1. Purpose of Policy

To expedite patient care by initiating evidence-based interventions by Registered Nurses based on patient complaint and acuity. These medical staff approved procedures are intended to be a guide for Medical Emergency Response Team (MERT) RNs to initiate basic interventions in the hospital.

2. Policy Statement

A. It is the policy of 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, Nurse Midwives, Registered Nurses, Pharmacists, Physician Assistants, Physicians and administrators and other affiliated staff and must conform to the Nurse Practice Act, Business and Professions Code Section 2725 and all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, a copy of the signed procedures will be kept in an operational manual located in the MERT office and on file in the Medical Staff Office.

2. 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.

3. Circumstances under Which RN May Perform Function

A. Setting
The MERT Registered Nurse may perform the following standardized procedure functions on the ZSFG campus consistent with their experience and training.

B. Scope of Supervision Required:
   1. The RN is responsible and accountable to the Critical Care Nursing and Medical Directors.
   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:
      a. Acute decompensation of patient situation.
      b. Upon the request of the registered nurse, patient or physician.
      c. Unexplained historical, physical or laboratory findings.
      d. Uncommon, unfamiliar, unstable, and complex patient condition.
      e. An adverse response to respiratory treatment, or a lack of therapeutic response.

4. Protocols to be used in practice area:
   Protocol #1 Assessment and Management of Adult Patient with Generalized Medical Illness and Abnormal Vital Signs
   Protocol #2 Assessment and Management of Altered Mental Status
   Protocol #3 Assessment and Management of Seizure
   Protocol #4 Assessment and Management of Shortness of Breath
   Protocol #5 Assessment and Management of Chest Pain
   Protocol #6 Assessment and Management of Severe Sepsis
   Protocol #7 Assessment and Management of Gastrointestinal Bleeding

5. Requirements for the Registered Nurse

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

   B. Special Training
      1. Minimum of 2 years critical care experience
      2. Successful completion of clinical orientation/training (24 hours preceptorship) requirements, including standardized procedures specific training

Commented [M(1)]: I agree with this addition
Commented [JK2]: CIDP reviewer Jennifer Kanemaga suggested adding in the NP/PA templated items in c. and d. I reformatted so the lettered items followed suit without gaps
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, Medical Director or designated physician will assess the RN's ability to perform the procedure:

      Clinical Practice:
      Successful completion of the RN orientation program (24 hours)
      Successful completion of a review of accuracy and completeness of documentation for actual patient cases by MERT Team Lead (minimum of five the first year, then two thereafter)

   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 or chart review may be used. The standardized procedures will be a required MERT Competency for annual review.

   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. This may include chart reviews.

6. Development and Approval of Standardized Procedures

   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 the Joint Conference Committee prior to use.

   C. Review Schedule
      The standardized procedure will be reviewed every three years or as practice changes, by the registered nurses, nurse managers and medical directors.

   D. Revisions
      All changes or additions to the standardized procedures are to be approved by
Protocol #1
Assessment and Management of Adult Patient with Generalized Medical Illness and Abnormal Vital Signs

Protocol: Adult Patient with Generalized Medical Illness and Abnormal Vital Signs

A. Definition: This protocol covers the initial assessment and management of adult patients with generalized medical illness and abnormal vital signs seen by Registered Nurses (RN) on the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications
- Any concern about a patient's clinical condition
- Change in vital signs 20% from baseline
- Change in mental status
- Acute change in oxygenation requirements
- Chest pain unrelieved by chest pain protocol
- Shortness of breath
- SpO2 <92% despite oxygen

B. Data Base

1. Subjective Data

- Signs and symptoms generalized medical illness
- Sequence of preceding events
- Actions that relieve symptoms
- Pertinent past medical history, current medications and allergies
- Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)
- Any treatments used prior to arrival

2. Objective Data
• Perform focused physical exam relevant to generalized medical illness
• Level of consciousness (may use Glasgow Coma Scale)
• Measure vital signs q 30 minutes and prn
• Attach cardiac monitor, assess rhythm and monitor for dysrhythmias
• Place on pulse oximetry and measure SpO2

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

4. Plan
   1. Administer supplemental oxygen if SpO2 <92%, maintain patent airway
   2. Stat EKG for HR >20% from baseline or dysrhythmia, show provider when completed
   3. Ensure adequate IV/IO access and IV/IO patency
   4. Obtain stat POCT fingerstick glucose
   5. If POCT glucose <70 mg/dl administer D50 25 grams (1 ampule) IV, notify provider and recheck POCT glucose in 1 hour
   6. If POCT glucose >180, notify provider
   7. Consider sending urinalysis
   8. Patient education and counseling appropriate to disease process
   9. Consultation with provider upon provider’s arrival to MERT activation, or:
      • Any new concern about a patient’s clinical condition
      • Vital signs remain 20% from baseline
      • New or worsening change in mental status
      • Acute change in oxygenation requirements
      • Chest pain unrelieved by chest pain protocol
      • Shortness of breath
      • Pulse oximetry <92% despite titration of oxygen therapy
      • Assess skin condition: color, temperature, moisture and capillary refill
Protocol #2
Assessment and Management of Altered Mental Status

Protocol: Altered Mental Status

A. Definition: This protocol covers the initial assessment and management of patients with altered mental status seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications
- Altered mental status
- History of seizure disorders, IDDM, trauma, infection, psychiatric disorders, stroke, or
- Decrease, cessation, or overdose of alcohol or drug intake

B. Data Base

1. Subjective Data
   - Signs and symptoms of altered mental status
   - Sequence of preceding events
   - Duration of episode
   - Actions that relieve symptoms
   - Pertinent past medical history, current medications and allergies
   - Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)
   - Any treatments used prior to arrival

2. Objective Data
   - Perform focused physical exam relevant to altered mental status and/or syncope
   - Level of consciousness (may use Glasgow Coma Scale) and pupillary response
   - Assess for airway patency, insert oral or nasal airway as needed
   - Measure vital signs every 30 minutes and prn
   - Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
   - Place on pulse oximetry and measure \( \text{SpO}_2 \)
• Assess skin condition: color, temperature, moisture, and capillary refill

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

D. Plan
   1. Administer supplemental oxygen if SpO₂ <92%, maintain patent airway
   2. Stat chest xray and ABG (VBG if unable to obtain ABG) if O₂ sat<92% despite oxygen therapy or if patient exhibits signs or symptoms of respiratory distress
   3. Stat EKG for HR >20% from baseline or dysrhythmia, show provider when completed
   4. Ensure adequate IV/IO access and IV/IO patency
   5. Obtain stat POCT fingerstick glucose
   6. If POCT glucose <70 mg/dl administer D50 25 grams (1 ampule) IV, notify provider and recheck POCT glucose in 1 hour
   7. If POCT glucose >180, notify provider
   8. Send urinalysis and urine toxicology, split and hold the sample for urine culture if not recently done
   9. Consider sending CBC comprehensive metabolic panel

10. Patient education and counseling appropriate to disease process

11. Consultation with provider upon provider’s arrival to MERT activation, or:
   • Any new concern about a patient’s clinical condition
   • Vital signs remain 20% from baseline
   • New or worsening change in mental status
   • Acute change in oxygenation requirements
   • Chest pain unrelieved by chest pain protocol
   • Shortness of breath
   • Pulse oximetry <92% despite titration of oxygen therapy
Protocol #3
Assessment and Management of Active Seizure

Protocol: Seizure

A. Definition: This protocol covers the initial assessment and management of patients with a seizure seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) or the Intensive Care Unit (ICU).

Indications
- Witnessed or suspected seizure

B. Data Base

1. Subjective Data
   - Signs and symptoms of seizure
   - Description of onset and duration of event
   - Sequence of preceding events
   - Actions that relieve symptoms
   - Pertinent past medical history, current medications and allergies
   - Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms
   - Any treatments used prior to arrival

2. Objective Data
   - Perform focused physical exam relevant to seizure
   - Level of consciousness (may use Glasgow Coma Scale) and pupillary response
   - Assess for and maintain airway patency. Insert oral or nasal airway as needed
• Measure vital signs every 30 minutes and prn
• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
• Place on pulse oximetry and measure SpO₂
• Assess skin condition: color, temperature, moisture, and capillary refill

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

D. Plan
   1. Stat EKG for HR > 20% from baseline or dysrhythmia, show provider when completed
   2. Ensure adequate IV/IO access and IV/IO patency
   3. Obtain stat POCT fingerstick glucose
   4. If POCT glucose <70 mg/dl administer D50 25 grams (1 ampule) IV, notify provider and recheck POCT glucose in 1 hour
   5. If POCT glucose >180, notify provider
   6. Consider sending urinalysis and urine toxicology
   7. Consider sending CBC and comprehensive metabolic panel
   8. Patient education and counseling appropriate to disease process
   9. Consultation with provider upon provider’s arrival to MERT activation, or:
      • Any new concern about a patient’s clinical condition
      • Vital signs remain 20% from baseline
      • New or worsening change in mental status
      • Acute change in oxygenation requirements
      • Chest pain unrelieved by chest pain protocol
      • Shortness of breath
      • Pulse oximetry <92% despite titration of oxygen therapy
Protocol #4
Assessment and Management of Shortness of Breath

Protocol: Shortness of Breath

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Room (ED) or the Intensive Care Unit (ICU).

Indications
- Chief complaint of shortness of breath
- Shortness of breath with confirmed wheezing and history of asthma/COPD
- RR>24, or
- RA SpO2<94%

B. Data Base

1. Subjective Data
   - Signs and symptoms of shortness of breath
   - Assess for signs and symptoms of asthma/COPD
   - Review pertinent past medical history, hospitalizations for respiratory disease, current medications and allergies
   - Characteristics of shortness of breath (PORST) and associated symptoms (cough, fever, chills)
   - 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
   - Note stridor or audible wheezing and notify physician/ordering provider/RT
   - Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
• Measure vital signs every 30 minutes x2
• Place on pulse oximetry and measure SpO₂
• Assess skin condition: color, temperature, moisture, and capillary refill

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

D. Plan

1. Administer supplemental oxygen if SpO₂<92%, maintain airway

2. Stat chest xray and ABG (VBG if unable to obtain ABG) if O₂ <92% despite oxygen therapy or if patient exhibits signs or symptoms of respiratory distress

3. Stat EKG for HR>20% from baseline or dysrhythmia, show provider when completed

4. Ensure adequate IV/IO access and IV/IO patency

5. If wheezes are present, administer nebulized duoneb (combination albuterol sulfate 2.5 mg and ipratropium bromide 0.5 mg per 3 mg saline) x 3 doses every hour prn

6. NPO until evaluated by provider

7. Patient education and counseling appropriate to disease process

8. Consultation with provider upon provider’s arrival to MERT activation, or:
   • Any new concern about a patient’s clinical condition
   • Vital signs remain 20% from baseline
   • New or worsening change in mental status
   • Acute change in oxygenation requirements
   • Chest pain unrelieved by chest pain protocol
   • Shortness of breath
   • Pulse oximetry <92% despite titration of oxygen therapy
Protocol #5
Assessment and Management of Chest Pain

Protocol: Chest Pain

A. Definition: This protocol covers the initial assessment and management of patients with suspected ischemic chest discomfort seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

   Indications
   • Suspected ischemic chest discomfort
   Exclusions
   • Acute chest trauma or suspected musculoskeletal pain

B. Data Base

   1. Subjective Data

      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
      • Pertinent past medical history, current medications and allergies
      • Characteristics of pain (PQRST); location, quality, and intensity (1-10)
      • Any treatments used prior to arrival
      • Duration and onset of chest pain

   2. Objective Data

      • Perform focused physical exam relevant to chest pain/cardiac disease
      • Level of consciousness (may use Glasgow Coma Scale)
      • Measure vital signs every 30 minutes x2
      • Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
• Place on pulse oximetry and measure SpO₂
• Skin assessment: color, temperature, moisture, and capillary refill

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

D. Plan
   1. Administer supplemental oxygen if SpO₂ <94%, maintain patent airway
   2. Stat EKG, show provider when completed
   3. Ensure adequate IV/IO access and IV/IO patency
   4. Consider sending stat CBC, basic metabolic panel, magnesium, phosphorus, calcium coagulation labs and troponin
   5. Patient education and counseling appropriate to disease process
   6. Consultation with provider upon provider’s arrival to MERT activation, or:
      • Any new concern about a patient’s clinical condition
      • Vital signs remain 20% from baseline
      • New or worsening change in mental status
      • Acute change in oxygenation requirements
      • Chest pain unrelieved by chest pain protocol
      • Shortness of breath
      • Pulse oximetry <90% despite oxygen
Protocol #6
Assessment and Management of Severe Sepsis

Protocol: Severe Sepsis

A. Definition: This protocol covers the initial assessment and management of patients with suspected severe sepsis seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications

- Confirmed or suspected infection with two OR more of the following SIRS criteria:
  - Heart Rate > 90
  - Respiratory Rate > 20 (or PaCO₂ <32)
  - Temperature ≥ 38 °C (100.4 °F)
  - Temperature ≤ 36 °C (96.8 °F)
  - WBC > 12 or < 4 or > 10% bands (if available)

Exclusions

- None

B. Data Base

1. Subjective Data

- Signs and symptoms suggestive of infection
- Review pertinent past medical history, current medications and allergies
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to infection
- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs every 30 minutes x2
- Attach cardiac monitor, assess rhythm, and monitor for arrhythmias
- Place on pulse oximetry and measure SpO₂
- Skin assessment: color, temperature, moisture, and capillary refill

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

D. Plan

1. Administer supplemental oxygen if SpO$_2$ <92%, maintain patent airway
2. Obtain ABG (VBG if unable to obtain ABG)
3. Stat chest xray if O2 sats<92% despite oxygen therapy or if patient exhibits signs or symptoms of respiratory distress
4. Consider sending stat CBC, comprehensive metabolic panel, and lactate
5. Send blood cultures x2, urine culture and sputum culture if not already pending
6. If SBP<90 initiate 1000 cc NS bolus over 60 minutes
7. Stat EKG for HR >20% from baseline or dysrhythmia, show provider when completed
8. Ensure adequate IV/IO access and IV/IO patency
9. Patient education and counseling appropriate to disease process
10. Consultation with provider upon provider’s arrival to MERT activation, or:
   - Any new concern about a patient’s clinical condition
   - Vital signs remain 20% from baseline
   - New or worsening change in mental status
   - Acute change in oxygenation requirements
   - Chest pain unrelieved by chest pain protocol
   - Shortness of breath
   - Pulse oximetry <92% despite oxygen
Protocol #7
Assessment and Management of Gastrointestinal Bleeding

Protocol: Gastrointestinal Bleeding

A. Definition: This protocol covers the initial assessment and management of patients with gastrointestinal (GI) bleeding seen by Registered Nurses (RN) of the Medical Emergency Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and Intensive Care Unit (ICU).

Indications
• Blood or coffee-ground emesis
• Melena
• Rectal bleeding (more than spotting on tissue), and vital sign abnormality suggesting hemodynamic instability (HR >100 or SBP < 90)

B. Data Base

1. Subjective Data

• Signs and symptoms suggestive of GI bleeding
• Amount, type, and frequency of blood in emesis or stools and other associated symptoms (abdominal pain, fatigue, syncope)
• Pertinent past medical history, including history of ulcer, coagulopathies, esophageal varices, CHF or renal failure; current medications and allergies
• Characteristics of any pain (PQRST); location, quality, and intensity (1-10)
• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to gastrointestinal disorders
• Level of consciousness (may use Glasgow Coma Scale)
• Measure vital signs every 30 minutes
• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
• Place on pulse oximetry and measure SpO₂
• Skin signs: color, temperature, moisture, and capillary refill; petechiae, purpura, or ecchymosis

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

D. Plan
   1. Administer supplemental oxygen if SpO₂ <92%, maintain patent airway
   2. Ensure adequate IV/IO access and IV/IO patency (2 large bore IVs)
   3. Consider sending stat CBC, comprehensive metabolic panel, send type and screen or type and cross
   4. Hold anticoagulant drips and medications until evaluated by a provider
   5. NPO until evaluated by a provider
   6. Patient education and counseling appropriate to disease process
   7. If SBP <90 initiate 1000 cc NS IV bolus over 60 minutes
   8. Consultation with provider upon provider’s arrival to MERT activation, or:
      • Any new concern about a patient’s clinical condition
      • Vital signs remain 20% from baseline
      • New or worsening change in mental status
      • Acute change in oxygenation requirements
      • Chest pain unrelieved by chest pain protocol
      • Shortness of breath
      • Pulse oximetry <92% despite oxygen
      • Massive hematemesis bleeding with potential airway compromise