes x2
   c. Measure peak flow before and after 1st nebulizer treatment
   d. Place on pulse oximetry and measure \( \text{SpO}_2 \)
   e. Skin signs: color, temperature, moisture, and capillary refill
   f. Laboratory and imaging evaluation:
      • If age > 50 years, 12-lead ECG. Show to provider when completed
      • Obtain CXR if fever > 38 °C (100.4 °F)

C. Assessment

1. Consistent with subjective and objective findings
2. Assessment of status of disease process

D. Plan

1. All patients presenting with shortness of breath require attending Consultation consultation.

2. Treatment
   a. Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain \( \text{SpO}_2 > 94\% \)
   b. Start saline heparlock and draw full tubes for lab, CBC, and metabolic panel for ANY of the following:
• RR >40
• Peak flow <150
• SpO₂ <90%
  
  c. Administer nebulized albuterol sulfate 2.5 mg/3 ml saline and irapratroprium bromide 0.5 mg x2 doses, then albuterol sulfate 2.5 mg/3 ml saline x 1 dose (over one hour) x 1.

2. All patients presenting with shortness of breath require attending consultation.
   
   Patient conditions requiring attending consultation
   a. HR >120
   b. BP <90
   c. RR >28
   d. SpO₂ <92%
   
   d. Transport to Emergency Department as directed by provider

3. Education
   • Patient education and counseling appropriate to disease including treatment modalities and lifestyle counseling

4. Follow-up
   • As indicated and appropriate to patient health status and diagnosis

E. Record Keeping
   All records relevant to patient care will be recorded in the electronic medical record
   All information relevant to patient care will be recorded in the medical record and or EMR and EMTALA log

Commented [JS25]: [Claire’s response in blue, below] page 13 - protocol #3n under Plan (D.2.b) - 2 questions about treatment. It states that a saline heplック should be started and labs drawn if the following conditions are met: RR>40, peak flow <150, SpO₂ <90%. The committee wondered whether the O2 level was kind of low? the ED SP indicates SpO₂ <94%. Please advise. Secondly do ALL of these conditions have to be met in order to start the heplック or just one of the 3. Please clarify from a clinical perspective. We have a lot of patient who are chronically dependent on O2 and arrive a little low or having to transfer their O2 to ours when they arrive. While we of course make sure they are on O2 during their visit with an adequate SpO₂, if we started a heplック and got labs on all of them, we’d get a lot of unnecessary heplック placed. This is unlike the ED, where the majority of people who arrive with an urgent issue and low SpO₂ are likely to have an acute respiratory issue occurring. I’m fine with the RR and peak flow guidelines, and I would think that EITHER one indicates an IV and labs.

Commented [ED26]: I would think the provider would get involved after the first neb, so perhaps we don’t need the additional heb orders here?

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Commented [ED27]: RNs should consult physician on all patients c/o shortness of breath

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Commented [JS28]: update
Protocol #4: Assessment and Management of Shortness of Breath Without Wheezes

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath without wheezes seen by Registered Nurses (RN) in the Adult Medical Center.

   Indications
   • Chief complaint of shortness of breath
   • Absence of wheezes, and
   • RR >24, or
   • RA SpO₂ <94%

B. Data Base

1. Subjective Data
   • Review history and symptoms of shortness of breath
   • Pertinent past medical history, hospitalizations for respiratory disease, current medications and allergies
   • Characteristics of shortness of breath and associated symptoms (cough, fever, chills, chest pain, ankle edema)
   • Any treatments used prior to arrival

2. Objective Data
   • Perform focused physical exam relevant to respiratory disease
     - Auscultate lung sounds bilaterally
     - Note respiratory rate, depth, and work of breathing
   • Measure vital signs every 30 minutes x2
   • Place on pulse oximetry and measure SpO₂
   • Skin signs: color, temperature, moisture, and capillary refill
   • Laboratory and imaging evaluation:
     - If age > 35 years, 12-lead ECG. Show to provider when completed
     - Obtain portable CXR or send for PA and lateral CXR if:
       - SpO₂ >94% on oxygen
       - RR <24
       - ECG cleared by physician
       - Patient is alert and cooperative

C. Assessment

1. Consistent with subjective and objective findings

2. Assessment of status of disease process
D. Plan

1. All patients presenting with shortness of breath require attending consultation.

2. Treatment
   - Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain \( \text{SpO}_2 > 94\% \)
   - Start saline heplock IV (20-gauge or larger). Draw full tubes, including CBC, ER panel metabolic panel, and hold.
   - Draw and hold first set of blood cultures if fever \( > 38 \, ^\circ\, C \) (100.4 \(^\circ\, F\))

3. Patient conditions requiring attending consultation:
   - HR \( > 120 \)
   - BP \( < 90 \)
   - RR \( > 28 \)
   - \( \text{SpO}_2 < 92\% \)
   - Transport to Emergency Department as directed by provider

4. Education
   - Patient education and counseling appropriate to disease including treatment modalities and lifestyle counseling

5. Follow-up
   - As indicated and appropriate to patient health status and diagnosis

E. Record Keeping

All records relevant to patient care will be recorded in the electronic medical record

All information relevant to patient care will be recorded in the medical record and/or EMR and EMTALA log

Commented [ED29]: Same comment that all of these patients should have an attending consult

Commented [JS30]: Update
Protocol #5: Assessment and Management of Pregnant Patients

All patients who present with pregnancy related complaints are referred to 5M/ED or Labor and Delivery. Pregnant patients who are 16 weeks gestation or less are escorted to 5M for evaluation when 5M is open and has the ability to see the patient; if 5M not open/available, they are escorted to the ED. Those who are 17 weeks or more are transferred to 6C Labor and Delivery.

A. Record Keeping

All records relevant to patient care will be recorded in the electronic medical record. All information relevant to patient care will be recorded in the medical record and/or EMR and EMTALA log.
Protocol #6: Assessment and Management of Abdominal Pain

A. Definition: This protocol covers the initial assessment and management of patients with abdominal pain which may include but not limited to vomiting and diarrhea seen in the Adult Medical Center.

- Vomiting more than two times today, or
- Diarrhea/loose stool more than four times today or bloody or melena stool more than four times today, and
- Vital signs suggesting hemodynamic instability (HR >100 or SBP <110), or
- Orthostatic vital signs or dizzy when standing.

B. Data Base

1. Subjective Data
   - Review history and symptoms suggestive of volume loss
     - Frequency, amount, and color of emesis
     - Frequency, amount, and color of stool and urine
   - Pertinent past medical history, CHF or renal failure; current medications and allergies
   - Characteristics of any pain location, quality, and intensity (0-10) and associated symptoms (abdominal pain, fever, chills)
   - Any treatments used prior to arrival

2. Objective Data
   - Perform focused physical exam relevant to gastrointestinal disorders
   - Auscultate bowel sounds and note abdominal distension and any focal areas of pain
   - Measure vital signs every 30 minutes x2. Include orthostatic vitals signs unless HR >100 or SBP <90.
   - Obtain urine HCG in woman who could be pregnant or are of childbearing age.
   - Attach EKG if known cardiac history
   - Place on pulse oximetry and measure SpO2
   - Skin signs: color, temperature, moisture, and capillary refill

C. Assessment

1. Consistent with subjective and objective findings
2. Assessment of status of disease process
D. Plan

1. All patients presenting with abdominal pain require attending consultation.

2. Treatment
   - Ask physician for anti-emetic medication if appropriate
   - If HR >100 or SBP <100 or orthostatic, start saline IV heparlock and ___draw labs full-tubes CBC.
   - Save stool sample if diarrhea

2. All patients presenting with abdominal pain require attending consultation.
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 38°C (102.2°F)
   - History of CHF or renal failure
   - Vomiting more than two times in Adult Medical Center prior to being seen by provider
     - Transport to Emergency Department as directed by provider consultation.

3. Education
   - Patient education and counseling appropriate to disease process

4. Follow-up
   - As indicated and appropriate to patient health status and diagnosis

E. Record Keeping

All records relevant to patient care will be recorded in the electronic medical record.

All information relevant to patient care will be recorded in the EMR or medical record and or EMR.