San Francisco General Hospital and Trauma Center
Positive Health Program

DROP-IN CLINIC
Registered Nurse

Standardized Procedures

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Positive Health Program
HIV/AIDS Division at SFGH

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San Francisco General Hospital and Trauma Center
Positive Health Program (PHP)
Drop-In Clinic Registered Nurse
Standardized Procedures Manual

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Distribution List:

Copy 1:	Triage Nurses
Copy 2:	CIDP committee
Master copy with disk:	Quality Management

San Francisco General Hospital and Trauma Center

PHP Urgent Care

Drop-In Registered Nurse

Standardized Procedures and Protocols

The following Registered Nurses have reviewed the standardized procedures and have demonstrated competency as Urgent Care Registered Nurses. They are authorized to practice in the Urgent Care Center under the Standardized Procedures and Protocols contained in this manual:

Joe Pelletier, RN
Val Robb, RN
Mary Shiels, RN
Guy Vandenberg, RN
Sheka Jones, RN
Eva Mureithi, RN

Deleted: Diane Jones,

Deleted: Deborah Zeitschel,

_____ _____

Monica Gandhi, MD Date
Medical Director, Positive Health Program
San Francisco General Hospital and Trauma Center

_____ _____

Eva Mureithi, RN Date
Nurse Manager, Positive Health Program
San Francisco General Hospital and Trauma Center

List updated 04/12/2016

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San Francisco General Hospital and Trauma Center

Standardized Procedures:
Drop-In Clinic Registered Nurse

Introduction

The Positive Health Program Adult Urgent Care at San Francisco General Hospital and Trauma Center is an ambulatory clinic that provides same-day care for medically stable sick and injured adults. PHP Nurses, Physicians and Nurse Practitioners possess expertise in the care of adults of all ages needing immediate care.

The following protocols (adopted from the SFGH Urgent Care Center) are the policies and guidelines for the care provided to patients at San Francisco General Hospital and Trauma Center (SFGH) PHP Drop-In Clinic by the Registered Nurse (RN). The RN will consult the Lead Clinician, regarding the appropriate assessment, treatment, or disposition of all patients presenting with medical chief complaints.

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.

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Commented [GS1]: This implies that a patient may, under some circumstances, not see a provider. Given that RNs are not performing MSE, patients must always see a provider.

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STANDARDIZED PROCEDURE ~ REGISTERED NURSE

Title: Registered Nurse in the Drop-In Clinic

I. Policy Statement

A. It is the policy of 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, Registered Nurses, Physicians, Administrators and other Affiliated Staff and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. A copy of the signed procedures will be kept in a policies and procedures manual in the Positive Health Program and on file in the credentialing liaison Medical Staff Office.

II. Functions to be performed

The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. The RN provides interdependent functions that overlap the practice of medicine. These overlapping functions require standardized procedures.

Commented [GS3]: Changes to treatment regimen should be covered under the SP (unless ordered by the provider).

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III. Circumstances Under Which RN May Perform Function

A. Setting
The Registered Nurse may perform the following standardized procedure functions in the Drop-In Clinic consistent with his/her experience and training.

B. Scope of Supervision Required
1. The RN is responsible and accountable to the PHP Nurse Manager and Medical Director or physician designee.
2. Overlapping functions are to be performed in areas, which allow for a consulting provider to be available to the RN, by phone or in person, including but not limited to the clinical area.
3. Provider consultation is to be obtained for all patients and obtained immediately according to specific criteria described in the protocols :
   a) Urgent conditions requiring prompt medical intervention
   b) Upon the request of the patient, registered nurse, or provider

4. Protocols

Protocol #1
Chest Pain

Protocol #2
Shortness of Breath with Wheezes

Protocol #3
Shortness of Breath without Wheezes

Protocol #4
Vaginal Bleeding

Protocol #5
Nausea, Vomiting and Diarrhea

IV. Requirements for the Registered Nurse

A. Experience and Education
1. Active California Registered Nurse license
2. Current Basic Life Support certification

B. 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 designee will assess the RN's ability to perform the procedures.
   a. Successful completion of the RN orientation program

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Commented [GS10]: Again, isn't consultation (MSE) by a provider always part of the visit?

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b. Successful completion of a review of accuracy and completeness of documentation for actual patient cases (minimum of ten).

2. Annual: Nurse Manager or 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.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, or designee at appropriate intervals until acceptable skill level is achieved. This evaluation may 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
The CIDP, and Credentials, Medical Executive, and Joint Conference Committees must approve all standardized procedures prior to the implementation.

C. Review Schedule
The standardized procedures 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: **Assessment and Management of Chest Pain (Adult)**

A. Definition: This protocol covers the initial assessment and management of high-risk patients with cardiac related chest pain by RNs during the assessment. "High-risk" includes patients with preexisting conditions increasing their risk for acute cardiac or pulmonary problems

Indications

- Complaint of pain anywhere in the front of the chest within the last 72 hours, whether patient has pain currently or not

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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 suggestive of ischemia
- 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
- Palpitations

B. Current medications, allergies and past medical history ("have you ever had…"), including

- High blood pressure
- Angina
- MI
- Coronary surgery or stent
- Congestive heart failure
- Stimulant use (crack, cocaine, speed, meth)
  - If yes: when?
- Abnormal heart rhythm
- Lupus
- HIV/AIDS
- Elevated cholesterol
- Stroke
- Blood clots in lung, leg or large blood vessels
- Hormones for birth control or menopause
- Peripheral artery disease

- Smoker
- Takes antihypertensive or nitroglycerin
- Kidney disease
- Diabetes

• Characteristics of pain; i.e., PQRST (provoking or palliating factors, quality, radiation, severity/intensity, timing/duration), location, patient self-rating of pain on 0-10 scale (0 = no pain, 10 = worst pain of one's life)

• Any treatments or medications used prior to arrival

2. Objective Data

Perform focused physical exam relevant to chest pain/cardiac disease
• Level of consciousness
• Measure vital signs with pain scale
• Place on pulse oximetry and measure SpO_2
• Skin signs: color, temperature, moisture and capillary refill
• Laboratory and imaging evaluation:
  • 12-lead ECG, show to Lead Clinician when completed

C. Assessment
a. Consistent with subjective and objective findings
b. Assessment of status of disease process
c. Determine whether pt. at **high risk** for cardiac or pulmonary emergency based on responses to subjective and objective questions:
High risk: 3 or more positive answers to history questions OR
Male > 55 yo + one positive answer OR
Female > 65 yo + one positive answer

D. Plan
1. High Risk: Treatment
a. Administer oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO_2 >94%
b. Administer Aspirin 325 mg chewed (if no contraindications)
c. If BP > 90/60 give Nitroglycerin 0.4mg tablets sublingual q5 minutes x up to 3 doses, and check BP q5 minutes x3
d. Call 9-911 for ALS transport to ED

2. Unclear Risk: Patient conditions requiring attending consultation **and/or** transport to ED
a. Vital signs consistent with Level 1 triage criteria:
(1) HR <50 or >120
(2) BP <90/60 or >170/110
(3) RR >24
(4) SpO_2 <90%

Commented [GS13]: Needs to be defined-anyone who isn't high risk?

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Commented [U14]: High Risk category defined so all other patients fall into this category.

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(5) T >39° C (102.2° F)

b. 12-lead ECG, show to Lead Clinician when completed

c. Transport to Emergency Department if indicated under provider 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 information relevant to patient care will be recorded in the electronic medical record as per the SFGH policy.

Appendix: Chest pain algorithm

High Risk History Questions:

- Have you ever had
  - High blood pressure
  - Angina
  - MI (heart attack)
  - Coronary surgery or stent
  - CHF (heart failure)
  - Abnormal heart rhythm
  - Lupus
  - HIV/AIDS
  - Elevated cholesterol
  - Stroke
  - Diabetes
  - Peripheral artery disease
  - Kidney disease
  - Deep venous thrombosis (blood clot in the legs or arms)
  - Pulmonary embolism (blood clot in the lungs)
- Have you taken or do you take
  - Blood pressure medication
  - Nitroglycerin for chest pain
- Do you smoke?
- Have you used stimulants (crack, speed, meth, cocaine)? When?

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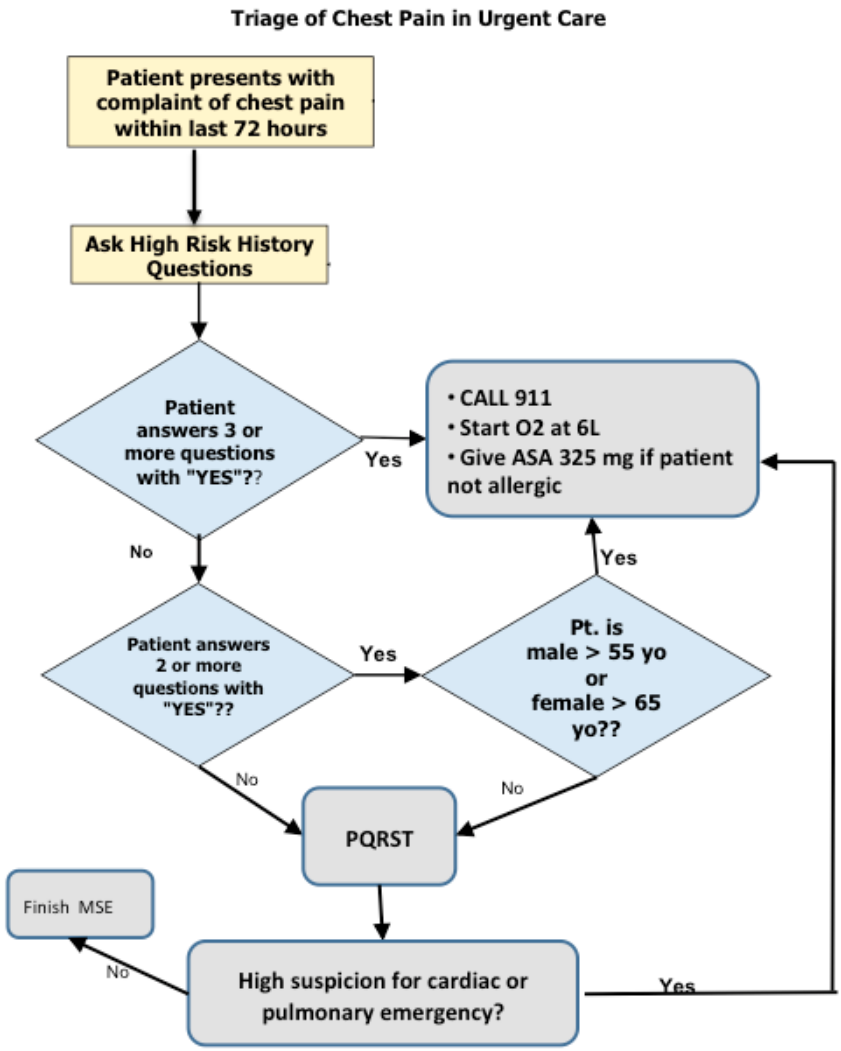
Commented [U18]: Algorithm deleted



Protocol #2: **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 drop-in clinic.

Indications

- Shortness of breath with confirmed wheezing and history of asthma/COPD

B. Data Base

1. Subjective Data

- Review history and signs and symptoms of asthma/COPD
- Pertinent past medical history, current medications and allergies
- Characteristics of shortness of breath and associated symptoms (cough, fever, chills)
- Any treatments used prior to arrival and/or provider or hospital visits

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 and repeat as necessary

c. Measure peak flow before and after 1st nebulizer treatment

d. Place on pulse oximetry and measure SpO_2

e. Skin signs: color, temperature, moisture, and capillary refill

C. Assessment

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Treatment

a. Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO_2 >94%

2. Patient conditions requiring immediate provider consultation or transport to ED

a. Vital signs consistent with Level 1 triage criteria:
   (1) HR <50 or >120
   (2) BP <90/60 or >170/110
   (3) RR >24

Commented [GS19]: Prompt or immediate consultation? Need to be clear that all of these patients would be assessed by a provider.

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(4) SpO_2 <90%
(5) T >39° C (102.2° F)

b. Transport to Emergency Department as directed by provider.

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 information relevant to patient care will be recorded in the electronic medical record as per SFGH policy.

Protocol #3: **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 drop-in clinic.

Indications

- Chief complaint of shortness of breath
- Absence of wheezes, and
- RR >24, or
- RA SpO_2 <90%

B. Data Base

1. Subjective Data

- Review history and signs 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, and/or provider or hospital visits

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 on triage with pain scale
• Measure vital signs and repeat as necessary
• Place on pulse oximetry and measure SpO_2
• Skin signs: color, temperature, moisture, and capillary refill
• Laboratory and imaging evaluation:

C. Assessment

a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Treatment
   ○ Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO_2 >94%

2. Patient conditions requiring immediate provider consultation and/or transport to ED
   a. Vital signs consistent with Level 1 triage criteria:
      (1) HR <50 or >120
      (2) BP <90/60 or >170/110
      (3) RR >24
      (4) SpO_2 <90%
      (5) T >39 ° C (102.2 ° F)
   b. 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 information relevant to patient care will be recorded in the electronic medical record as per the SFGH policy.

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Protocol #4: **Assessment and Management of Vaginal Bleeding**

A. Definition: This protocol covers the initial assessment and management of patients with vaginal bleeding seen by Registered Nurses (RN) in the drop-in clinic.

Indications

- Vaginal bleeding,
- Age < 50 years

B. Data Base

1. Subjective Data

• Review history and signs and symptoms related to gynecological emergency
    - Gravida, para, abortions
    - Date of last menstrual period; duration and amount of flow, length of time for pad/tampon saturation, presence of clots or tissue
    - Pregnancy suspected or confirmed. If confirmed, expected date of confinement (EDC)
    - If patient is postpartum: date of delivery, complications
• Pertinent past medical history, current medications and allergies
• Characteristics of any pain (PQRST); location, quality, and intensity (0-10) and associated symptoms (abdominal cramping, fever, chills)
• Any treatments used prior to arrival, and/or provider or hospital visits

2. Objective Data

• Vital signs with pain scale. Include orthostatic vitals signs if HR >100 or SBP <90
• Laboratory:
    - Stat urine B-HCG

C. Assessment

a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Treatment

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Commented [GS23]: The remainder of the protocol indicates application to patients who are not pregnant (e.g. postpartum patients), so pregnancy should not be listed as a required indication.

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- Age appropriate screening and/or diagnostic purposes of disease identification

2. Patient condition requiring immediate provider consultation and/or transport to ED or 6C
   a. Vital signs consistent with Level 1 triage criteria:
      (1) HR <50 or >120
      (2) BP <90/60 or >170/110
      (3) RR >24
      (4) SpO_2 <90%
      (5) T >39° C (102.2° F)
   b. nonpregnant with heavy vaginal bleeding as defined by saturating a pad in one hour or less
   c. confirmed pregnancy

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

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

E. Record Keeping
All information relevant to patient care will be recorded in the medical record as per the SFGH policy.

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Deleted: Negative stat urine beta-hCG

Deleted: Pregnancy-related problem listed under Level 1 triage criteria as noted in Urgent Care Nursing Medical Screening Evaluation Grid (transfer to 6C Birth Center if ≥14 weeks of gestation or if <14 weeks send to the ED as directed by provider if symptoms present.)

Protocol #5: **Assessment and Management of Nausea, Vomiting and Diarrhea**

A. Definition: This protocol covers the initial assessment and management of patients with vomiting and diarrhea seen by Registered Nurses (RN) in the drop-in clinic.

Indications

- Vomiting more than two times today, blood or coffee ground emesis
- Diarrhea/loose 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 signs and symptoms suggestive of volume loss
  - Frequency, amount, and color of emesis, hemoptysis
  - Frequency, amount, and color of stool , melena
- Pertinent past medical history, CHF or renal failure; current medications and allergies
- Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (abdominal pain, fever, chills)
- Any treatments or medications used prior to arrival

2. Objective Data

- Measure vital signs with pain scale. Include orthostatic vital signs.
- Place on pulse oximetry and measure SpO_2
- Skin signs: color, temperature, moisture, and capillary refill

C. Assessment

a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. Plan

1. Treatment
   - Consult with Lead Clinician re: any of the following treatments or tests:

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- anti-emetic medication
- If HR >100 or SBP <100 or orthostatic, start saline IV heplock draw ordered labs.
- Save stool sample if diarrhea
- IV Fluids infusion

2. Patient conditions requiring immediate provider consultation and/or transport to ED
   a. Evaluation criteria consistent with Level 1 triage criteria
      (1) HR <50 or >120
      (2) BP <90/60 or >170/110
      (3) RR >24
      (4) SpO_2 <90%
      (5) T >39° C (102.2° F)
   b. Altered mental status
   c. History of CHF or renal failure
   d. Vomiting more than two times prior to being seen by provider
   e. Transport to Emergency Department as directed by provider

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 information relevant to patient care will be recorded in the electronic medical record as per the SFGH policy.

CROSS REFERENCE
SFGH Administrative Policy and Procedures:

13.11: Medical Record Documentation

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