University of Wisconsin Hospital and Clinics
Emergency Department
Standards of Emergency Nursing Practice

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Preamble

Nursing standards of practice are used to describe a competent level of nursing care as demonstrated by the nursing process. They serve as a reference when creating practice guidelines, policies, and procedures. Nursing standards illustrate quality of care and provide support for developing educational programs. The UWHC Standards of Emergency Nursing Practice will be reviewed and updated every three years. The nurse clinician is held accountable in his/her practice as defined and supported by the Emergency Department Standards of Care.

The Profession of Emergency Nursing

Emergency nurses at UWHC are expected to deliver nursing care with "…compassion and respect for human dignity and the uniqueness of the individual." (ENA, 2011, p. 10). Care delivery is patient and family centered, and the nurse integrates unique patient characteristics into the plan of care.

Triage:

The emergency nurse triages each patient to "…obtain pertinent subjective and objective data while providing physical, emotional and psychosocial support" for the patient." (ENA, p. 21). The emergency nurse interprets a patient's assessment data for prioritization based on the seriousness of his/ her medical and/or psychological needs.

A. The triage system is based on the five-level Emergency Severity Index (ESI), current version (Version 4; 2012 Edition) developed by the Agency for Healthcare Research and Quality (AHRQ). The ESI is used to identify high-risk situations and to anticipate needed resources.
    1. The triage nurse will have two years nursing experience with at least the most recent year being Emergency Department (ED) experience.
    2. The triage nurse will be current in Advanced Cardiac Life Support (ACLS), Trauma Nursing Core Course (TNCC), Emergency Nursing Pediatric Course (ENPC) and Pediatric Advanced Life Support (PALS).
    3. The triage nurse will successfully complete the ED course in triage. Attendance at this course requires approval from the Nurse Manager.
    4. The new triage nurse will "shadow" an experienced triage nurse for 4 hours after completing the triage course.
    5. All triage nurses are required to complete an annual competency in triage.

B. The emergency nurse promotes access to care through appropriate screening of patients along with a medical screening examination by a physician, in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) and UWHC policies and guidelines.
C. When the ED is not at capacity, patients will be placed directly in an open room and assigned a primary nurse.
D. All patients will have a verified identification bracelet as soon as possible after admission to the ED. Any ID bands from referring facilities will be removed once the UWHC band is applied.
E. When patients must wait in the waiting room, they will be reassessed with 'across the room assessments' and repeat vital signs, as needed, based on acuity and condition. This will be documented in the patient's medical record. The vital signs may be delegated to an ED tech.
F. VS will be assessed and documented a minimum of every 2-4 hours (despite acuity) and more frequently based on patient's condition.

Assessment:

"The emergency registered nurse collects comprehensive data pertinent to the health care consumer's health or situation." (ENA, 2011, p. 19).

A. Patients arriving by ambulance will be roomed, if appropriate, in the ED upon arrival. With space and staffing permitting, all other patients will be placed in a patient room immediately upon arrival or after triage, rather than being assigned to wait in the waiting room.
B. The initial assessment is based on the patient's presentation and chief complaint. The nurse will obtain initial focused subjective and objective data through history taking, physical examination, review of records (if available), and communication with health care providers and significant others, as appropriate.
C. Patient screening information will be assessed and documented with the initial assessment, as required. Re-assessments will be completed as needed.
D. Patient medications, allergies and past medical and surgical history will be assessed and reviewed. This is the responsibility of the primary nurse.
E. Patient weights are measured and recorded for adults who may receive weight based thrombolytic, or other medications requiring accurate weights. Weights are required for all pediatric patients (in kilograms). The amount of clothing that may be worn by the pediatric patient being weighed is as follows:
    - <1 year of age: naked
    - 1-2 years of age: dry diaper only
    - >2 years of age: dry diaper (if applicable), no shoes or heavy clothing
F. A complete set of vital signs is obtained with the initial assessment (T, BP, HR, RR). Pulse oximetry is obtained for patients with respiratory and/or cardiac chief complaint.
    1. Pediatric patients:

a) Rectal temperatures are taken on all patients less than 12 months of age, unless the child has an immunocompromised condition, bowel, perineal, or rectal surgery.
b) The temporal artery (T.A.) thermometer can be used on all pediatric patients ≥ 12 months old.
    - If the patient presentation/condition does not match the T.A reading, then the temperature will be re-assessed via a different appropriate route.
c) Axillary temperatures are not to be obtained on any pediatric patients.
d) When a blood pressure (BP) is assessed on a pediatric patient, the nurse will assure that the BP cuff is 2/3 the length of the arm. BP will be assessed on all patients ≥ 3 years or < 3 years with any of the following:
    - Cardiac history or complaint (If history or scheduled CV surgery, document BP with pulse oximetry on all four extremities.)
    - Neurological history and/or complaint
    - Renal history and/or complaint
    - Showing signs of dehydration
    - Level 1 & 2 trauma patients
e) HR and RR will be auscultated for 1 full minute for children < 1 years.
f) Glucose is a vital sign for pediatric patients. Glucometer checks should be obtained for any child with a decreased level of consciousness and repeated hourly until the reading is within normal range.
g) Pediatric early warning signs (PEWS) score will be assessed and documented for all pediatric patients who may be admitted to inpatient.

G. Visual acuity will be obtained on patients with ocular or periorbital injuries/complaints.
    1. Shapes eye chart is available for non-reading patients.
    2. This assessment may be delayed if immediate flushing of the eye is indicated, such as a potential chemical splash to the eye
H. Fetal heart tones are assessed and recorded for pregnant patients (>12 weeks gestation) if this applies to their chief complaint, such as abdominal pain, trauma, etc.
I. Other assessment parameters such as pulse oximetry, end-tidal CO2 monitoring and cardiac monitoring are assessed and monitored as the patient's condition warrants.
J. All patients will be screened for the presence of pain. Assessment of pain will include a description, including location, quality, onset, severity, aggravating/alleviating measures, duration and frequency will be documented. Intensity will be assessed and documented using one of the following developmentally appropriate UWHC pain scales:
    1. 0-10 for adults
    2. For adult patients who cannot report/describe their pain, use nonverbal pain indicators: (UWHC policy 8.76, *Pain management*)
        a) Facial cues

b) Increase or decrease in movement (guarding, rubbing, etc.)
c) Restlessness and/or vocalizations
d) Other physiological parameters are incorporated into the assessment like changes in vital signs

3. For pediatric patients, pain is assessed using an age-appropriate scale.
   a) Neonatal Infant Pain Scale (NIPS) is to be used for infants up to one year of age. A score of 3 or more indicates that the infant is experiencing pain that needs to be addressed.
   b) Faces, Legs, Activity, Cry, Consolability Revised (FLACC-R) scale is to be used for children one year and older who cannot identify or report their pain. A score of 3 or more indicates that the child is experiencing pain that needs to be addressed.
   c) FACES Pain Scale Revised (FPS-R) is typically used for 4 – 8 year olds. It will aid the provider of care in assessing the degree of pain.
   d) Numeric Rating Scale (NRS) is typically used for children eight years and older who are cognitively able to rate their pain.

   Adequate pain control will be implemented including non-pharmacological and pharmacological interventions. Pain assessments and reassessments following interventions are documented.

K. Reassessment of pain will be implemented and documented for patients receiving any pain relief interventions, in accordance to UWHC policy, at a minimum of every eight hours.
L. Patients will be screened for abuse, neglect, and domestic violence when *not* in the presence of family, friends, or any visitors. (UWHC Policy 4.52, Abuse, Neglect and Domestic Violence).
M. The patient learning assessment will be completed as needed. Patient and family understanding of education provided will be assessed by having the patient and family explain or demonstrate back what they have learned. Communication barriers will be addressed with assistance from the language line and/or use of interpreters through Interpreter Services.
N. Patients will be undressed and placed in a patient gown to the degree their exams require. If a patient has a suicidal ideation, their belongings are searched for harmful/dangerous items and they are placed in a safe room. Their belongings can also be scanned by Security with their metal-detecting wand.

Planning:

The emergency nurse formulates a plan of care in partnership with the patient, family, guardian, and/or significant other(s). This plan includes strategies for promoting and restoring "…health and prevention of illness, injury and disease, the alleviation of suffering, and the provision of supportive care for those who are dying." (ENA, p. 24).

A. The plan of care is based on patient, family and staff safety. Priorities are always airway, breathing, circulation, and immobilization of the spine in trauma patients. Pain management, both pharmacologic and non-pharmacologic strategies, is included in the plan

of care. Priorities will also focus on the patient's and other's emotional and physical safety.

B. The plan of care is documented in Healthlink and communicated verbally with physicians, ED technicians, and other members of the healthcare team. Documentation will reflect the ongoing plan of care.

C. Patient/family learning needs will be addressed through teaching and reinforcement throughout the patient's ED stay. Patient/Family education includes but is not limited to prescribed therapies, planned procedures and discharge planning

Implementation:

The emergency nurse incorporates evidence-based interventions and treatments specific to the diagnosis or issues (ENA, p. 26).

A. Interventions will be implemented and documented per UWHC policies and procedures.
    1. Nurses must perform bar code scanning of Patient ID, Clinician ID and medication bar code at patient bedside utilizing Alaris Auto ID module whenever possible, (UWHC Policy 1.24).
    2. Safe practices for administering High Alert Medications will be followed according to UWHC policy 8.33.
    3. Intake and output will be monitored and recorded in the electronic medical record.

B. Primary nursing is the professional care delivery system in the ED. Each patient in the ED will have a primary nurse. The emergency nurse will utilize the HealthLink track board to assign him/ herself as the primary nurse within the first 30 minutes that a patient has been settled.

C. Documentation will include:
    1. Serial vital signs and/or assessments/reassessments
        a) Patient contact will occur minimally every thirty to sixty minutes to assess for safety and basic comfort needs. Updates will be given to patients (and/or families) advising them of their status.
        b) Vital signs (VS) will be repeated based on clinical status and interventions (i.e. fluid administration, narcotic/sedative administration, etc.). *At a minimum*: VS will be reassessed at least every hour for a changing patient condition (and more frequent for unstable patients) and every 2-4 hours for stable patients.
        c) VS will be repeated within one hour prior to being discharged, admitted, and/ or transferred. At a minimum, reassessment of symptoms related to the chief complaint will be done prior to discharge/admission/transfer to determine if the patient's condition has improved, remained unchanged, or worsened during the ED visit. A deterioration in condition will be reported to the physician and documented. Tachycardia at discharge, for adult and pediatric patients, will be investigated as to the cause and reported to the physician prior to discharging the patient.

d) When a patient has left the ED (for a test, procedure, etc.) and returned to the ED.

2. For patients placed on ECG monitoring, an interpretation of the patient's rhythm, including any ectopy, will be documented in the patient's record.
3. Procedures, medications, and interventions, including the patient's response, will be noted.

D. The call light will be within the patient's/family's reach. Stretchers will be in the lowest position. Patients with altered mental status, pediatric patients, and/or those who have received medication that may produce drowsiness will have side rails in the raised position.

E. The emergency nurse will screen patients for potential safety risks, as identified in policy 10.0, "Screening of ED patients." Safety measures will be implemented, as needed to prevent fall/injury to patients at risk for injury. The scope and content of further assessment/reassessment are based on the patient's condition, the care setting, the patient's desire for care and the patient's response. ED screening will include:

1. Advance Directives and POA for Healthcare
2. Suicide Risk Screening (for patients >9 years of age)
3. Alcohol Intake Screening (for patients > 9 years of age)
4. Fall Risk Assessment
5. Safe Environment Assessment

F. To expedite patient care and throughput, the emergency nurse may implement UWHC *Emergency Department Physician Delegated Immediate Protocols* based on the patient's chief complaint and/or presenting symptoms. *ED adult protocols* will be implemented for patients >17 years of age and *ED Pediatric Protocols* will be implemented for younger patients.

G. The emergency nurse seeks consultation from other disciplines such as social work, case management, and child life, when applicable. When the emergency nurse suspects child abuse or neglect, the procedure for reporting will be followed according to UWHC Policy 4.52. The emergency nurse will implement appropriate interventions for the elder-at-risk, or the adult- at-risk, with suspected abuse in accordance to Policy 4.52

H. Patient safety is promoted through face-to face report between the ED nurses at change of shift. Verbal report will follow the Situation-Background-Assessment-Recommendation (SBAR) format when a patient hand-off occurs.

I. A visual bedside safety check will occur during shift-to-shift handoff between the off-going and on-coming ED nurses. The safety check will involve:

- Noting of patient vital signs and other assessment parameters, including monitor alarm status
- Oxygen status
- Pain status
- Vascular access device
- IV infusions/pump rates/high alert medications
- Other tubes and lines (Line reconciliation if applicable)
- Safety concerns (fall risk, suicide risk, etc.)

- Visual scan of the environment
- Patient room checked and re-stocked
- Introduction of family/significant other or report of family notification status
- Report of patient's current living conditions/situation

Evaluation:

The emergency nurse evaluates and modifies the plan of care based upon "…progress toward attainment of expected outcomes," (ENA, 2011).

A. Responses to interventions will be documented when a response is expected to be observable during the ED stay. (For example, decreased pain, reduction in fever, decrease in shortness of breath, etc.)
B. Ongoing assessment data is integrated into the plan of care and revisions are incorporated as needed.

Disposition:

The emergency nurse will integrate patient information including assessment data, throughout the ED course in planning appropriate discharge plans, based on the patient's illness or injury, and needed support mechanisms. This will involve communication and collaboration with other health care providers to facilitate patient care.

A. Patients admitted to inpatient areas
    1. Once an inpatient bed has been assigned, the emergency nurse will follow the *Capacity Grid* for calling report to the floor. The Care Team Leader determines the "capacity" based on department activity.
        a. Emergency Surge: Rooms will be assigned for all patients waiting for admission. Patient report will be taken immediately after a room is assigned. The patient will arrive on the unit directly after report
        b. Overcrowded: Patient report will be taken immediately after a room is assigned. Patient will arrive on the unit 15 minutes from time first call is placed.
        c. At Capacity: Patient report to be taken within 15 minutes. Patient will arrive on the unit 30 minutes from the time first call is placed.
        d. Open: Patient report to be taken within 30 minutes. Patient will arrive on the unit 60 minutes from the time first call is placed.
    2. Utilizing the SBAR format, report will be phoned to the receiving RN or RN designee. Verbal report will be called to the receiving nurse or a designated nurse
    3. Patient belongings will be documented in HealthLink, according to Policy 7.27.
    4. Patient transport:

- Critical care patients and IMC patients will have at least one RN (ACLS certified) on the transport team.
- Telemetry patients will be transported by an ED nurse, SOS nurse, or an ED Tech who has successfully completed the Basic Arrhythmia Class/Examination.
- Patients who will be admitted to a general inpatient unit (not an ICU or IMC) can be transported by an ED tech or Patient Escort.
- The ED nurse and other members of the transport team are responsible for the return of ED equipment.
- Patients stabilized on a heparin or insulin infusion, when no rate change has occurred within the past 15 minutes, can be transported by an ED tech. (Providing that the patient is not being admitted to an IMC or ICU).
- Patients receiving blood products may be transported by an ED tech (providing that the patient is not being admitted to an IMC or ICU) if the infusion was started > 20 minutes prior and will not end within 20 minutes of transport.

B. Patient discharge to home:

1. The emergency nurse will assure that the patient is able to care for him/ herself, or that sufficient support mechanisms are in place. If needs are identified, they will be communicated to the other members of the health care team (ED physician, Social Worker, Case Manager) so a plan can be made to address the patient's needs.
2. Patients will receive written discharge instructions and any other pertinent discharge information such as prescriptions, work excuse, school form, Health Facts for You, safety and/or injury prevention information, etc.
3. Patients will be asked if they can be telephoned, following discharge, by the Emergency Department Clerk. This information will be documented in the HealthLink patient record.
4. The emergency nurse will complete follow up discharge telephone follow-up within 1-2 days of the patient's discharge to home.

Standards of Professional Practice

Quality of Care:

The emergency nurse evaluates "…one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations." (ENA, p. 41).

A. Emergency nurses are involved in ongoing assessment and continual improvement of quality of care for emergency patients. Nurses can participate in a variety of ED committees and projects to improve the quality of emergency nursing practice at UWHC. Some of the ED committees and other house-wide opportunities for ED nurses include:

1. ED Nurse Council: The Council is chaired and co-chaired by ED nurse clinicians. Members are ED nurse clinicians and the clinical nurse specialist (CNS). The nurse manager participates as a guest. All unit council members are assigned a group of staff to help communicate news, share and gather ideas and ongoing council work. The chair creates the agenda and prepares the meeting minutes for distribution. The chair is a 1-year term. After the 1-year term, the co-chair becomes the Chair of the council. Annually this group reviews the RN Satisfaction data from NDNQI and develops an action plan.
2. Service Excellence Committee: This committee is comprised of ED nurses as well as other ED team members such as Child Life, ED physicians, ED techs and volunteers. There is also a Patient and Family Advisory Council member on the committee. This committee meets to evaluate patient satisfaction assessments and strategies for improving quality of care and patient satisfaction. Initiatives are launched to improve overall patient and staff satisfaction in the ED.
3. ED Clinical Operations: This interdisciplinary committee, chaired by an ED physician, discusses clinical operations and makes decisions regarding ED processes and daily activity. Membership includes ED nurses, ED techs, EDC representation, CNS, Pediatric Emergency Education Coordinator (PECC) and Nurse Manager. ED nurses are encouraged to bring ideas and concerns to this committee.
4. ED Performance Improvement (PI) Committee: This interdisciplinary committee meets monthly to review any quality care concerns (specific instances) and/or opportunities for improvement (system issues). Membership is interdisciplinary, including at least one ED nurse clinician.
5. Hospital Nursing Councils and Resource Nurses: Each year, ED nurses are invited and encouraged to apply for membership to one of the several Nursing Councils or to be a Resource Nurse in a specific area (such as diabetes). Participation within these groups contributes to the collaborative governance structure. More information is available on U-Connect regarding the councils and nursing resources.
6. Pediatric Champions: Any and all ED staff interested in learning more about the care of pediatric patients can join this group for monthly educational meetings and updates. The group is led by the PECC.
7. Emergency Department Steering Committee: This committee leads and approves changes to be implemented. The committee is comprised of interdisciplinary team members including the nurse manager, assistant nurse manager, CNS, PECC and the Chair of Nurse Unit Council. The committee is co-chaired by the Emergency Medicine Division Chief and Emergency Services Director.

B. Emergency nurses at UWHC, continually assess and evaluate the care delivery system to identify opportunities for improving the quality of care:

1. ED nurses assess the needs of internal and external customers (e.g.: patients, families, EMS staff, physicians, community agencies, other UWHC customers).
2. Nurses collaborate with other departments (e.g.: Med flight, Laboratory, Radiology, etc.), and disciplines, (e.g.: Social work, Case management, Child life, Pharmacy, etc.) to improve and enhance the delivery of care.
3. The Care Team Leaders and Nurse Manager meet monthly to address and resolve issues related to the daily operations of the department. In addition, the Assistant Nurse Manager, CNS, and PECC attend.
4. The Emergency Services multi-disciplinary leadership team meets regularly to share information and collaborate on the Emergency Services service line. The Nurse Manager, Assistant Nurse Manager, CNS, Nursing Education Specialist (NES) and PECC participate.

C. All emergency nurses will participate in patient call backs for patients that have been discharged to home from the ED. The ED nurse will complete the call-back assessment form in Healthlink when discharging a patient. Call backs will occur within 1-2 days of the ED visit.

II. Performance Appraisal:

Emergency nurses are "…accountable for their professional actions to themselves, the health care consumers, their peers, and ultimately to society. " (ENA, p. 17).

A. Emergency nurses are accountable for their own actions.
   1. Nurses accept responsibility for their actions.
   2. Nurses understand the regulatory and legislative issues that affect their practice and adhere to the UWHC polices that deal with these regulatory issues (e.g.: The Joint Commission, EMTALA, HIPPA, mandatory reporting laws, WI State Statues, etc.)

B. Emergency nurses participate in clinical and peer review processes.
   1. Nurses use self-evaluation, peer evaluation and feedback from the Nurse Manager and Assistant Nurse Manager to modify and improve their nursing practice.
   2. The emergency nurse is accountable for completing the initial and annual verification of clinical competencies.

III. Education:

The emergency nurse attains knowledge, skills and competence that reflect current practice. "Emergency nurses must remain diligent in the pursuit of lifelong learning." (ENA, p. 13) The emergency nurse will "…provide care to the national's population and to positively influence the decisions that drive emergency health care..." (ENA, p. 13)

A. The emergency nurse participates and completes educational activities needed to acquire knowledge and skills to care for emergency department patients. The new orientee will complete his/her orientation checklists by the end of orientation. Additionally, the new orientee will complete the orientation programs (from the UWHC Nursing Education & Development Department). The emergency nurse will:

1. Maintain CPR certification.
2. Maintain Advanced Cardiac Life Support (ACLS) certification. The new nurse resident will complete ACLS within 6-12 months of hire. The new experienced nurse will complete ACLS within 2-6 months of hire, if not already ACLS certified.
3. The ED nurse will maintain Trauma Nurse Core Course (TNCC) certification. The new nurse resident and all other new nurses will complete TNCC within 12-18 months of hire.
4. The ED nurse will maintain Pediatric Advanced Life Support certification (PALS) and Emergency Nurse Pediatric Course (ENPC) certification. The new nurse resident and all other new nurses will complete ENPC and PALS within 12-18 months of hire.
5. Other educational topics, determined as mandatory, (such as new equipment and/or procedure) will be required for all ED nurses.

B. The emergency nurse is strongly encouraged to attain certification in emergency nursing (CEN) and/or emergency pediatric nursing (CPEN).
C. The emergency nurse is encouraged to participate in professional activities that will foster continued advancement of emergency nursing skills and knowledge, such as attending state and national ENA meetings and joining the Emergency Nurses Association (ENA).
D. The emergency nurse is encouraged to attend and participate in monthly Nursing Grand Rounds at UWHC, the Academy courses with Nurse Manager approval, and other hospital educational programs.
E. The experienced emergency nurse is encouraged to participate in the preceptor class after two years of ED experience. The emergency nurse is encouraged to teach and mentor new ED staff.

IV. Ethics:

"The emergency nurse acts with compassion and respect for human dignity and the uniqueness of the individual." (ENA, p. 50). Additionally, "The emergency nurse acts to protect the individual when health care and safety are threatened by incompetent, unethical, or illegal practice." (ENA, p. 50)

A. The nurse delivers care in a nonjudgmental and nondiscriminatory manner and preserves/protects patient autonomy, dignity, and rights.
B. The nurse maintains patient confidentiality
C. The nurse acts as a patient advocate.
D. The nurse conveys respect and compassion to the individual patient.
   Examples of this are:
   - Introducing self to the patient
   - Addressing the adult patient by his or her preferred name (not "Honey or Sweetie")
   - Addressing the pediatric patient by his or her first name and approaching the patient in an age and developmentally appropriate manner

- Allowing the family to be present during crisis, and per patient wishes providing this does not create a safety threat, when a family member can be the greatest advocate for the patient (UWHC ED Policy 8.0, Patient and family centered care)

E. No personal electronic devices will used or present in the ED, unless retrieving textbook information on medications and diagnoses.

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UWHC Policy References:

Abuse, Neglect and Domestic Violence, Policy #4.52

Alaris System, Policy # 1.24

Basic Care Standards (Adult), Policy #13.12

Basic Care Standards-Inpatient Pediatrics, Policy # 13.16

Blood and Blood Component Transfusion, Policy # 8.12

ED Protocols, Policy 11.0

High Alert Medication Administration, Policy # 8.33

Interpreter Services, Policy #7.53

Management of Patient Belongings, Policy #7.27

Nurse to Nurse Change of Shift Hand-Off, Policy #14.33

Pain Management, Policy # 8.76

Patient and Family Centered Care (ED Policy) # 8.0

Screening of ED Patients #10.10

Suicide Assessment and Prevention, Policy # 10.10

Transfer of the Patient, Policy #14.17

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