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ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Emergency Department

Emergency Department Registered Nurse

Standardized Procedures and Protocols

Zuckerberg San Francisco General Hospital and Trauma Center
Emergency Department

Emergency Department Registered Nurse
Standardized Procedures and Protocols Manual

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List updated ~~1/6/2021~~9/28/2021

Zuckerberg San Francisco General Hospital and Trauma Center

Emergency Department

Standardized Procedures:
Emergency Department Registered Nurse

Introduction

The following protocols are the policies and guidelines for the care provided to patients at Zuckerberg San Francisco General Hospital (ZSFG) Emergency Department (ED) by the Registered Nurse (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 RN will consult the Attending Physician by 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. Every patient presenting to the Emergency Department is evaluated by a provider (MD/NP/PA) regardless of the initiation of a standardized procedure by the RN. All Standard Procedures are intended for adult patients >18 years, unless otherwise indicated. When the Standardized Procedure is initiated and any diagnostic test is ordered (blood tests, radiologic exams as listed in the procedure), the Attending in Charge will be listed as the ordering provider.

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.

Zuckerberg San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE Registered Nurse Order Entry in the Emergency Department

Title: Registered Nurse in the Emergency Department

I. Purpose of Policy

To expedite patient care by initiating evidence-based interventions by Registered Nurses based on patient complaint and acuity. These medical ~~medical~~ staff approved procedures and protocols are intended to be a guide for RNs to initiate basic interventions in the Emergency Department.

II. 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, 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. 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 in the Emergency Department, 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 or changes in treatment regimen 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. These standardized procedures include guidelines stating specific conditions requiring the RN to seek provider 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 Emergency Department 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 as specified in the protocols and under the following circumstances:
   a) Emergency conditions requiring prompt medical intervention
   b) Upon the request of the patient, registered nurse, or provider
4. Every patient who presents to the Emergency Department is evaluated by a provider, regardless of the initiation of a Standardized Procedure by the RN.

IV. Requirements for the Registered Nurse

A. Experience and Education
1. Active California Registered Nurse license
2. Current Basic Life Support certification
3. Current Advanced Cardiac Life Support certification
4. Current Emergency Nurse Pediatric Course certification

B. Special Training
1. Enrollment in the Emergency Department orientation program by the Emergency Department Nurse Manager
2. Successful completion of the orientation program, including protocol specific training, 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 designee will assess the RN's ability to perform the procedures.
      a. Successful completion of the RN orientation program
      b. Successful completion of a review of accuracy and completeness of documentation for actual patient cases (minimum of ten the first year, then five thereafter)
   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, Credentials, Medical Executive, Nursing 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 manager, nurse director 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 Abdominal Pain

Protocol: Infestation

A. Definition: This protocol covers the initial assessment and management of patients with abdominal pain seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Generalized abdominal pain
- Reliable history of abdominal pain

Exclusions
- Gastrointestinal bleeding, vomiting and diarrhea, vaginal bleeding, suspected renal colic, sickle cell crisis

B. Data Base

1. Subjective Data

• Review history and signs and symptoms related to abdominal pain.
- Date of last menstrual period in women age <50 years

• Pertinent past medical history; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (cramping, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to abdominal pain
- Measure vital signs every 30 minutes x2.
- Level of consciousness (may use Glascow Coma Scale)
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Laboratory and imaging evaluation
   - CBC, BMP, LFT, Lipase
   - Urinalysis, urine culture, stat POCT urine pregnancy test for women < age 50 years
   - Stat 12-lead ECG if concern for cardiac ischemia. Show to Attending MD when completed.

2. Start IV (20-gauge or larger). Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Patient education and counseling appropriate to disease process
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4. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
     Altered mental status with GCS <13

Protocol #2
Assessment and Management of Acute Allergic Reaction

Protocol: Acute Allergic Reaction

A. Definition: This protocol covers the initial assessment and management of patients with acute allergic reaction seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Respiratory distress with history of provoking allergenic exposure prior to symptoms or
- Vital signs suggesting hemodynamic instability (HR >120 or SBP <110)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of acute allergic reaction

- Onset, Provoking Factor/Exposure prior to symptoms
- History of past allergic reactions
- History of anaphylaxis or anaphylactic shock

• Pertinent past medical history; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to allergic reactions

• Measure vital signs

• Place on pulse oximetry and measure SpO_2

• Check skin signs for color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula or non-rebreather mask. Titrate to maintain SpO_2 >94%.

2. Start IV (18-gauge or larger). Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Administer nebulized ~~duoneb~~DuoNeb (albuterol sulfate 2.5 mg and ipratroprium bromide 0.5 mg in 3 mL saline solution) x 1 dose if wheezing

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - Altered mental status with GCS <13
   - Signs & Symptoms of Anaphylactic Shock

Protocol #3
Assessment and Management of Agitation/Hallucinations

Protocol: Agitation/Hallucinations

A. Definition: This protocol covers the initial assessment and management of patients with agitation and/or hallucinations seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Agitated behavior or hallucinations and any of the following:
  1. History of psychiatric disorders, IDDM, or IVDU,
  2. Decrease or cessation of alcohol or sedative intake
  3. Drug intoxication
  4. Sepsis/CNS infection
  5. Vital signs suggesting hemodynamic instability HR > 120 or SBP < 90, or temperature >38.5C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of agitation and/or hallucinations

- Sequence of preceding events
- Duration and frequency of present symptoms
- 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 agitation/hallucinations

- Observe for signs of injury, needle marks, and characteristic breath odor

- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs every 30 minutes x2.
- Place on pulse oximetry and measure SpO_2
- Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Restrain Limbs per *Use of Restraints in the ED* policy.
2. Ask provider for sedation order.
3. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%
4. Obtain POCT fingerstick glucose.
5. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dl, followed by 0.9% NS flush 10ml with medication administration.
6. Notify provider and recheck POCT fingerstick glucose in one hour.
7. Patient education and counseling appropriate to disease process
8. Consultation with provider as needed, or:
    - HR >120 or <50
    - SBP <90
    - RR >28
    - SpO_2 <92%
    - New onset focal neurological symptoms
    - Altered mental status with GCS <13

Protocol #4
Assessment and Management of Suspected Alcohol Withdrawal

Protocol: Suspected Alcohol Withdrawal

A. Definition: This protocol covers the initial assessment and management of patients with suspected alcohol withdrawal seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of alcohol withdrawal with a decrease or cessation of alcohol, and
- Vital signs suggesting hemodynamic instability HR > 120 or SBP < 90, or temperature >38.5C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of alcohol withdrawal
- History of daily alcohol intake and last drink
- 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 alcohol withdrawal
- Observe for tremors, tongue wag, hallucinations, seizure-like activity, and altered mental status (CIWA-Ar scale)
- Observe for signs of injury, needle marks, and characteristic breath odor

• 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 SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- 12-lead ECG for HR > 120, show to Attending MD when completed
- Portable chest x-ray if indicated by symptoms or history

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

D. Plan
1. Start saline lock IV for HR >120 or SBP <90. Draw full tubes. Administer 1L NS IVF bolus if HR >120 or SPB <90. May repeat x 1 if HR >120 after 1st liter bolus unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, and liver function tests.

3. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

4. Obtain POCT fingerstick glucose.

5. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dl. Notify provider and recheck POCT fingerstick glucose in one hour.

6. Restrain Limbs per *Use of Restraints in the ED* policy.

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13
- Seizure-like activity

Protocol #5
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) in the Emergency Department (ED).

Indications

- Altered mental status and
- 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

• Review history and signs and symptoms of altered mental status

- History of seizure disorders, diabetes, trauma, infection, psychiatric disorders, stroke
- 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 altered mental status

- Assess for and maintain airway patency. Insert oral or nasal airway as needed.

• Level of consciousness (may use Glasgow Coma Scale) and pupillary response.

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• 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 Attending MD when completed
- Portable chest x-ray

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

D. Plan

1. Start saline lock IV for HR > 120 or SBP <90. Draw full tubes. Administer 1000 mL NS IVF Bolus if HR >120 or SPB <90, unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, liver function tests, and urinalysis.

3. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

4. Obtain POCT fingerstick glucose.

5. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dl. Notify provider and recheck POCT fingerstick glucose in one hour.

6. Obtain and send urine toxicology. Split and hold sample for urine culture.

7. Restrain Limbs per *Use of Restraints in the ED* policy.

8. Patient education and counseling appropriate to disease process

9. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #6
Assessment and Management of Cardiac Catheterization Lab Preparation

Protocol: Cardiac Catheterization Lab Preparation

A. Definition: This protocol covers the initial assessment and management of patients being prepped for the Cardiac Cath Lab seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Known or suspected STEMI with need to go to the Cardiac Cath Lab

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of ischemia

- Chest discomfort with STEMI
- 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

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 SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed
- Repeat EKG 15 minutes after the initial EKG
- Right Sided EKG (if inferior ST elevation)
- Posterior EKG (if septal or anterior ST depression)
- Portable CXR

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger). Draw full blood tubes. Send CBC, —basic metabolic panel, liver function tests, troponin I, BNP, PT/PTT/INR, and type and screen. Start a second saline lock IV. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Administer Aspirin 325 mg PO/PR x1 (if no contraindications or not administered prior to arrival)

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%

Protocol #7
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) in the Emergency Department (ED).

Indications

- Suspected ischemic chest discomfort

Exclusions

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

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

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 SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger). Draw full tubes. Send CBC, BMP, Troponin. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Imaging:
   - ~~2.~~ Chest x-ray

~~3.~~4. Patient education and counseling appropriate to disease process

~~4.~~5. Consultation with physician as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%

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Protocol #8
Assessment and Management of Dislocation/Deformity/Injury of Extremity

Protocol: Dislocation/Deformity/Injury of Extremity

A. Definition: This protocol covers the initial assessment and management of patients with a dislocation, deformity, or injury of extremity seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Obvious dislocation, deformity, or injury of extremity

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of dislocation, deformity, or injury of extremity

- 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 dislocation, deformity, or injury of extremity

- Assess circulation, movement, and sensation distal to injury

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:

- X-ray affected extremity per protocol

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start IV Saline Lock. Draw full blood tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer Td/Tdap 0.5 mL IM x 1, if immunization status not up to date and an open wound is present (hold if contraindicated).

3. If open fracture, cover wound with sterile dressing and notify provider immediately.

4. Place sling/splint on effected extremity if applicable.

5. Patient education and counseling appropriate to disease process.

6. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Temp > 39°C (102.2°F)

Protocol #9
Assessment and Management of Dysuria/Suspected Pyelonephritis

Protocol: Dysuria/Suspected Pyelonephritis

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

Indications

- Dysuria or
- History of a urinary tract infection

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of pyelonephritis

- Frequency, amount, and color of urine
- Onset and duration of symptoms
- Actions that relieve symptoms

• 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 used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to urinary disorders

• Measure vital signs

• Check skin signs for color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start IV Saline Lock if HR >120 or SBP <90. Draw full tubes. Administer 1000 mL NS IV bolus for HR > 120 or temp >38.5F if no history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and Basic Metabolic Panel if CVA tenderness, vomiting, and/or temp > 38.5.

3. Obtain and Send Urinalysis; Hold specimen for Urine Culture

4. Obtain POCT urine pregnancy for women < age 50 years.

5. Administer acetaminophen 975 mg PO x 1 for temp ≥ 38.5C if not contraindicated.

6. Notify provider if acetaminophen was administered by the ED nurse.

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - History of CHF or renal failure

Protocol #10
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) in the Emergency Department (ED).

Indications

- Subjective history of:
  1. Blood or coffee-ground emesis, or
  2. Melena, or
  3. Rectal bleeding (more than spotting on tissue), and Vital sign abnormality suggesting hemodynamic instability (HR >100 or SBP < 110)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of GI bleeding
- As noted above
- 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 x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• 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 of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start IV NS (18-gauge or larger). Draw full blood tubes. Obtain stat HCT POCT. Administer 1000 mL NS IV bolus (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Start 2nd IV (18-gauge or larger) if HR >110, SBP <120, conjunctiva pale, or history of esophageal variceal bleeding

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Massive hematemesis bleeding (with potential airway compromise)
   - Altered mental status with GCS <14
   - History of CHF or renal failure

Protocol #11
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) in the Emergency Department (ED).

Indications

- History of generalized medical illness and
- Vital signs suggesting hemodynamic instability HR > 120 or SBP < 90

B. Data Base

1. Subjective Data

• Review history and signs and symptoms generalized medical illness

- Sequence of preceding events
- Actions that relieve symptoms
- Observe for signs of injury, needle marks, and characteristic breath odor

• 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.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Check skin signs for color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG for HR > 120. Show to Attending MD when completed

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV for HR > 120 or SBP <90. Draw full tubes. Send CBC and basic metabolic panel. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Obtain stat POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Send urinalysis.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms

Protocol #12
Assessment and Management of Head Trauma

Protocol: Head Trauma

A. Definition: This protocol covers the initial assessment and management of patients with head trauma seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Blunt or penetrating trauma to the head and
- Vital signs suggesting hemodynamic instability (HR >120 or SBP <90)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of head trauma

- Sequence of preceding events
- Actions that relieve symptoms
- History of patient's baseline neurological function

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, seizure, or amnesia)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to head trauma

- Assess for and maintain airway patency. Insert oral or nasal airway as needed and if not contraindicated.
- Observe for periorbital ecchymosis, battle's sign, and drainage from nose or ears
- Apply direct pressure to areas of active bleeding
- Assess neurological status: determining gross motor strength and lateralization of limbs

• Level of consciousness (may use Glasgow Coma Scale) and pupillary response.

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias if GCS <13

• Place on pulse oximetry and measure SpO_2 if GCS <13

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock if GCS <13. Draw full blood tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send Trauma Panel for 900 Trauma: CBC with platelets, basic metabolic panel, PT/PTT/INR, ethanol level, and type and screen.

3. Obtain and send urine toxicology per Head Injury Panel (HIP) order set.

4. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

5. Patient education and counseling appropriate to disease process

6. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #13
Assessment and Management of Hyperglycemia

Protocol: Hyperglycemia

A. Definition: This protocol covers the initial assessment and management of patients with hyperglycemia seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Documented elevated glucose

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of hyperglycemia

- Diabetic history and medication regiment
- History of trauma, or infection
- Sequence of preceding events
- Actions that relieve symptoms

• 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

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to hyperglycemia

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock. Draw full blood tubes. Send CBC and basic metabolic panel. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Obtain stat VBG with potassium POCT.

3. Obtain POCT fingerstick glucose.

4. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

5. Obtain and send urinalysis.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fingerstick blood glucose <60 mg/dL or >400 mg/dL
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13
   - VBG potassium level > 5mEq/L

Protocol #14
Assessment and Management of Hyperthermia
Temperature ≥ 41 degrees C (105.8 degrees F)

Protocol: Hyperthermia Temperature ≥ 41 degrees C

A. Definition: This protocol covers the initial assessment and management of a patient with hyperthermia (temperature ≥ 41C) seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Temperature ≥ 41C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of hyperthermia

- History of infectious process or hyperthermic episode
- Sequence of preceding events and symptoms
- 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, back pain, rash)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to hyperthermia

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock IV. Draw full tubes. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and basic metabolic panel. Obtain and hold blood cultures x 2. Obtain stat lactic acid POCT (if meets sepsis protocol criteria).

3. Administer acetaminophen 975 mg PO/PR x 1, if not contraindicated.

4. Obtain and send urinalysis and urine culture.

5. Place indwelling urinary catheter with temperature sensor.

6. Initiate cooling measures.

7. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

8. Patient education and counseling appropriate to disease process

9. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Temp > 41
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #15
Assessment and Management of Hypoglycemia

Protocol: Hypoglycemia

A. Definition: This protocol covers the initial assessment and management of patients with hypoglycemia seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Documented low glucose level

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of hypoglycemia

- History of hypoglycemia
- History seizure disorders, trauma, or infection
- History of diabetes and medication regiment
- 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 hypoglycemia

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock. Draw full blood tubes. Send basic metabolic panel. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if fingerstick blood glucose <60 mg/dl. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Patient education and counseling appropriate to disease process

6. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fingerstick blood glucose <60 mg/dl after glucose administered by ED nurse
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #16
Assessment and Management of Hypothermia
Temperature ≤ 35 degrees C (95 degrees F)

Protocol: Hypothermia Temperature ≤ 35 degrees C

A. Definition: This protocol covers the initial assessment and management of a patient with hypothermia (temperature ≤ 35C) seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Temperature ≤ 35 degrees C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current symptoms

- Hypothermic episode or pertinent medical history
- History of infectious process
- History of immunocompromising disease processes
- Social history (homeless)
- Sequence of preceding events and symptoms
- 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 Hypothermia

- Observe for shivering (usually stops about 31°C)

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG. Show to Attending MD when completed.

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

D. Plan

1. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IVF bolus via fluid warmer (Hotline™ or Level 1) , unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and basic metabolic panel. Obtain stat lactic acid POCT.

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Consider placing indwelling urinary catheter with temperature sensor.

6. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

7. Use Bair Hugger™.

8. If using warm blankets, place over torso only if temperature ≤ 33C degrees.

9. Patient education and counseling appropriate to disease process

10. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- Temp <32 or >38.5
- New onset focal neurological symptoms

- Altered mental status with GCS <13

Protocol #17
Assessment and Management of Immunocompromised Patient with a Temperature ≥38.5C

Protocol: Immunocompromised Patient with a Temperature ≥38.5C

A. Definition: This protocol covers the initial assessment and management of an immunocompromised patient with a temperature ≥ 38.5C seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of temperature ≥ 38.5C and
- History of immunocompromised illness

B. Data Base

1. Subjective Data

• Review history and signs and symptoms surrounding fever
- History of immunocompromised disease
- Sequence of preceding events and symptoms
- 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, back pain, chest pain)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to an immunocompromised patient with a Temp ≥ 38.5C

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• 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 Attending MD when completed
- Portable chest x-ray

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

D. Plan

1. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IVF Bolus for HR >120 or SBP <90, unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, liver function tests, blood cultures x 2. Obtain stat VBG with lactic acid POCT.

3. Administer acetaminophen 975 mg PO x 1 for temp ≥ 38.5, if not contraindicated

4. Obtain and send urinalysis and urine culture

5. Obtain POCT urine pregnancy for women < age 50 years

6. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- Temp > 39°C (102.2°F)
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #18
Assessment and Management of Infestation

Protocol: Infestation

A. Definition: This protocol covers the initial assessment and management of patients with infestation seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Visible bed bugs, lice, and/or scabies or
- Exposure to bed bugs, lice, and/or scabies with concurrent symptoms

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of an infestation
- 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 an infestation
- Assess patient safety needs as pertains to showering with or without staff member assistance.
- Itchiness, multiple generalized body scratch marks.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis
a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Properly contain all contaminated clothing items and provide instructions for proper handling and cleaning of contaminated clothing.

2. Provide patient directions with shower instructions. Providing soap, towels, and clean clothes for after showering.

3. Apply Permethrin 5% cream to hair x 1 for presence of lice.

4. Apply Permethrin 1% lotion to skin x1 post showering with soap and water.

5. Patient education and counseling appropriate to disease process

6. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Altered mental status with GCS <13

Protocol #19
Influenza Vaccine

A. **DEFINITION**: This protocol covers the administration of the influenza vaccine to patients being discharged from the Emergency Department (ED) by Registered Nurses (RN). Once a discharge order has been placed by the provider, the RN caring for the patient will perform the Influenza Screening in the electronic health record (EHR). The ED RN will use the screening to document the patient decision to be vaccinated and that there are no contraindications to administration.

1. Indications: Annually during Flu season any patient older than 18 years of age seen at ZSFG will be offered the inactivated influenza vaccine unless there are documented contraindication(s) and/or a documented immunization for that year. ~~During the COVID-19 Pandemic for the 2020-2021 Flu season any adult patient older than 18 years of age being discharge from the ED will be offered the inactivated influenza vaccine unless there are documented contraindication(s) and/or a documented immunization for that year.~~

2. Precautions:
   - Utilize standard precautions for medication administration by intramuscular injection

3. Contraindications:
   - Previous administration of Influenza vaccine during existing Flu season
   - Previous adverse reaction to vaccination or component
   - Fever >/= 38 degrees Celsius in the last 48 hours
   - History of Guillain Barre Syndrome

4. Procedure
   - Screen Patient for Influenza Vaccination at ED prior to discharge
     - Review chart for documented objective contraindications
     - Review temperature documented for this emergency department visit in the patient's chart or take the patient's temperature
     - Talk to patient/decision maker for subjective contraindications

- For patients that qualify, offer vaccination and document accepts or declines vaccination in the screen.
- For patients that are not responsive, unable to engage, the screener may answer "No" to the first screening question "Are you able to assess patient at this time?" and be done

- Patient conditions requiring Physician Consultation
  - Questions regarding interpretation of a contraindication
  - Patient questions unable to be addressed by nursing expertise
- Education
  - Prior to vaccination, patients/decision maker will be provided education via Vaccine Information Sheets (VIS)
- Administration of Vaccination
  - RN to enter appropriate order for Influenza Vaccination using the mode "per protocol no co-sign required" for patients that qualify and accept vaccination and do not require further physician consultation.
    - Inactivated Influenza vaccine (IIV) is given IM. There is no upper age limit. IIV is the preferred formulation for influenza vaccination
  - Timing of administration will occur prior to discharge.
  - RNs are not authorized to place orders for Live Attenuated Influenza Vaccine
- RECORD KEEPING
  - Vaccination lot number, expiration date, and location of injection will be documented in the medical record

B. **DATA BASE/ DOCUMENTATION OF PROCEDURE**

Subjective Data (Adult ≥ 18 years)

a. Patient/decision maker declaration of previous administration of Influenza vaccine during existing Flu season.
b. Patient/decision maker declaration of prior reaction to vaccination or component.
c. Patient/decision maker declaration of history of Guillain Barre Syndrome

Objective Data (Adult ≥ 18 years)

a. Fever ≥ 38 degrees Celsius in the last 48 hours

b. Documentation in the medical record of a prior administration of the Influenza vaccine during existing Flu season, prior reaction the vaccination or component, or history of Guillain Barre Syndrome

C. SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY

Prerequisite: a. Completion of a training module on flu vaccination b. Review of Protocol
Proctoring Period: a. For RNs in orientation: observe placement of order in EHR for "ordered per protocol, no signature required" b. Designated RN Preceptor will provide supervision
Annual Competency Documentation: a. Annual performance appraisal b. Nurse Manager or their designee will be the evaluator
Any additional comments:

Protocol #2019
Assessment and Management of IVDU with a Temperature ≥ 38.5C

Protocol: IVDU with a Temperature ≥ 38.5C

A. Definition: This protocol covers the initial assessment and management of IVDU with a temperature ≥ 38.5 seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Temperature ≥ 38.5C and
- History of IVDU

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current drug use and fever
- Sequence of preceding events and symptoms
- 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, back pain, chest pain)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to IVDU with a Temp ≥ 38.5C

• Level of consciousness (may use Glasgow Coma Scale)

• Obtain core temperature, measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• 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 Attending MD when completed
- Portable chest x-ray

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

C. Plan

1. Start saline lock IV. Draw full ~~tubes~~blood tubes. Administer 1000 mL NS IVF Bolus for HR >120 or SBP <90, unless history of CHF or renal failure. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC, basic metabolic panel, blood cultures x 3. Obtain stat VBG with lactic acid POCT.

3 Administer acetaminophen 975 mg PO x 1 for Temp ≥ 38.5, if not contraindicated (e.g. liver disease)

4 Obtain POCT urine pregnancy for women < age 50 years.

5 Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

6 Patient education and counseling appropriate to disease process

7 Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #210
Assessment and Management of Missed Dialysis/Renal Failure

Protocol: Missed Dialysis/Renal Failure

A. Definition: This protocol covers the initial assessment and management of patients who have missed dialysis or have renal failure seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of missed dialysis/renal failure or
- Predetermined hyperkalemia with a history of dialysis

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of missed dialysis/renal failure history

- Dialysis/renal failure history
- Dialysis type and schedule
- Onset and duration of symptoms
- Actions that relieve symptoms

• Pertinent past medical history, CHF; current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (chest pain, palpitations, shortness of breath)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to dialysis/renal failure

• Measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat POCT venous blood gas (VBG) with a potassium level
- Stat 12-lead ECG, show to Attending MD when completed
- Portable chest x-ray

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Patient education and counseling appropriate to disease process

3. Consultation with provider as needed, or:
- VBG potassium level >5 mEq/L
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%
- Fever > 39 ° C (102.2 ° F)
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #221
Assessment and Management of Intentional Overdose

Protocol: Overdose

A. Definition: This protocol covers the initial assessment and management of patients with overdose seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Intentional overdose

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of an overdose
- History of psychiatric disorders
- History of past accidental or suicidal ingestion
- 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 an overdose
- Assess for and maintain airway patency. Insert oral or nasal airway as needed.

• Level of consciousness (may use Glasgow Coma Scale) and pupillary response.

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock IV. Draw full tubes. Send CBC, basic metabolic panel, liver function tests, acetaminophen level, and salicylate level. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Initiate 5150 or ”At Risk” precautions

6. Obtain and send urine toxicology

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms
- Altered mental status with GCS <13

Protocol #232
Assessment and Management of a Pediatric Patient with a Temperature ≥ 38.5 degrees C

Protocol: Pediatric Patient with a Temperature ≥ 38.5 degrees C

A. Definition: This protocol covers the initial assessment and management of pediatric patients with a temperature ≥ 38.5C seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Temperature ≥ 38.5C

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current pediatric illness
  - Sequence of preceding events and symptoms
  - Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (age appropriate pain scale) and associated symptoms (headache, crying, irritability, decreased appetite, tachycardia)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to pediatric temperature ≥ 38.5C
  - Observe for signs of injury, infection, rash, sepsis, and characteristics of meningococcal meningitis

• Level of consciousness (may use Pediatric Glasgow Coma Scale)

• Obtain core temperature, measure vital signs per *Guidelines for Emergency Nursing Practice*, assess central and peripheral pulses

• Obtain patient's weight in kg

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill (central and peripheral)

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via blow by if SpO_2 <94%

2. Administer acetaminophen 15 mg/kg PO/PR x 1 for Temp ≥38.5, if not contraindicated or if not previously administered within 4 hours.

3. Administer Ibuprofen 10 mg/kg PO x1 for Temp ≥39.0 only in children older than 6 months, if not contraindicated or if not previously administered within 6 hours.

4. Notify physician if anti-pyretics were administered by the ED nurse.

5. Send urinalysis. Hold specimen for urine culture. Anticipate collection of urine by catheterization for any male child less than 6 months old that is circumcised, any male child less than 12 months old that is uncircumcised, or any female child who is less than 24 months old.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
   - Abnormal vital signs based on patient's age. See addendum for table.
   - SpO_2 <92%
   - New onset focal neurological symptoms, rash
   - New onset listlessness, irritability, or change in Pediatric Glascow Coma scale

Protocol #243
Assessment and Management of Suspected Renal Colic

Protocol: Suspected Renal Colic

A. Definition: This protocol covers the initial assessment and management of patients with suspected renal colic seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Hematuria or
- Flank pain or
- History of renal colic, with or without
- Vomiting more than two times today

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of renal colic
  - Frequency, amount, and color of urine
  - Onset and duration of symptoms
  - Actions that relieve symptoms

• 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 (flank pain, abdominal pain, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to renal disorders

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start IV Saline Lock. Draw full blood tubes. Administer 1000 mL NS IV bolus for HR > 120 or temp >38.5C (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Send CBC and Basic Metabolic Panel.

3. Obtain and Send Urinalysis, split for urine culture if ordered

4. Obtain POCT urine pregnancy for women < age 50 years.

5. Administer ondansetron 4 mg IV x 1, if patient is nauseous and not contraindicated

6. Administer ketorolac 30 mg IV x 1 for pain, if not contraindicated (renal disease, hx GIB, allergy) If patient <50kg and or >65 years old, administer ketorolac 15 mg IV x1.

7. Notify provider if ondansetron and/or ~~ketorlac~~ketorolac was administered by the ED nurse.

8. Patient education and counseling appropriate to disease process

9. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - History of CHF or renal failure
   - Uncontrolled vomiting or pain not relieved by ondansetron and/or ~~ketorlac~~ketorolac

Protocol #254
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) in the Emergency Department (ED).

Indications

- Witnessed or suspected seizure

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of seizure

- History of seizure disorders & type of seizure-like activity
- History of post-ictal state
- History of diabetes, alcohol withdrawal, head trauma, drug effects, stroke, infection, or CNS lesion
- 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

- Assess for and maintain airway patency. Carefully suction as needed.

• Level of consciousness (may use Glasgow Coma Scale), pupillary response

• Measure vital signs every 30 minutes x2.

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Start saline lock. Draw full blood tubes. Send CBC, basic metabolic panel, liver function tests, and specimen for drug levels as appropriate: Dilantin level, Tegretol level, Valproic Acid level, ~~Phenobarbitol~~Phenobarbital level. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

2. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94% NRB.

3. Obtain POCT fingerstick glucose.

4. Administer D50 25 grams (1 ampule) IV x 1 if glucose <60 mg/dL. Notify provider and recheck POCT fingerstick glucose in one hour.

5. Administer lorazepam 2 mg IV x 1 for seizure activity (if not contraindicated~~), and~~) and notify provider.

6. Patient education and counseling appropriate to disease process

7. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - New onset focal neurological symptoms
   - Altered mental status with GCS <13

Protocol #265
Assessment and Management of Severe Sepsis

Protocol: Sever Sepsis

A. Definition: This protocol covers the initial assessment and management of patients with suspected severe sepsis seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Confirmed or suspected infection with two ***OR*** more of the following SIRS criteria:
- Heart Rate > 90
- Respiratory Rate > 20 (or $PaCO_2$ <32)
- Temperature ≥ 38 º C (100.4 º F)
- Temperature ≤ 36 º C (96.8 º F)
- WBC > 12 or < 4 or > 10% bands (if available)

Exclusions

- None

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of infection

• 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 SpO_2

- Skin signs: color, temperature, moisture, and capillary refill

- Laboratory and imaging evaluation:
    - POCT VBG with lactate

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Initiate the following:
    - Check POCT VBG with lactate
    - Administer oxygen in order to maintain SpO_2 >94%
    - Start saline lock IV (18-gauge or larger). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration
    - Draw full blood tubes.
    - Draw and hold blood cultures x 2
    - Obtain UA and split for culture

2. Additionally, if POCT Lactate ≥ 3 ***OR*** Systolic BP < 90 (MAP < 65):
    - Notify charge nurse and provider
    - Send blood cultures
    - Administer 0.9% NS IV fluid bolus of 30 mL/kg (each liter over 30 min)

3. Patient education and counseling appropriate to disease process

4. Consultation with provider as needed

Protocol #276
Assessment and Management of Shortness of Breath with Wheezes (Asthma/COPD)

Protocol: Shortness of Breath with Wheezes

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 Emergency Department (ED).

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 (PQRST) 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
  - Stridor or audible wheezing

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Measure vital signs every 30 minutes x2

• Measure peak flow before and after 1st nebulized treatment

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation
- None

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger) and draw full blood tubes if, and Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.
   - RR >40
   - Peak flow <150
   - SpO_2 <94%

3. Administer nebulized duoneb (combination albuterol sulfate 2.5 mg and ~~ipratropium~~ipratropium bromide 0.5 mg per 3 mL saline) x3 doses every 1 hour.

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%

Protocol #287
Assessment and Management of Shortness of Breath Without Wheezes

Protocol: 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 Emergency Department (ED).

Indications

- Chief complaint of shortness of breath
- Absence of wheezes, and
- RR >24, or
- RA SpO_2 <94%

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 (PQRST) 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
• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Measure vital signs every 30 minutes x2

• Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Obtain 12-lead ECG. Show to Attending MD when completed
- Obtain portable CXR or send for PA and lateral CXR if:
  - SpO_2 >94% on oxygen
  - RR <24
  - ECG cleared by provider
  - Patient is alert and cooperative

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (20-gauge or larger). Draw full blood tubes, including BNP, and hold. Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Draw and hold first set of blood cultures if fever > 38 ° C (100.4 ° F)

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%

Protocol #298
Assessment and Management of Sickle Cell Crisis

Protocol: Sickle Cell Crisis

A. Definition: This protocol covers the initial assessment and management of a patient with sickle cell crisis seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- History of sickle cell disease and
- Severe and uncontrolled sickle cell pain (as described by the patient)

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of sickle cell crisis

- Determine precipitating factors: illness, dehydration, stress, cold, or pregnancy
- History of therapeutic interventions for pain
- 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 a sickle cell crisis

• Level of consciousness (may use Glasgow Coma Scale)

• Measure vital signs

• Place on pulse oximetry and measure SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Provide large pitcher of water and encourage oral hydration.

3. Start saline lock IV. Draw full blood tubes. Administer 1000 mL NS IV bolus if unable to tolerate oral hydration (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

4. Send CBC, basic metabolic panel, and reticulocyte count.

5. Obtain and send urinalysis.

6. Obtain POCT pregnancy for women < age 50 years.

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
   - HR >120 or <50
   - SBP <90
   - RR >28
   - SpO_2 <92%

Protocol #3029
Assessment and Management of Surface Trauma

Protocol: Surface Trauma

A. Definition: This protocol covers the initial assessment and management of patients with surface trauma seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Trauma resulting in abrasions, lacerations, contusions, puncture wounds, avulsions, and bites

B. Data Base

1. Subjective Data

• Review history and signs and symptoms suggestive of surface trauma

- History of Tetanus immunization status
- For bites: obtain history including species of animal, location of animal, ~~and~~ time of trauma and vaccination status
- Time of occurrence of surface trauma to ensure lacerations are repaired within the appropriate time frame (6 hours for extremity, 12 hours for face and head)
- 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 surface trauma

- Assess circulation, movement, and sensation distal to injury
- Apply direct pressure to areas of active bleeding

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer Td/Tdap 0.5 mL IM x 1, if immunization status not up to date or contraindicated.

2. Patient education and counseling appropriate to disease process.

3. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Temp > 39°C (102.2°F)

Protocol # 310
Assessment and Management of Syncope
(Abrupt and Transient Loss of Consciousness)

Protocol: Syncope

A. Definition: This protocol covers the initial assessment and management of patients with syncope seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Reliable history of syncope or near-syncope

B. Data Base

1. Subjective Data

• Review history and signs and symptoms related to loss of consciousness
  - Sequence of preceding events
  - Duration of episode
  - Actions that relieve symptoms
  - Observe for signs of injury, needle marks, and characteristic breath odor

• 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 syncope

• 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 SpO_2

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Stat 12-lead ECG, show to Attending MD when completed
- Portable CXR

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer oxygen via nasal cannula at 2 liters/minute if SpO_2 <94%

2. Start saline lock IV (18-gauge or larger). Draw full blood tubes. Send CBC and basic metabolic panel. Administer 1000 mL NS IV bolus if HR >100 or SBP <120 (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Obtain stat fingerstick glucose. Obtain POCT urine pregnancy test for women < age 50 years.

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120 or <50
- SBP <90
- RR >28
- SpO_2 <92%
- New onset focal neurological symptoms

Protocol #~~31~~32
Trauma Laboratory Tests Order Set

A. **DEFINITION**: This protocol covers the initial laboratory tests for trauma patients seen by Registered Nurses (RN) in the Emergency Department (ED). On the arrival of an injured patient, who is ≥ 11 years of age and meets Trauma Team Activation (TTA) criteria, the RN caring for the patient will draw blood and obtain the urine samples as defined by the specific TTA "Trauma Laboratory Order Set". The pediatric lab order set (patients < 11 years of age) will be determined by the Trauma Team with consultation from the pediatric service.

For the **900 TTA Trauma Lab Order Set** the following samples will be obtained and sent to the laboratory for processing:

- Type and Screen
- ABO/Rh Recheck
- CBC
- Basic metabolic panel
- Coagulation panel (PT, PTT, INR)
- Ethanol
- Urinalysis
- Urine drugs of abuse screen
- POCT Urine pregnancy (females)
- POCT VBG with hematocrit, potassium, lactic acid

1. Performance of procedure:

   Indications: Injured patients with 900 Trauma Team Activation (TTA)

   Exclusions: Patients deemed by the Resuscitation Team (Trauma Attending, Emergency Medicine Attending, Anesthesia Attending) to be stable and not requiring lab panel processing

2. Precautions:
   - Utilize standard precautions for specimen collection and handling

3. Contraindications:
   - None

For the **911 TTA Trauma Lab Order Set** the following samples will be obtained and sent to the laboratory for processing

- CBC
- Basic metabolic panel
- Coagulation panel (PT, PTT, INR)
- Ethanol
- Urinalysis
- Urine drug of abuse screen
- POCT Urine pregnancy (females)

1, Performance of procedure:

Indications: Injured patients with a 911 Trauma Team Activation (TTA)

Exclusions: Patients deemed by the Emergency Provider /Resuscitation Team to be stable and not requiring lab order set processing

2. Precautions:
   - Utilize standard precautions for specimen collection and handling

3. Contraindications:
   - None

B. **DATA BASE/ DOCUMENTATION OF PROCEDURE**

Documentation of the Trauma Lab Order Set procurement or provider's decision not to obtain lab samples will be recorded in the ED medical record ~~and LCR as appropriate~~.

C. **SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY**

The prerequisites and proctoring are the same as RN's approved to care for trauma patients in the ED

Protocol #332
Assessment and Management of Vaginal Bleeding

Protocol: Vaginal Bleeding

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

Indications

- Vaginal bleeding, and
- Known or suspected pregnancy, and
- 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 (1-10) and associated symptoms (abdominal cramping, fever, chills)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to vaginal bleeding

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

• Laboratory and imaging evaluation:
- Obtain POCT urine pregnancy for women < age 50 years.

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Prepare patient for pelvic exam. Patient should empty bladder prior to exam.

2. If urine pregnancy test is positive OR known to be pregnant: Start IV NS (18-gauge or larger). Draw full blood tubes. Obtain stat HCT POCT. Send CBC, Type and Screen, serum B-HCG, and urinalysis (by quick-cath if more than spotting). Administer 1000 mL NS IV bolus if HR >100 or SBP <120 (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Start a second IV if SBP <90.

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:
- HR >120
- SBP <90
- RR >28
- SpO_2 <92%
- Fever > 39 ° C (102.2 ° F)
- Pad soaked more than one per hour

Protocol #343
Assessment and Management of Vomiting and Diarrhea

Protocol: 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 Emergency Department (ED).

Indications

- Vomiting more than two times today or diarrhea/loose stool more than four times today, PLUS
- 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
- Frequency, amount, and color of stool

• 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 used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to gastrointestinal disorders

• Measure vital signs every 30 minutes x2.

• Skin signs: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer ondansetron 4 mg IV x 1 if emesis x2 while in ED and not contraindicated. Notify provider if ondansetron is administered by the ED nurse.

2. If HR >100 or SBP <100 or orthostatic, start IV (18-gauge or larger). Draw full blood tubes. Administer 1000 mL NS IV bolus (if no history of CHF or renal failure). Give IV push, 0.9% NS flush 10ml PRN for PIV maintenance and with medication administration.

3. Send CBC and Basic Metabolic Panel with Magnesium and Phosphorous for persistent vomiting

4. Obtain and Send Urinalysis

5. Obtain POCT urine pregnancy for women < age 50 years.

6. Save stool sample if diarrhea

7. Patient education and counseling appropriate to disease process

8. Consultation with provider as needed, or:
   - HR >120
   - SBP <90
   - RR >28
   - SpO_2 <92%
   - Fever > 39 ° C (102.2 ° F)
   - Altered mental status with GCS <13
   - History of CHF or renal failure
   - Vomiting more than two times in ED prior to being seen by provider

Protocol #35
ABO/Rh Recheck Test

A. **DEFINITION**: This protocol covers the second blood bank test for a recheck of patient's blood type for which a non-emergency blood transfusion has been ordered by a provider. Upon notification from the Blood Bank that an ABO/Rh Recheck is required, the RN caring for the patient will place an order for an ABO/Rh Recheck, draw blood and send it Blood Bank.

1. Performance of procedure:

Indications: Notification from Blood Bank that the patient requires an ABO Recheck

Exclusions: None

2. Precautions:
   - Utilize standard precautions for specimen collection and handling

3. Contraindications:
   - None

B DATA BASE/ DOCUMENTATION OF PROCEDURE

Documentation of the ABO/Rh Recheck will be recorded in the ED medical record as appropriate.

C. **SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY**

The prerequisites and proctoring are the same as RN's approved to care for patients in the ED.

Protocol #36
Ordering Xrays in Triage

Protocol: Ordering xrays in triage

A. Definition: This protocol covers the initial assessment and management of patients with injuries to body sites seen by Registered Nurses (RN) in the Emergency Department (ED).
   1. Location to be performed: ED Triage ~~only?~~
   2. Performance of procedure:

      a. Indications: ~~LIST Wonder if could be~~ "See "presentation" column in table below"
      b. Precautions: LIST See "note" column
      c. Contraindications:

B. Data base
   1. Subjective Data
      a. History and review of symptoms (see "Common History" column in table
      b. Pertinent past medical history, surgical history, family history, hospitalizations
   2. Objective Data
      a. Physical Exam appropriate to the procedure to be preformed

C. Diagnosis
   Assessment of subjective and objective data to identify disease processes.

D. Plan
   See "Order" column in table

SITE OF INJURY	COMMON HISTORY	PRESENTATION Subjective/objective	Diagnosis/Plan: ORDER	NOTE
Clavicle	Fall on arm or shoulder. Direct lateral trauma.	Point tenderness and pain. Inability to raise arm. Swelling, deformity and/or crepitus may be present.	Clavicle	If subcutaneous emphysema (crepitus) is present, the patient should be moved directly to the treatment area. Clavicle film should be ordered only when the injury is felt to be confined to the clavicle.
Shoulder	Direct trauma.	Point tenderness and	Shoulder	If severe deformity, pain

	Fall on arm. Sudden deformity and pain.	pain. Inability to raise arm. Swelling and/or deformity may be present.	OR Shoulder with dislocation	or neurovascular compromise is seen patient should be moved to treatment area.
Upper Arm	Direct trauma. Fall on arm. Pathological fractures of the elderly.	Point tenderness. Inability to move. Pain on movement. Swelling	Humerus	May be associated with shoulder fracture of dislocation. Humeral fractures in mid to distal area may damage radial nerve. Check distal sensation on back of hand. If unable to straighten arm or if any deformity is seen move directly to treatment area.
Elbow	Fall on outstretched arm. Fall on flexed elbow.	Pain and point tenderness. Usually significant swelling. Possible deformity and discoloration.	Elbow	Associated with a significant incidence of brachial artery laceration and/or ulnar/radial nerve injury. Check for wrist pulses and sensation in hand for each nerve. If unable to straighten arm. Or if any deformity is seen, move to treatment area.
Proximal to wrist/distal to elbow	Fall on extended arm. Direct trauma.	Pain and point tenderness. Deformity and angulation usually evident. Occasionally shortening.	Forearm	If severe deformity, angulation or shortening is noted that patient should be moved directly to the treatment area.
Wrist	Fell on extended arm. Direct trauma	Pain and point tenderness. Swelling, deformity and/or discoloration may be present.	Wrist ~~1~~1-2 views OR Wrist with navicular view	If navicular tenderness is noted on palpation order "navicular view" also. Be specific about point tenderness since there are many small bones in the wrist. Wrist

				dislocation is associated with a significant incidence of neurovascular comprise and/if such is noted expedite to treatment area.
Hand	Impactive closed fist trauma (Boxers fx) Direct trauma. Fall on outstretched hand.	Pain and point tenderness. Swelling, deformity and/or discoloration may be present.	Hand PA lateral oblique minimum 3 views OR Hand with wrist	If a wrist fracture is suspected "wrist" must also be ordered (Hand with wrist)
Chest	Cough. Fever. TB screening	Cough, fever, decreased or abnormal breath sounds	Chest 2 view	Portable chest xray if patient is unable to stand or in patient room.
Knee	Direct trauma Impactive trauma.	Pain and point tenderness at joint. Swelling, deformity and/or discoloration may be present.	Knee OR Knee with patella	Special attention to lower leg for associated fracture or patella if direct trauma. Dislocation is associated with a significant incidence of vascular compromise. Pulses in foot should be specifically checked. If absent, of if motion or sensation are not normal, move directly to treatment area.
Proximal to ankle Distal to knee	Direct trauma.	Pain and inability to bear weight. Point tenderness. Swelling, deformity and/or discoloration may be present.	Tibia Fibula	A compartment syndrome may develop secondary to the large amount of soft tissue swelling and hemorrhage. The triage sheet must contain

				documentation of foot pulses and ability to dorsiflex the foot. Fibular fx by itself is a rare injury which manifests as point tenderness and pain.
Ankle	Frequently an athletic injury. Lateral stresses.	Pain and point tenderness. Swelling, deformity and/or dislocation may be present. Dislocation may present as "locked joint".	Ankle	Patient with single malleolar fx's will frequently walk in c/o severe pain. The bi- and tri-malleolar fx's are more dramatic and present with unstable ankles, unable to bear weight. Be specific about point tenderness sincere are many small bones of the ankle. Dislocation is associated with a significant incidence of neurovascular compromise and/if such is noted expedite to treatment area. Special attention to the knee for associated injury.

E. ~~E.~~ DOCUMENTATION/RECORD KEEPING

- **Documentation of x=ray will be recorded in the medical record as appropriate**

F. **SUMMARY OF PREREQUSITIES, PROCTORING AND REAPPOINTMENT COMPETENCY**

The prerequisites and proctoring are the same as RN's approved to care for patients in the ED.

Protocol # 37
Assessment and Management of a Pediatric Patient with vomiting

Protocol: Pediatric Patient with > 2 episodes of vomiting within 24 hours, with most recent episode < 4 hours prior to presentation

A. Definition: This protocol covers the initial assessment and management of pediatric patients with vomiting seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications

- Weight ≥ 8 kg
- Vomiting with past four hours
- Not tolerating liquids per history
- No antiemetic use with four hours
- No history of cardiac arrhythmia

B. Data Base

1. Subjective Data

• Review history and signs and symptoms of current pediatric illness

- Sequence of preceding events and symptoms
- Actions that relieve symptoms

• Pertinent past medical history, current medications and allergies

• Characteristics of any pain (PQRST); location, quality, and intensity (age appropriate pain scale) and associated symptoms (headache, crying, irritability, decreased appetite, tachycardia)

• Any treatments used prior to arrival

2. Objective Data

• Perform focused physical exam relevant to pediatric vomiting
  - Observe for signs of abdominal pain, injury, headache, dehydration, surgical abdomen (bilious vomiting, severe pain, distension, right lower quadrant tenderness)

• Level of consciousness (may use Pediatric Glasgow Coma Scale)
• Obtain core temperature, measure vital signs per *Guidelines for Emergency Nursing Practice*, assess central and peripheral pulses

• Obtain patient's weight in kg

• Obtain full vital signs including temperature and blood pressure

• Skin signs: color, temperature, moisture, and capillary refill (central and peripheral)

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status of disease process

D. Plan

1. Administer ondansetron oral dissolving tablet
   a. 8-15kg patient: 2mg PO/SL
   b. >15kg patient: 4 mg PO/SL

2. Notify physician if anti-emetic was administered by the ED nurse.

3. If patient has no abdominal pain, give oral liquids to allow patient to slowly hydrate 15 minutes after administration of antiemetic

4. Patient education and counseling appropriate to disease process

5. Consultation with provider as needed, or:

- Abnormal vital signs based on patient's age. See addendum for table.
- New onset focal neurological symptoms or altered mental status
- Severe abdominal pain
- Focal right lower quadrant pain
- New onset listlessness, irritability, or change in Pediatric Glascow Coma scale

Protocol # 38
Syphilis screening and Laboratory Test Order set

A. DEFINITION

This protocol covers the syphilis screening and laboratory test for patient populations within one of the following categories below seen by registered nursing (RN) staff in in the Emergency Department (ED) and Adult Urgent Care Center

1.Frequency: Testing for syphilis should be done in any person:

- pregnant who has not had syphilis testing
- requests to be tested
- with signs or symptoms suggestive of syphilis
- with an oral, anal, or vaginal sex partner who has been recently diagnosed with syphilis
- presents with signs and symptoms of syphilis

a. Every three months testing in persons who are:

- On PreP for HIV prevention
- living with HIV and are sexually active
- having unprotected sex and risk factors
- reports that their sex partner has been recently diagnosed with syphilis
- Unstable housing
- Men who have sex with men (MSM)
- Pregnant -
- Sexually active adolescents

b. Every 6-12 months: all others

2. Location to be performed: **Emergency Department and Adult**

3. Performance of procedure:
   a. Indications: Patients within special categories listed above who meet subjective/objective data criteria
   b. Exclusions: Patients outside of special categories listed above or who do not meet subjective/objective data criteria
   c. Precautions: Use standard precautions for specimen collection and handling
   d. Contraindications: Patients who do not agree/consent to the test

B. DATA BASE
   1. Subjective Data

a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.

- rash, small bumps, sores or ulcers on the genitals, mouth or anus
- genital or anal discharge
- wart-like growth on the genitals or anus
- fatigue, itching, rash on the palms and soles, sore throat, swollen lymph nodes, weight loss, or rectal lining inflammation

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

   2. Objective Data
      a. Physical exam consistent with subjective datat listed above.
      b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
      c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS
   Risk for syphilis infection as indicated by subjective and objective data in persons within the designated categories.

D. PLAN
   1. Therapeutic Treatment Plan
      a. Identifying patients that satisfy criteria for syphilis screening
      b. Confirm accurate contact information for the patient
      c. Perform RPR testing per current workflow

d. If using POCT and the result is positive; send a blood sample to the laboratory for confirmatory testing

2. Patient condition requiring Attending Consultation: Patient questions regarding the test that the nurse is unable to answer

3. Education: Discharge information and instructions.

4. Follow-up: As appropriate for procedure performed.

E. RECORD KEEPING

Documentation of the Syphilis Laboratory Test Order Set procurement or patient's declination will be recorded in the electronic medical record as appropriate.

F. Summary of Prerequisites, Proctoring and Competency Documentation

Prerequisite: a. Review of CDC guidelines on syphilis b. Completion of departmental orientation program
Initial Evaluation: Three chart reviews needed to ensure that syphilis screening test was indicated and completed
Annual Competency Documentation: a. Nurse Manager, Medical Director or designated physician will evaluate the RN's competence through an annual performance appraisal and skills competency review. Feedback from colleagues, direct observation and/or chart review may be used. b. The standardized procedures will be a required Unit Based Competency for annual review.
Any additional comments: None