San Francisco General Hospital and Trauma Center
Emergency Department

Medical Screening
Registered Nurse

Community Health Network of San Francisco

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Introduction

The following protocols are the policies and guidelines for the care provided to patients at San Francisco General Hospital and Trauma Center (SFGH), Emergency Department (ED) Medical Screening area by Registered Nurses (RN). 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 ED 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 Standardized Procedures were developed with assistance from the following:

1. Implementation of Standardized Procedures. Position Statement of the California Nurse Association
2. Standardized Procedure Work Sheet, State of California Board of Registered Nursing, Department of Consumer Affairs.

San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE ~ REGISTERED NURSE

Title: Medical Screening Nurse in the Emergency Department

I. Policy Statement

A. It is the policy of the Community Health Network and 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, Nurse Midwives, Registered Nurses, Physicians, Pharmacists, Administrators and other Affiliated Staff.

B. A copy of the signed procedures will be kept in an operational manual in the telemetry room of the Emergency Department, and on file in the Medical Staff Office.

II. Functions to be performed

The Registered Nurse based upon the nursing process determines the need for a standardized procedure. 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 RN May Perform Function

A. Setting
The Registered Nurse may perform the following standardized procedure functions in the Emergency Department consistent with their experience and training.

B. Scope of Supervision Required
1. The RN is responsible and accountable to the Emergency Department Nurse Manager and Medical Director or physician designee.

2. Overlapping functions are to be performed in areas, which allow for a consulting physician to be available to the RN, by phone or in person, including but not limited to the clinical area.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
    a. Emergency conditions requiring prompt medical intervention
    b. Upon the request of the registered nurse or physician

IV. Requirements for the Registered Nurse

A. Experience and Education
    1. Active California Registered Nurse license
    2. Current Advanced Cardiac Life Support certification from an approved American Heart Association provider.

B. Special Training
    1. Enrollment in the Emergency Department Medical Screening training by the Emergency Department Nurse Manager
    2. Successful completion of the didactic (six hours) and clinical training (24 hours preceptorship) requirements described by the *Guidelines for Emergency Nursing Practice*

C. Evaluation of the Registered Nurse competence in performance of standardized procedures
    1. Initial: at the conclusion of the standardized procedure training the Nurse Manager or Medical Director or physician designee will assess the RN's ability to perform the procedure.
        a. Successful completion of the medical screening skills checklist
        b. Successful completion of Emergency Nurse Educator, or designee, review of accuracy and completeness of documentation for actual patient cases (minimum of ten).
    2. Annual: Nurse Manager, Medical Director or physician designee will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation and or chart review may be used.
    2. 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 physician designee at appropriate intervals until acceptable skill level is achieved. This may also include chart reviews.

V. Development and Approval of Standardized Procedure

A. Method of Development
    Standardized procedures are developed collaboratively by the registered nurses, nurse managers, physicians, and administrators and must

conform to the eleven steps of the standardized procedure guidelines 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 Joint Conference Committee prior to use.

C. Review Schedule

The standardized procedure will be reviewed every three years by the registered nurses, nurse managers, and medical director and as practice changes.

D. Revisions

All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.

Protocol #1
Medical Screening Examination

Protocol: Medical Screening Examination

A. Definition: This protocol covers the medical screening examination (MSE) performed in the Emergency Department (ED). The MSE is an examination performed by physicians, or qualified Registered Nurses, on all patients who present to the ED seeking care. The examination, viewed as an ongoing process, may range from a brief to a detailed examination involving all the laboratory, x-ray, and consultative resources available within SFGH's range of services, so that it is possible to reasonably determine whether an emergency medical condition exists or not.

B. Data Base

1. Subjective Data

- Statement of chief complaint
- Patient history, and signs and symptoms relevant to disease process/injury and organ systems affected
- Pain assessment to include location and intensity (1-10 scale)
- Pertinent past medical history, medications, and allergies
- Current immunization status for children and adults with surface trauma
- Any treatments used prior to arrival

2. Objective Data

- Limited physical exam appropriate to disease processes/injury
- Level of consciousness (may use Glasgow Coma Scale)
- Vital signs
- Skin signs
- Emotional state

- Physical appearance, size and location of injuries, with assessment of distal circulation, movement and sensation, as appropriate

- Ability to ambulate and assessment of gait, as appropriate

- Assessment of symptoms of pregnancy or possible labor, including term gestation, as appropriate

- Disease and age appropriate and radiological studies (see Protocol # 2)

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process/injury

D. Plan

1. Initiation of treatments per *Medical Screening and Triage* policy

2. Patient education and counseling appropriate to disease process/injury

3. Consultation with physician as per *Medical Screening and Triage* policy

4. Determination of triage category: emergent, urgent, or non-urgent

5. Documentation of plan

Protocol #2
Radiological Studies Ordered from Medical Screening Area

Protocol: Radiological Studies Ordered from Medical Screening Area

A. Definition: This protocol covers the ordering of radiological studies from the Medical Screening area.

B. Inclusions: This protocol includes chest and extremity x-rays, and other radiological studies in consultation with attending physician.

C. Data Base

1. Subjective Data

• Statement of chief complaint

• Patient history, and signs and symptoms relevant to disease process/injury and organ systems affected

• Pain assessment to include location and intensity (1-10 scale)

• Any treatment used prior to arrival

2. Objective Data

• Limited physical exam appropriate to disease process/injury

• Ability to ambulate and assessment of gait, as appropriate

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process/injury

D. Plan

1. Initiation of radiological studies per *Medical Screening and Triage* policy

2. Patient education and counseling appropriate to disease process/injury

3. Consultation with physician as per *Medical Screening and Triage* policy

4. Documentation of radiological study ordered