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We have tried to eliminate errors in this book, but in a work of this magnitude, errors are likely to be found. All corrections, comments, and suggestions that are sent to Starr Vision Productions, Inc. will be welcomed.

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The information contained in the aftercare discharge instructions represent suggestions on instructions for post-visit and post-treatment patient care. This information is intended to serve as an information resource for a competent health care professional on your staff. It must be reviewed by such a professional and interpreted in light of all available indications, contraindications, and other sources of information regarding the patient. The instructions, as all other material and information provided in this book, must be approved by the appropriate health care professional on your staff prior to its use.

All standards of practices, policies, procedures, information, instructions, and protocols should be reviewed and approved by appropriate health care professionals and committees before implementation. They also should be reviewed annually, dated and signed by the reviewing authorities.

This book is provided for use as an aid in establishing and updating hospital policies and procedures. It is provided "as is" and is not intended to be used as policies or procedures without review and approval by appropriate hospital health care professionals. The policies, procedures, forms and other information in this book are intended as examples only, and are not to be used as a substitute for medical treatment for specific cases. No claim are made that the examples and information provided in this book are correct and proper for use in their present form. Each hospital must have its specific committee responsible for formulating and approving policies and procedures, write and approve each policy and procedure.

Change is frequent in health care and although the information in this book may serve as a guide for formulating policies and procedures, this book is not intended as a substitute for individual research.

Many policies and procedures involve legal requirements. The hospital's legal representatives should be consulted to insure that the policies and procedures conform to state and/or federal laws.

STATEMENT OF POLICIES AND PROCEDURES

Our written standards of practices, policies, procedures, and protocols shall define and describe the care to be provided by the medical staff. These standards of practices, policies, procedures, and protocols are reviewed annually, dated and signed by the reviewing authorities. The reviewing authorities are:

John Doe
Jane Doe
John Hancock
Jane Hancock

EMERGENCY DEPARTMENT STANDARDS OF CARE

Every Emergency Department patient at General Hospital can expect to receive the following Standards of Care.

1. Personalized attention on admission including:

    A. A warm and efficient approach by the nursing staff.

    B. Assessment for life threatening conditions and initiation of appropriate intervention without delay.

    C. An interview and assessment by a licensed nurse to obtain a nursing history to determine physiological needs, safety needs, educational needs, and needs for emotional and spiritual support.

    D. Prompt notification of physician regarding condition.

2. Provision of the following:

    A. Continuous evaluation, updating and modification of care as needed.

    B. Updated information to patient and family concerning condition, changes and/or delays of treatment.

    C. Administration of medication and treatments according to procedure.

    D. Proper positioning.

    E. Provisions for a safe environment.

    F. Provisions for infection control.

    G. Prompt response to needs.

    H. Provide comfort measures as needed.

    I. Provision for privacy.

    J. An uncluttered and orderly environment.

3. Emotional and spiritual support for patient and family through:

    A. Opportunities to verbalize.

    B. Reassurance.

    C. Utilizing appropriate support persons.

4. Provision of the following prior to transfer:

    A. Assessment, stabilization, and appropriate preparation for transfer.

    B. A detailed report of condition and management to be given to the receiving physician, as well as to licensed nurse at the receiving facility.

    C. An explanation of the transfer procedure with the family included.

    D. Confort measures for the transfer.

    E. Assurance that receiving facility will accept patient prior to transfer to another hospital.

5. Appropriate discharge planning including:

    A. Explanation and rationale of treatment and procedures.

    B. Information on available community resources as indicated.

    C. Provision of discharge instructions.

6. Strict confidentiality of all patient information but notification of the following when appropriate:

    A. Next of kin.

    B. Health Department.

    C. Law Enforcement Officials.

7. The following guidelines will be maintained:

   A. Established nursing standards which guide the entire nursing staff shall be maintained.

   B. Nursing standards recommended by the American Nurses Association shall be maintained.

   C. All patients admitted to the Emergency Department shall have a formal chart with systemic and pertinent collection of data about the health status of the individual patient.

   D. All Emergency Department personnel will be certified in Cardiopulmonary resuscitation. All Registered Nurses, Licensed Vocational Nurses and Unit Secretaries shall successfully complete a structured EKG course so that they may properly recognize and treat dysrhythmias seen in emergency care patients. The Unit Secretaries must have the capability to recognize these dysrhythmias and notify the proper personnel for treatment.

   E. All nurses in the Emergency Department shall be ACLS certified. This is encouraged within the first year of employment.

   F. All Emergency Department nurses shall be able to respond to an emergent situation anywhere in the hospital and function appropriately according to the guidelines set down in the General Hospital Code Procedure.

   G. All Emergency Department nurses shall possess current comprehensive knowledge and skills in the emergency health care field.

   H. All Emergency Department nurses shall analyze assessment data to formulate a nursing diagnosis.
      1. Nursing diagnosis is bases on identifiable data.
      2. Nursing diagnosis is compared to established norms or prior assessment findings.
      3. Nursing diagnosis is congruent with findings of other health care professionals.
      4. Nursing diagnosis is consistent with accepted current knowledge.

HOSPITAL STANDARD POLICY MANUAL

This Hospital Emergency Department Standard Policy Manual contains statements established to serve as guides from which realistic plans for operations are developed. These Emergency Department Standard policies, issued to attain specific goals and objectives, place an obligation for compliance on the Emergency Department.

The Emergency Department Standard Policies are approved by the hospital medical staff and hospital administration who are also to see that policies are followed and that Hospital goals and objectives are attained.

The development of policies is an on-going process and all levels of personnel are encouraged to communicate ideas to their immediate supervisor. However, ideas for improving methods must be thoroughly evaluated by Directors before a policy is changed. Directors present suggested policy statements to their proper committees. Review is made by the appropriate committee(s), Medical Staff, and Hospital Administration and approved before a statement of policy is issued.

In summary, the Hospital Emergency Department Policy Manual of General Hospital is a guide for cooperation, and ultimately, a means for improvement of patient care.

SUBJECT: NURSING SERVICE POLICY ON POLICY CHANGES

Policy changes shall be made at the discretion of the department head, or upon instructions from the administration. All new or revised policies shall be approved by the Medical Staff and Administration before being instituted. All new or revised policies shall be explained to the department personnel. Personnel shall also be instructed in the procedures to carry out the new or revised policies.

All policies shall fit within the scope of the policies of General Hospital.

SUBJECT: POLICIES AND PROCEDURES FOR PATIENT CARE

General Hospital shall have written policies and procedures specifically relating to patient care to be rendered in the Emergency Department. These policies and procedures must be approved by the Medical Staff and Hospital Administration, and shall be reviewed at least annually, revised as necessary, dated to indicate the time of the last review, and enforced.

SUBJECT: STATEMENT OF PHILOSOPHY OF GENERAL HOSPITAL

General Hospital has undertaken the responsibility for the delivery of health care to all the people of this community. Toward this end, we shall strive to build and promote the community and to respect human dignity and human personality by providing comprehensive health care, which involves preventive, curative, supportive and rehabilitative, services to the community. This care must be administered with excellence, compassion and justice to the total person, body, soul and spirit.

1. We believe that each individual is a child of God, created to His image and likeness and possesses a dignity which is worthy of reverence, protection and preservation from the moment of conception throughout his whole life span until death.

2. We believe that in a pluralistic American society we can best fulfill our social and community obligations by our clear and uncompromising witness to our moral beliefs and practices.

3. We believe that we can best serve the health needs of each community by cooperating with other health-related agencies and planning organizations, and by the advancement of medical science through education and research within the limits of our resources and the goals of each health care center.

4. We believe that technical and professional competence must be demonstrated by every person involved in the health care provided by General Hospital. Department Heads, Directors, and Administration have the responsibility for the performance of all persons directing or rendering care under jurisdiction.

5. We believe that the governing body of General Hospital has an obligation to require an accountability for performance from all persons involved in the health care field. This includes adherence to professional and institutional standards, the ethical and moral principles held by the institution and respect for the dignity of the total person.

6. We believe that professional and prudent management of the resources of General Hospital is vital. The resources must first be expended to meet our present commitments first and then to develop programs and services which have a high priority to meet special community needs.

SUBJECT: DISCLOSURE OF CERTAIN INTERESTS OF THE ADMINISTRATOR, STAFF MEMBERS, SELECTED EMPLOYEES, VOLUNTEERS, AND MEDICAL STAFF WITH ADMINISTRATIVE RESPONSIBILITIES

GENERAL STATEMENT

Since the relationships of the administrator, administrative staff members, employees, volunteers, and medical staff members having administrative responsibilities with General Hospital carry with them a requirement of loyalty and fidelity; and

Since it is the responsibility of such persons to administer General Hospital's affairs honestly and economically, exercising their best care, skill, and judgement for the benefit of General Hospital; and

Since it is also the responsibility of the administrator to make full disclosure of any interest that might result in a conflict on his/her part, and the governing body makes a like requirement of administrative staff members, certain employees, and medical staff members with administrative responsibilities, and forbids any material conflict of interest on the part of such persons; and

Since it is deemed to be timely and appropriate to adopt a policy on conflicts of interest for the guidance of all persons so as to ensure adherence to the aforementioned policy and avoidance of conflicts of interest;

The following policy on conflicts of interest is hereby adopted:

POLICY STATEMENT

The administrator, administrative staff members, employees, volunteers and medical staff members with administrative responsibilities shall exercise the utmost good faith in all transactions touching upon their duties to General Hospital, they shall be held to a strict rule of honest and fair dealing between themselves and General Hospital. They shall not use their positions, or knowledge gained therefrom, in such a way that a conflict might arise between the interest of General Hospital and that of the individual.

All acts of such persons shall be for the best interest of General Hospital.

Such persons shall not accept any personal gifts, favors, or hospitality that might influence their decision making or actions affecting General Hospital.

Although it is recognized that a degree of dual interest may exist from time to time, such degree of dual interest shall not be permitted to influence adversely the decision-making process of General Hospital. To this end, any person subject to this policy shall promptly report the possible existence of a conflict of interest for himself or any other person subject to the policy. This report shall be made to the Administrator.

SUBJECT: DISCLOSURE OF CERTAIN INTERESTS OF THE ADMINISTRATOR, STAFF MEMBERS, SELECTED EMPLOYEES, VOLUNTEERS, AND MEDICAL STAFF WITH ADMINISTRATIVE RESPONSIBILITIES

A full disclosure of all facts pertaining to any transaction that is subject to any doubt concerning the possible existence of a conflict of interest shall be made before consummating the transaction.

This policy shall be available for the information and guidance of the administrator, administrative staff members, selected employees, volunteers, and medical staff members with administrative responsibilities, and any other new member should be advised of the policy upon entering the duties of his position.

SUBJECT: PHILOSOPHY OF NURSING SERVICE DEPARTMENT OF GENERAL HOSPITAL

The Emergency Department Nursing Service of General Hospital recognizes and accepts the overall philosophy of General Hospital and its Board of Directors. We acknowledge that the primary responsibility of the Nursing Service is to the patient. We believe that this is fulfilled by assisting the patient in meeting his needs of daily living in order to help restore him to his optimum state of health or support him toward a dignified and peaceful death.

In General Hospital, the patient participates in experiences that will uniquely influence his physical and emotional state of being. Nursing Service, as the patient's advocate, has the responsibility to help interpret daily experiences and to provide emotional, physical and spiritual support for the patient as well as helping him to maintain his family and community role. Since we believe that each person is a unique individual possessing human dignity and worth, his rights regardless of race, creed, color, sex or age must be preserved and protected. The patient has the right to make decisions regarding his care.

Nursing Service bears a primary responsibility and accountability for the nursing care patients receive. We believe this care is best achieved through scientific problem-solving. We endorse the nursing process as a systematic method within the nursing context that helps the nurse to make a positive difference in the patient's ability to meet his or her daily health needs. The nursing process is composed of assessment, planning, intervention and evaluation.

We also believe that the patient can best be served by a professional relationship with other health team members and services within the hospital. Mutual respect between all the health team members is an integral part of this cooperation. Nursing Service recognizes this as necessary for staff development and learning with its focus on improved patient care. Nursing Service accepts its responsibility to act as role model to other members of the health care team through attitudes, values and behavior that leads to exemplary patient care.

It is our belief that Nursing Service has an obligation to study what constitutes effective nursing care measures, to exhibit leadership in finding answers to many of nursing's unsolved problems and to be responsive to changes in approaches to patient care.

Finally, we believe that each nurse, regardless of personal beliefs, is responsible for upholding the professional standards of conduct and ethics.

SUBJECT: NURSING SERVICE STANDARDS OF NURSING CARE

These standards include, but are not limited to, the standards of Nursing Practice as formulated by the American Nurses' Association and provides a means for determining the quality of nursing care given to patients in General Hospital.

All licensed personnel shall:

1. Show evidence of understanding of the nursing process through goal-directed nursing care.
2. Exhibit good decision making and problem solving skills.
3. Continuously and systematically collect data about the health status of the patient and verify data collected by non-licensed personnel.
4. Provide data on the health status of the patient to other members of the health team through effective written and verbal communication.
5. Identify nursing care needs from assessment of the collected data.
6. Develop goals for meeting these needs that the realistic, measurable and, when possible, are arrived at jointly with patient and/or family.
7. Plan comprehensive care based on priorities and consistent with the therapy prescribed by the patient's physician.
8. Administer therapeutic measures in a safe, efficient manner, using scientific techniques.
9. Supervise and serve as resource parsons to ancillary personnel on the unit and assist in the performance of their duties.
10. Prepare the patients, physically and psychologically, for procedures and treatments in order to promote understanding and cooperation.
11. Participates in patient and/or family teaching in all areas regarding health needs.
12. Assess all patients for ongoing health needs and participate in discharge planning when needs are identified.

13. Participate in reassessing, reestablish priorities, setting new goals and revising the plan of care, where appropriate.

14. Systematically evaluates, in collaboration with patient and/or family, the patient's progress, or lack of progress, toward goal achievements.

15. Promote and maintain a professional department at all times.

SUBJECT: NURSING SERVICE PHILOSOPHY

The Department of Nursing Service believes that the dignity of every human being is to be respected in life and death. We believe General Hospital Department of Nursing Service is responsible for providing the highest attainable quality of individualized nursing care for each patient while in the hospital and for the continuity of each patient after leaving the hospital through the home health care program and the many services that may be available. We support and/or believe in using local students participating in health careers.

We believe each patient has a right to expect the Nursing Service to provide a safe and therapeutic environment in which his physical, emotional, social and spiritual needs can be assessed and met during any stage of his illness.

We believe that Nursing Service is the Department through which the team effort of the entire hospital organization can be coordinated to achieve its objectives for each patient.

We believe that continuing education for all levels of personnel is essential to create and maintain an atmosphere conducive to learning in order for each employee to reach his potential and experience constant and increasing job satisfaction.

SUBJECT: HOSPITAL EMPLOYEES PROBLEM SOLVING

Where numbers of individuals work together, it is only natural that problems or questions arise from time to time on wages, job opportunities and working conditions. Every employee of General Hospital is expected and urged to present any question or problem relating to his or her job to their supervisor, as experience has shown that most problems can be solved in these discussions. If the problem is not satisfactorily solved, you may submit the problem in writing to your Department Director. If the answer from your Department Director does not solve your problem to your satisfaction, you may request that the problem be submitted to the Grievance Committee.

The Grievance Committee will review the problem so that it may be resolved in an equitable manner. This problem solving procedure, as outlined in the employee Handbook, is available to all employees of General Hospital and it may be used freely without fear of being penalized in any manner. It is the policy of General Hospital to handle all employee problems on an individual basis and final decision will be made only after full consideration of all aspects of the problem.

The Administration would like to restate that General Hospital does not discriminate against any employee or applicant for employment because of race, color, creed, national origin, age, sex, or handicap.

General Hospital, in making job assignments to new employees and in making promotions, utilizes the best available person in each position without discrimination because of race, color, creed, national origin, age, sex, or handicap.

All changes of assignment or transfers between departments, terminations or other change in employees' status, are made without regard to race, color, creed, national origin, age, sex, or handicap.

General Hospital affords employees an equal opportunity to participate in training procedures for various jobs without discrimination because of race, color, creed, national origin, age, sex, or handicap.

As an employee, regardless of your job assignment, you should always remember that you are contributing to the care and well-being of the patients in our hospital.

SUBJECT: PATIENT CARE RESPONSIBILITY OF THE EMERGENCY DEPARTMENT NURSE

POLICY: The nurse shall have the following responsibilities for initial patient care in the Emergency Department.

1. Upon arrival of the patient, he/she shall be placed in an appropriate examination room.

2. The nurse shall then obtain a brief history and vital signs (temperature, pulse, respirations, blood pressure). Any wounds shall be examined and assessed as to severity.

3. After all information is obtained, the physician on call shall be notified.

4. The nurse is not responsible for patient disposition, nor is she to serve as mediator between physician and patient.

5. If the physician desires further history or financial information, he/she may obtain this from the patient or from the Emergency Department Registration Clerk.

6. In regard to obstetrical patients, no pregnant woman who is actively bleeding shall be examined without a doctor's order. Otherwise, if a pregnant woman presents to the Emergency Department, a competent vaginal exam should be done prior to calling the physician.

SUBJECT: STATEMENT ON NONDISCRIMINATION

POLICY: It is the policy of General Hospital to admit and provide health care related services, under medical direction, to all patients without regard to the poverty or riches of the recipients and without regard to their race, color, religion, national origin, sex, age, or handicap.

Patients are assigned and transferred within the facility without regard to the poverty or riches of the recipient and without regard to their race, color, religion, national origin, sex, age, or handicap. Smoking preference and sex of patients will determine assignment to multiple accommodations. There is no distinction in eligibility for, or in the manner of providing, any patient services provided by the Hospital.

General Hospital provides general and special facilities for inpatients with the exception of (insert exceptions here). Consultative services may be obtained by the patient's attending physician and arrangements made for transfer based on medical decision.

General Hospital's Governing Body grants staff privileges to qualified persons with proper credentials without regard to race, color, religion, national origin, sex, age, or handicap.

General Hospital is an Equal Opportunity Employer and manages employment and employee relations practices without regard to race, color, religion, national origin, sex, age, or handicap.

SUBJECT: ORGANIZATIONAL PLAN AND DEPARTMENTAL RELATIONSHIPS

POLICY: There is an organizational plan to delineate line of authority establishing communication of the Nursing Department with other hospital departments and services to maintain a highly organized method of assuring quality patient care.

1. ORGANIZATIONAL PLAN:

   A. Director of Nursing:
   Authority: The Director of Nursing has the authority and responsibility to direct and supervise the nursing care provided to patients. She/he analyzes and evaluates nursing and related services to improve the quality of patient care and to plan better utilization of staff time and abilities. She/he is responsible for creating a system which fosters participation of the administrative and nursing staff in planning, implementing, and formulating policies to insure safe, efficient and therapeutically effective nursing care. The director participates in the interviewing process of potential nursing service employees, is a member of all committees of the hospital having input in policy decisions that affect patient care services in the hospital, attends Medical Staff Meetings monthly to serve as liaison between the medical staff and the nursing department, and is the designee in charge in the absence of the Administrator.
   Accountability: The Director of Nursing is accountable to and reports to the Administrator of the hospital.
   Communication: The Director of Nursing coordinates nursing service activities with other departments and communicates with nursing personnel, medical staff, other department directors, patients, and the public in order to promote and maintain harmonious relationships and encourage quality care of patients through department managers meetings and serving as a committee member of hospital committees.

   B. Unit Supervisors:
   Authority: The RN unit supervisors have the authority and the responsibility to supervise, direct and evaluate the performance of all nursing personnel assigned to their specific unit. They are responsible for planning, organizing, and coordinating patient care activities. In the absence of the Director of Nursing, are responsible to maintain adequate staff for patient care activities and accountable to the Administrator. In the absence of the Director of Nursing and the Administrator, will act in the Administrator's behalf.
   Accountability: Accountable to and report directly to the Director of Nursing.
   Communication: Communicate and maintain a rapport directly with administration, medical staff, other hospital department directors as well as patients and the public. Serves on committees to maintain high quality patient care.

C. Registered Nurse:
Authority: The registered nurse has the authority and responsibility to supervise, direct, and evaluate the performance of the nursing personnel on his/her specific shift; and when designated, performs supervisory duties in the absence of the unit supervisor.
Accountability: The registered nurse is accountable to the RN unit supervisor.
Communication: Communicates and maintains rapport with the nursing staff, physicians, patients and families, as well as other departments in the hospital, including but not limited to, admitting, dietary, Emergency Department, and intensive care unit. Participates in patient care activities, nursing committees, and or hospital committees.

D. Licensed Vocational Nurse:
Authority: The LVN has the responsibility to administer comprehensive care to his/her patients. The LVN has the authority to supervise nurses's aides and works under the supervision of a registered nurse.
Accountability: Accountable to the supervisory registered nurse, the unit supervisor, and the Director of Nursing.
Communication: The LVN works closely and communicates with the patients, families, physicians, and other members of the nursing staff, as well as other departments in the hospital. Serves on committees to maintain high quality patient care in nursing.

E. Nursing Assistant:
Authority: Responsible for performing basic nursing care duties under direct supervision of licensed nursing personnel.
Accountability: Accountable for performance to the RN Supervisor or licensed nurse.
Communication: Maintains lines of communication with the RN Supervisor, unit staff members, as well as patients and families.

F. Unit Secretary or Ward Clerk:
Authority: Is responsible for performing receptionist and secretarial duties on the patient care unit while functioning as the focal communication source in the nursing station.
Accountability: Accountable to the designated licensed nurses, Unit RN Supervisor, and the Director of Nursing.
Communication: Focal communication source who interrelates with patients, families, visitors, nursing personnel, physicians, and all hospital departments.

G. Nursing Administration Secretary:
Authority: Responsible to perform a variety of secretarial and clerical skills.
Accountability: accountable to the Director of Nursing.
Communication: Communicates with all of the Nursing employees as well as other department personnel.

2. DEPARTMENTAL RELATIONSHIPS

The Nursing Department communicates with other hospital departments and other services to maintain a highly organized method to provide quality patient care. Through Quality Assurance, Nursing Service reports the status of nursing care and monitors compliance to the standards of care. Nursing Service representative is a member of all committees of the hospital having input in policy decisions that affect patient care services in the hospital. Department managers meet at scheduled intervals for communication throughout the hospital and policy additions, changes, and goal planning. The Director of Nurses attends Medical Staff Meeting monthly to serve as liaison between the medical staff and the nursing department. A designee may attend in the absence of the Director of Nursing. Qualified registered nurses participate in patient care activities, nursing committees, and/or hospital committees. Nursing Service directs patient care and activity in the event of an internal or external disaster.

A. ADMITTING:
The nurse supervisor acts as a liaison between Nursing and the Admitting Office and is responsible for assigning patient rooms. The admitting clerk takes patient to the Nurses Station and may call for assistance if necessary. After business hours (8am-5:00pm), admissions are handled by the clerk in the Emergency Department under the direction of the Nursing Supervisor. Nursing notifies the Admitting Office of discharges. Observation patients are taken to the Admitting Office for dismissals.

B. BUSINESS OFFICE:
Nursing will notify the Business Office when patient has concern with billing. The Business Office will call Nursing concerning a visit to the patient.

C. DIETARY SERVICES:
Nursing will notify the Dietary Department of all new changed diet orders. Trays will be brought to the Nursing units, checked by member of the nursing staff, and then served to the patient by the nursing staff or auxiliary member. Nursing prepares the patient for his meals and provides any necessary assistance. Nursing will notify the Dietary Department of any needs for dietary instruction for patients or families.

D. RESPIRATORY THERAPY:
The Unit Secretary or member of the Nursing staff completes a requisition and/or notifies the therapist for any new or changed order and places the requisition in the appropriate drawer at the Nurses Station. The therapist will collect the sputum

specimen if ordered to do so by the physician. EEGs and EKGs are scheduled with Respiratory Therapy.

E. PHARMACY:
A carbon copy of the physician's order is forwarded to the Pharmacy each time a medication order is written. The patient's medication drawer in the medication cart is filled by the Pharmacy daily Monday through Saturday. In so far as possible, all IV admixtures are prepared in the Pharmacy.

F. PURCHASING DEPARTMENT:
A supply area is stocked for each nursing unit and checked daily. Additional supplies may be obtained by sending a requisition to Purchasing. Purchasing will obtain supplies and equipment from outside this institution when the need arises.

G. HOUSEKEEPING SERVICES:
Linen is supplied from State Linen Service. Additional linen may be obtained by calling housekeeping. Housekeeping is responsible for the routine cleaning of patient rooms and work areas. Nursing staff logs rooms needing cleaning on Housekeeping clip at the Nurses Station after patients are discharged after 4pm. During regular working hours, Housekeeping may be notified by telephone. Soiled linen hampers are collected at regular intervals.

H. CENTRAL STERILE SUPPLY:
Sterile supplies kept at the Nurses Station are checked periodically by Surgery personnel. After use of sterile items from Central Sterile Supply, items are washed and returned to the clean up room adjacent to Central Sterile Supply.

I. MAINTENANCE:
Request for this service is accomplished by completing the appropriate requisition and placing it in the appropriate receptacle at the Nurses Station. Work involving disruption of service to any nursing unit is coordinated through the appropriate nursing personnel.

J. MEDICAL RECORDS:
Physician requests for old charts are forwarded to the Medical Records Department. If the request is received when the department is closed, nursing personnel will obtain a chart by documenting on the appropriate sign out request in Medical Records and marking the area where chart was removed with red plastic index sheet. Incomplete charts are to be completed by nursing personnel on a timely basis during Medical Records Department operating hours.

K. PHYSICAL THERAPY:
Nursing notifies Physical Therapy of any new or changed orders by written request or by telephone when not in the building. Physical Therapy will either provide the prescribed therapy at the patient's bedside or transport the patient to the physical Therapy Department.

L. LABORATORY:
Specific tests or procedures are scheduled with the Laboratory by sending appropriate request to the department and clocking in the request in this department. Tests results are posted on the patient's chart by laboratory personnel and/or nursing personnel.

M. RADIOLOGY:
Specific tests or procedures are scheduled with the Radiology Department by sending the appropriate requisition to the department. The patient is prepared by nursing personnel specific to the procedure ordered by the physician. Report is typed by Medical Records and placed on the chart by nursing personnel.

N. SOCIAL SERVICES:
The Social Service/Discharge Planner will cooperate with Nursing in the provision of appropriate services to the patients. Nursing initiates discharge planning with the Discharge Planning Worksheet at the time of the patient's admission completing and initialing this worksheet. A Social Service Resource manual is kept at the Nurses Station and in the Emergency Department.

O. DISASTER: INTERNAL - EXTERNAL:
Key personnel, or pending the arrival of key personnel, the senior person on duty (supervisor or supervisory nurse) is responsible for beginning emergency operations; notification of Administrator, switchboard (to call key personnel), clear Emergency Department waiting area and Emergency Department treatment rooms of patients who are not in critical condition, notify the County Sheriff's Department of the emergency situation and request personnel for guard coverage and traffic control around the hospital; alert all physicians in the hospital, then those on the staff; and divert nursing personnel from less critical units to assist in casualty treatment in the Emergency Department. Triage Nurse will be assigned to the Emergency Department to assist the Triage Physician. Copy of the Internal and External Disaster Plan is kept in each Nursing unit.

P. QUALITY ASSURANCE, INFECTION CONTROL, AND STAFF DEVELOPMENT:
Patient care activities are monitored by Nursing and reported on a monthly basis to the Director of Quality Assurance. Reporting of hospital acquired and communicable infections to include isolation of patients by Nursing to the Infection Control Nurse. Desired inservice and inservice reported to Staff Development who makes availability of same to the Nursing personnel.

THE ORGANIZATION PLAN FOR THE DEPARTMENT OF NURSING SERVICE

1. General Organization
   The Department of Nursing Service is organized to provide optimal nursing care for patients within the hospital. It functions to achieve the departmental objectives in accordance with the policies approved by the controlling authority of the hospital and is directly responsible to the hospital administrator. Membership in the department consists of all personnel utilized in the performance of its functions.

2. Functions of the Department

   A. Planning, organizing, directing, administering and evaluating patient care with the philosophy, objectives and policies of the Nursing Service always in mind.

   B. Defining and implementing a departmental system of authority clearly describing the roles and relationships of all levels of nursing personnel.

   C. Coordinating functions of the department of nursing with the functions of other departments and services of the hospital.

   D. Maintaining meaningful and useful records and reports.

   E. Budgeting.

   F. Participating in and cooperating with various educational programs, including community health.

   G. Participating in the formulation of sound personnel policies; implementing established policies and evaluating their effectiveness.

   H. Evaluating the effectiveness of the department on a continuing basis.

3. Components

   A. Nursing Service Administration includes the Director of Nursing Service, Head Nurses, Operating Room Supervisor, and the Director of Inservice Education.

   B. The Clinical Sections of the nursing service are Medical Nursing, Surgical Nursing, Operating Room Nursing, Recovery Room Nursing, Out-Patient/Emergency Department Nursing, Maternity Nursing. Each shift is managed and directed by a Head Nurse who reports to the Director of Nursing Service.

4. Authority

A. The Director of Nursing Service is responsible to the Hospital Administrator for planning, organizing, directing, controlling and evaluating the activities of the department of Nursing Service. These responsibilities include:

1. Development of departmental philosophy and objectives.
2. Selection of staff members and defining their respective duties.
3. Designing and implementing a pattern of delegated authority and responsibility within the department.
4. Determination of staffing needs, current and projected.
5. Approval of "personnel action" within the department including promotion, transfers, dismissals, leaves of absence, salary adjustment, etc.
6. Providing all levels of departmental personnel with opportunities for growth and development through a progressive staff development program.
7. Maintaining liaison with medical staff, department heads or supervisors of other departments and services.
8. Creation of an educational environment and attitude among Nursing Service personnel.
9. Planning cooperatively with the administration staff of the department for determining, evaluating and promoting quality standards in patient care practices.
10. Conducting systematic review and continuous appraisal of the effectiveness of the department.
11. Preparation and administration of the departmental budget including salaries, equipment and supplies.
12. Maintaining meaningful and useful records and reports.

B. The Head Nurse on each shift is directly responsible to the Director of Nursing Service and is delegated the responsibility for planning, organizing, directing, controlling and evaluating the activities of the nursing department on a day to day and shift to shift basis. She is responsible for scheduling personnel and maintaining an adequate staff according to the current needs of the patient. In the absence of the Director of Nurses, the Head Nurse of each shift will assume administrative responsibility.

C. The Charge Nurse of each shift is responsible to the Director of Nursing for the leadership, development and supervision of personnel and patient care. The Charge Nurse is responsible for the proper interpretation and implementation by the nursing staff of nursing care practices, hospital policies, and personnel policies. Each Charge Nurse is responsible for promoting the conservative utilization of personnel, supplies and equipment.

D. The Staff Nurses, Licensed Vocational Nurses, Nursing Aides, and Orderlies assigned to the individual shifts are delegated duties and responsibilities by the Charge Nurse according to their ability, education, individual differences and needs of the patients. Nursing Care assignments of the staff members are made by the Charge Nurse, and are planned to accomplish the best possible combination to assure quality patient care and optimal utilization of personnel.

5. Administrative Meetings

Administrative meetings are conducted by the Director of Nursing Service for purposes of communication and problem solving. Attendance at these meetings is considered to be a responsibility of the individual, and is expected unless prior permission to be absent has been received. In such instances of necessary absence, the individual shall secure a copy of the minutes of the meeting and thoroughly familiarize herself with the business conducted, the topics discussed and the decisions reached. Administrative meetings shall be scheduled regularly; will begin promptly; will have a prepared agenda; and will provide opportunity to bring up problems. Written minutes of each meeting are on file in the office of the Director of Nursing.

A. Meetings of the Nursing staff shall be held monthly. These meetings shall be for the purpose of planning, problem solving, and decision making.

B. Open Meetings of the Nursing Staff shall be held as needed. These meetings shall be for the purpose of communication and feed back, and public relations among all workers.

C. In addition to the formalized meetings discussed above, the Charge Nurses meet informally with the Director of Nursing as needed.

6. Inservice Education

The total concept of operation in the inservice education program is the:

A. Orientation of each new employee to the Hospital and to the Department of Nursing Service

B. Skill training for the non-professional nursing staff designed to meet the specific needs of the specific job in which they are functioning.

C. Inservice education programs designed to appeal to all levels of nursing staff and attuned to changing practices and procedures emerging in hospital nursing.

Members of the nursing staff are recruited for service on committees and for their assistance in preparing and presenting programs of educational value to groups. New experiences and responsibilities are planned for members of the staff as their developmental level is perceived to be receptive to it. It is believed that this type of learning contributes substantially to continuing education in an informal but nevertheless meaningful manner.

7. Relationships with Educational Programs
   The Department of Nursing Service cooperates with the local high school and to the best interest of the students. The hospital helps by training, education, and exposure which encourages students to continue in one or more areas of the health-related fields.

SUBJECT: COMMUNITY BASED EMERGENCY CARE PLAN

General Hospital and its Medical Staff shall promote, help to develop and implement a community based emergency plan and do so cooperatively with other area hospitals. General Hospital will participate in community education relative to availability and location of emergency care and be involved with the community in disaster planning and drills. The Hospital shall cooperate with other area hospitals in a joint effort to identify the readiness of each hospital and its staff to receive and treat emergency patients effectively.

General Hospital has established a procedure whereby ill and Injured patients are assessed and either treated or referred to an appropriate facility.

General Hospital District will provide emergency care in the Emergency Department. Medical care will be provided by the patient's private physicians or the designated emergency physician.

Patients requiring additional care in other facilities will be transferred after their condition has been stabilized, as directed by the physician, and in accordance with the Texas Department of Health.

In the event of a community disaster, the Emergency Department will act as a triage area for patients. See Disaster Plan.

The Hospital will staff the Emergency Department with at least one R.N. Those persons working in the Emergency Department will have relevant training and experience, participate in continuing education programs related to emergency care and have participated in an orientation to the department.

On an annual basis, General Hospital shall evaluate and classify itself regarding the capability of providing emergency medical services in the community. Such classification shall be based on the overall capability of General Hospital and its medical staff to meet the needs of the community.

SUBJECT: GUIDELINES (STANDARDS) OF CARE EMERGENCY DEPARTMENT

An emergency exists when a patient believes that his or her physical or emotional well-being is compromised. The Emergency Department physician and nurse must remain calm and quickly think what has happened, and what should be done, or a life may be lost.

1. Admission of the Patient to Emergency Department

    A. All patients will be assessed and given care as indicated.

    B. Patient teaching will be a primary goal of the Emergency Department nurse.

    C. The Emergency Department nurse will be highly skilled in public relations, stress management and creative problem solving, since the Emergency Department is the first impression of the health care system.

    D. Due to the sudden onset of an emergency the patient is usually anxious and fearful, the nurse should:
        1. Be aware of these anxieties and allay them with an introduction, smile and a warm touch.
        2. Be aware of the needs of the significant others and communicate patient's condition as frequently as the situation indicates.

2. Initial Assessment of the Patient

    A. Establish priority of care through triage, which is a continual process.

    B. The nurse must quickly identify what life sustaining measures are indicated, and identify any injuries or problems all within a period of two minutes.

    C. The nurse must gather a history from the patient and significant others.

    D. Vital signs, patient condition, and patient problems should be fully assessed and documented.

3. Treatment through Assessment Priorities in Emergencies

    A. The nurse must assess and treat the immediate patient needs as indicated. All actions and observations should be recorded.

    B. Initial plans and treatments are as follows:
        1. Maintenance of a patent airway.
        2. Stop major bleeding.
        3. Note and treat major dysrhythmias as indicated by physician.
        4. Immobilization of cervical or spinal injuries.

SUBJECT: EMERGENCY DEPARTMENT INTRODUCTION

1. General Hospital offers emergency care 24 hours a day with at least one Physician available 24 hours a day through a medical staff call roster.

2. Laboratory, X-ray, and Surgery Services are available 24 hours a day through an on-call roster.

3. General Hospital is equipped with a heli-pad for use when patients require transport by flight to another facility.

4. Ambulance Service is available 24 hours a day through City Volunteer Fire Department and Smith Ambulance Service.

SUBJECT: DIRECTOR OF EMERGENCY DEPARTMENT SERVICES

1. The Emergency Department is under the direction of the Medical Chief of Staff.

2. One Physician is available to the Emergency Department through a medical staff call roster which rotates daily (or weekly, etc).

3. The Emergency Department is under the direction of the R.N. on duty until the Physician arrives on the scene.

SUBJECT: REGISTERED NURSE DUTIES BEFORE ARRIVAL OF PHYSICIAN

As necessary, the following procedures will be instigated by the Registered Nurse:

1. Start IV solutions via intracath or scalp vein needle (Lactated Ringers).
2. Administer cardiopulmonary resuscitation (Mechanical or manual).
3. Apply sterile dressing direct pressure to wounds to control bleeding, clamping artery if needed.
4. Give oxygen via nasal cannula or mask.
5. Connect patient to heart monitor; doctor will defibrillate patient.

SUBJECT: IDENTIFYING SIGNS

PURPOSE

To insure that appropriate signs, consistent with applicable law, are provided for proper directions to General Hospital from major thoroughfares.

GENERAL INFORMATION

1. Appropriate signs which are consistent with applicable state law shall be erected on all access routes to major thoroughfares entering the city. Such signs shall indicate the direction to the Hospital and the availability of emergency care services.

2. Additional signs will be placed on or near hospital property to indicate the emergency access area.

SUBJECT: EMERGENCY DEPARTMENT DESIGN

1. The entrance to the Emergency Department shall be clearly identified externally and shall at all times be readily accessible to emergency vehicles and pedestrian traffic.

2. All Emergency Department and service entrance doors shall at all times be well lighted and protected from the weather. An entrance door shall be wide enough to accommodate patients, attendants and equipment.

3. Stretchers and wheel chairs shall be stored immediately adjacent to the Emergency Department service entrance. The stretchers and wheel chairs shall not obstruct entry.

4. The Emergency Department treatment area shall have a specialized treatment area for patients with life threatening conditions. This specialized treatment area shall be equipped to handle the life threatening conditions for which it is designated.

5. The Emergency Department treatment and work areas shall be restricted of unauthorized individuals.

6. The Emergency Department treatment area shall be clean and safe. The treatment area shall provide sufficient space for patient examination and treatment.

7. The Emergency Department waiting area shall be clean and safe. The waiting area shall provide acess to a public telephone and lavoratory facilities.

SUBJECT: OPERATING SUITE REQUIREMENTS

1. The Emergency Department shall have prompt access, as needed, to operating suites with the following capabilities:

    A. Thermal control equipment for the patient and for blood.

    B. Fracture table.

    C. Appropriate endoscopic equipment.

    D. EKG-oscilloscope-defibrillator.

    E. Mechanical ventilator.

    F. Temperature monitoring equipment.

    G. Cardiopulmonary resuscitation equipment and medications.

    H. Radiographic equipment is readily available.

2. The Hospital and Medical Staff shall provide a plan to insure that appropriate surgical specialists and anesthesiology and operating room personnel are readily available within a few minutes.

SUBJECT: EMERGENCY DEPARTMENT ORIENTATION

Welcome to General Hospital Emergency Department! The following information will assist you with your orientation to Nursing service provided for the Emergency Department . The Emergency Department head nurse is Jane Doe, RN.

1. The normal 24 hour staffing pattern for the Emergency Department is:

   7:30 am - 4:00 pm (Day shift) - two RN's or more with one LVN and one N/A.

   3:35 pm - 12:15 am (Evening shift) - Two RN's or more with one LVN and one N/A.

   12:00 midnight - 8:00 am (Night shift) - One RN with one LVN and one N/A.

   The Minor Medicine Clinic is open from 3:00 pm to 11:00 pm.

2. Emergency Admissions

   A. A medical record will be initiated on all patients who enter the Emergency Department. Vital signs will be obtained and documented, the patient's name will be entered on the Emergency Department Log along with age, sex, mode of presentation, time and chief complaint, diagnosis and disposition. The current date will be on top of the Emergency Department Log.

   B. The Emergency Department physician is to determine whether the patient requires Emergency Department care or is stable enough for evaluation in the Minor Medicine Clinic.

   C. All Emergency Department patients will be assigned a primary nurse. The assigned nurse is responsible for the total care and safety of this patient. The name of that nurse will appear on the bottom of the patient's Emergency Department record.

   D. Only RN's can perform venipunctures. RN's are not permitted to draw ABG's.

   E. The clerk is responsible for the physician's orders for lab, EKGs, x-rays, and retrieves medical records and obtains pending results.

3. Emergency Department Visitations

   A. The visiting policy for the Emergency Department is only one person at the bedside at a time, with the permission of the primary nurse.

4. Other

   A. All patients admitted to an Intensive Care Unit will be placed on a cardiac monitor, have an intravenous access and be accompanied by a physician during transfer, unless specifically ordered otherwise by the physician.

   B. All deaths and special incidents such as medication errors, falls, etc., must be documented on an "Incident Report" form.

SUBJECT: LEVEL OF EMERGENCY SERVICES/HOSPITAL CLASSIFICATION

General Hospital provides emergency services at Level II, as defined in Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations, 1990 Edition. That is, the Hospital provides emergency care twenty-four hours a day with at least one physician experienced in emergency care on duty in the emergency care area, and specialty consultation available within 30 minutes by members of the Medical Staff. The Hospital's capability includes in-house management of physical and related emotional problems, with provision for patient transfer to another facility when needed.

CLASSIFICATION

The emergency service of General Hospital is classified as Level II. Emergency care is offered 24 hours a day, with an emergency physician on duty in the emergency care area, and specialty consultation available within 30 minutes by members of medical staff on back-up. Call lists of back-up physicians are posted in the nursing station. These include: medical, surgical, orthopedic, obstetrical/ gynecological, pediatric, dental, and ophthalmological consultation services with inhouse capabilities for managing physical and related emotional problems.

Psychiatric consult is available with staff physicians. The hospital's scope of service includes in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another facility when needed.

SUBJECT: LEVEL OF EMERGENCY SERVICES/HOSPITAL CLASSIFICATION

General Hospital provides emergency services at Level III, as defined in Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations, 1990 Edition. That is, the Hospital offers emergency care twenty-four hours a day, with at least one physician on duty in the emergency area or available within 30 minutes to the emergency care area through a medical staff call roster. Specialty consultation is available by request of the attending Medical Staff or by transfer to a designated hospital where definitive care can be provided.

SUBJECT: TO ACCOMPLISH BEST MEDICAL CARE

POLICY: Policy is written to accomplish the best medical care in the Emergency Department.

1. For best medical and surgical care:

    A. To keep a list of specialists posted in the Emergency Department.

    B. An Emergency Department Physician will be on the premises at all times.

    C. Physicians on call for special services will serve as back up physicians for the Emergency Department physician as necessary.

    D. To have Emergency Department committee to act as liaison between the staff, nursing department and administration.

2. To provide the best nursing care:

    A. To have nurses assigned to be on duty in the Emergency Department 24-hours daily.

    B. To have the auxiliary nursing personnel on duty as needed to help the head nurse.

    C. To have a supervisor on duty to see that the best nursing care is provided.

    D. To have representatives from the Emergency Department on the Emergency Department Committee.

3. To provide care to each patient presenting himself to the Emergency Department.

    A. No one is refused treatment.
        1. Every patient is either treated in the Emergency Department, or
        2. Sent to the physician's office or other facility as ordered by the physician.

    B. No one is refused treatment for race,creed, religion, national origin, or from being an alcoholic.

4. To provide Spiritual needs.
    A. In D.O.A. or critical patients,try to get a priest or minister of the patient's and family's choice or a substitute.

B. To refer a patient to a clergy member at any time if the Emergency Department sees a need.

C. To try to provide privacy to patients, family, or friends in time of spiritual needs by use of family room located in the Emergency Department.

D. To show them the chapel for their use.

5. To institute a feeling of the patient's confidence, patient's family and friends' confidence and trust and respect in the Emergency Department personnel.

   A. By being courteous.

   B. By explaining what we are doing.

   C. By treating the patients as soon as possible after their arrival.

6. To always improve our knowledge, equipment and supplies.

   A. To improve our knowledge:
      1. To attend in-services for hospital care.
      2. To attend outside (hospital) workshops relating to patient care.
      3. To have weekly in-service in the Emergency Department.

   B. For purpose to improve the Emergency Department:
      1. To attend short courses in medical field.

   C. To improve equipment and supplies.
      1. To have Maintenance repair any equipment as it becomes faulty.
      2. To keep any drug on hand that might be needed and to educate ourselves to new drugs.
      3. To do periodic inspections of drugs.
      4. To keep needed equipment on hand at all times.
         a. To keep purchasing new advanced life-saving equipment.
         b. To have periodic inspections of equipment.

7. To be conscious of expanding needs of community.

    A. To expand our Emergency Department to care for more people.

    B. To have more personnel on duty at times of heavy patient load.

    C. To have a telephone list in the nursing director's office and switchboard to alert off-duty personnel at time of major disaster for additional help.

    D. To have identifying card in possession of all hospital personnel to get through police blocks to the hospital for a disaster.

    E. To keep a disaster plan:
        1. To have all personnel review disaster plan often.
        2. To have in-services on disasters.
        3. To hold at least two disaster drills a year.

8. To educate citizens of the community to better health.

    A. By the personnel being ready to give lectures, demonstrations, or take part in programs in the community on health care.
        1. To support established health organizations, and to help organize new ones in community as needed.
        2. To talk and help at schools, clubs, churches, or other places needed.
        3. To use the press, T.V., or radio to help educate.

    B. To work in inoculation clinics.
        1. To work in schools and churches to alleviate fear of doctors and nurses as we realize fear starts early in life on being examined and getting medical care.

9. To work with all members of a medical team to promote harmony and improvement in the Emergency Department.

    A. To work with the emergency department committee.

    B. To have orientation in the emergency department on the level of work of the emergency department personnel.

    C. To have liaison with Nursing Service.

    D. To work with all departments in the medical field and to understand that all are working for the best care of patients.

    E. To hold monthly meetings in the Emergency Department with the personnel for discussion for a better department.

SUBJECT: THE GOALS FOR THE EMERGENCY DEPARTMENT

POLICY: Policy is written to establish goals for the Emergency Department.

1. To provide the best Emergency care for the community
2. To provide the best medical and surgical care.
3. To provide the best nursing care.
4. To provide care to every patient who presents himself to the Emergency Department.
5. To administer spiritual needs to patient's, family, and friends when needed.
6. To institute a feeling of trust,, respect and confidence in the Emergency Department personnel to patients, the patient's family and friends.
7. To always improve our knowledge of equipment and supplies.
8. To always be mindful of expanding needs of the community.
9. To be ready to work to educate citizens of community regarding importance of regular physical exams, inoculations, and health programs to improve their health and have a longer, fuller life.
10. To work with all members and the medical team and try and maintain harmony and improvement in the department.
11. To instruct each patient in the Emergency Department to adapt to self care at home.
12. To plan personnel policies and procedures for effectiveness in patient care.
13. To cooperate with other departments in providing best care possible.
14. Close and/or continuous observation of the patients.
15. Specially trained personnel to provide supervision and specific care.
16. Specially designed hospital space and support facilities.
17. Special equipment.

18. Delegation of responsibility to qualified personnel so that major emergencies may be quickly treated at any time.

19. Proper administrative organization to provide consistent care and maintain standards.

20. A continuing education program to maintain previously learned staff skills and to develop new skills.

SUBJECT: CODE OF ETHICS FOR HOSPITAL EMPLOYEES

POLICY: Hospital employees will adhere to the code of ethics for General Hospital.

1. I will remember, above all, that the patient is a person with the same basic needs of all human beings - respect, security, recognition, love etc. Above this, the patient has specific physical and emotional needs related to his illness and I will do my best to meet these needs willingly and cheerfully.

2. I will remember that serving the patient is not an interruption of my work, it is my work.

3. I will hold in confidence any personal information that may come to my knowledge about a patient because I realize that gossip has never been known to help a person -- it only does harm.

4. I will willingly carry out the orders of those in charge -- doctor, supervisor, or charge nurse.

5. I will never attempt a procedure about which I am unsure without first asking sufficient questions to clarify my understanding.

6. I will do all in my power to inspire the patient's confidence in his doctor. Under no circumstances will I make a derogatory remark about a physician. If I think he is inadequate, I will report this in private to the Hospital Administrator. Neither will I refer any potential patient to any particular doctor.

7. I understand that courtesy to the patient, their families and friends is a must under any and all circumstances; and I will not allow myself to be rude or display anger to them.

8. When I am expected to be on duty, I will report on time, properly and neatly attired, and ready to do my job with loyalty, honesty, dependability, and willingness. If for reason of illness or an emergency I cannot be on duty, I will notify my superior as early as possible so that arrangements may be made for substitution.

9. I will do all in my power to create a pleasant atmosphere, not only for the patient, but for my co-workers as well, because I know that patients sense and feel when there is strife among the personnel and this gives them a feeling of insecurity. Also, I will never make uncomplimentary comments to patients about my co-workers.

10. I will absolutely refrain from the use of alcoholic beverages and profane language on duty and will never accept tips from any patient.

SUBJECT: GENERAL INSTRUCTIONS FOR ALL PROCEDURES

POLICY: Standards of good practice that are basic to all procedures are defined.

1. THE PATIENT:

    A. Introduce yourself to the patient. Gain his confidence and cooperation by showing interest and understanding.

    B. Explain the procedure to the patient, including appropriate information concerning the purpose and value; and attempt to relieve anxiety.

    C. Provide privacy, including proper draping, screening, etc., and comfort during and following each procedure.

    D. Keep signal light within reach of patient at all times.

2. THE ENVIRONMENT:

    A. Provide proper room ventilation, adequate lighting and convenient working space.

    B. Provide proper protection for furniture and equipment.

    C. Leave unit in order after performing any procedure.

3. THE NURSING PERSONNEL:

    A. Wash hands preceding and following each procedure to minimize cross infection and contamination.

    B. Use good body mechanics for maximum efficiency, safety and comfort when lifting or carrying out procedures:
        1. Stand erect with a wide base of support.
        2. Flex knees and bend hips.
        3. Stand in close proximity and use largest and strongest muscles.
        4. Have bed at proper height.
        5. Position patient side of bed nearest you when carrying out procedures.

4. THE EQUIPMENT:

   A. Assemble all equipment in proper location and have ready for use before beginning procedures.

   B. Handle equipment carefully to avoid unnecessary noise, breakage and contamination.

   C. Handle linens gently to avoid spreading bacteria and dust and discard promptly. Following use, clean and return to Central Service in the designated area.

SUBJECT: PAYMENT FOR SERVICES

It is the primary function The General Hospital is to provide health care related services to our patients without regard to the poverty or riches of the recipients and without regard to their race, color, religion, national origin, sex, age, or handicap. This care must be administered with excellence, compassion and justice to the total person -- body, soul and spirit.

The hospital maintains the right and policy to inquire into our patients' ability to pay for the services. The policy is sound financial management which is necessary for the above function. It is, therefore, the hospital's policy that payment for all services rendered, not covered by third party payers, must be made at the time of admission. At discharge the remaining balance, after estimated insurance coverage, should be collected.

The Hospital recognizes that this payment policy may result in extreme hardship for certain patients, and in those limited cases, payment can be extended to four periods; any exceptions must have the hospital Administrator's written approval. Emergency care shall be rendered without expressed written approval until the emergency situation is ended.

SUBJECT: VOLUNTARY FREE CARE TO PATIENTS

POLICY: Policy is written regarding voluntary free care to patients.

The General Hospital will make available a determined amount of "voluntary free care" services, within the resources available at The General Hospital to patients "unable to pay". These services will be without charge or at a charge which is less than our usual charge for such services. This determination as to the amount to be charged, if any, will be made according to the patient's ability to pay.

SUBJECT: SOCIAL WORK SERVICES IN THE EMERGENCY DEPARTMENT

POLICY: Policy is written to provide Emergency Department coverage by Social Service.

1. Monday through Friday 6:45 a.m. through 3;15 p.m. a daytime Social Service Coordinator/Discharge Planner provides coverage for the Emergency Department.

2. On the weekend and at night the Social Service Coordinator can be reached by contacting the hospital operator for assistance. The Charge nurse is contacted if the Social Service Coordinator/Discharge planner is not available by phone. If the charge person can not make a decision, follow the chain of command to implement the needed services. The booklet titled "Social Service List of Resources" is available for some assistance and is located in the Emergency Department.

3. If the Social Service Coordinator is not available, refer the patient or family to her for follow-up on the next working day. Any counseling and/or referral done by the Emergency Department staff must be documented in the Emergency Record.

SUBJECT: GENERAL EMERGENCY DEPARTMENT POLICIES

1. Policy has been written explaining that all medical staff members may use Emergency Department for examination and treatment of his patients or patients of physician he is relieving of duty. The Emergency Department physician is not to refuse to see a patient without a family doctor. Policy has been written to explain duties of the emergency Physicians. This includes a written list of the Medical Staff members designating if the Emergency Department physician is to see his patient, if he is to evaluate his patient, if he is to entirely examine and treat his patient, or to notify the Medical Staff doctor. Each service, such as: surgery, ENT, orthopaedic, etc., has a rotation by days list located in the Emergency Department.

2. Policy is written concerning a list of documentation of cardiopulmonary resuscitative training is to be kept in Continuing Education.

3. Policy is written stating someone has to be with all possible myocardial infarction patients and monitor them. Someone has to stay with an emotionally ill patient, someone under the influence of drugs, or alcohol, but does not have to be a nurse. Must be checked by a nurse every few minutes, unless the patient is a seriously ill or critically ill person, then a nurse has to be with the patient at all times.

4. A female is to stay with an alleged rape victim and patient is to be kept away from visitors in waiting rooms.

5. On child abuse patients, the parent or parents suspect.d of abusing the child are to be kept away from the Child. Someone is to talk with the patient as a friend to the patient. This should be done by a staff member, and not someone trying to ask questions. This child should be kept away from waiting rooms.

6. Persons suspected of radioactive contamination should be monitored with detector outside in Emergency Department drive, and not brought into contact with others, and severity decided. These people are to be sent to ?????? hospital by ambulance.

7. Dead on Arrival patients are to be treated as someone having an arrest, until pronounced dead by doctor, unless death is evident such as rigor mortis having already set in. The family needs to be escorted to a private room away from traffic.

8. New Policy states no general oral anesthetic is to be given in emergency department, no extreme debridement of Burns is to be performed, no D&C procedures, and no extensive repair of tendons.

9. Observation beds are not to be used by patients who have had family or friends to just leave them in the area, and are not ill enough to need prolonged observation or treatment. The beds available should be used to observe patients such as drug reactions, or insect or snake bites, or drug overdoses, that will probably not need hospitalization unless condition gets worse, but will only be there for few hours. These patients will be charged observation charges as established by the Business Office.

SUBJECT: GENERAL EMERGENCY DEPARTMENT PROCEDURES

1. The R.N. Supervisor (Charge Nurse) will be responsible for care of patients coming to the Emergency Department. She or designated personnel will fill out the patient history, chief complaint portions and all facets of patient care rendered on the ER form. Her presence in the ER during treatment of severely injured or critically ill patients is mandatory. Delegation of routine duties to other personnel is acceptable, but the quality of care rendered will be her responsibility.

2. The Emergency Department is primarily responsible for treatment to acutely sick and injured patients, inpatients and return patients for chemotherapy and dressings. When possible, all other patients seeking care during regular physicians office hours will be referred to their doctor after Emergency Department staff contacts their doctor for approval.

3. If possible, patient physician preference will be honored or the services of another staff physician will be arranged. Nursing personnel will assure attendance and privacy at all times until final disposition of patient.

4. Emergency Department Record: An Emergency Department Record will be completed on every patient entering the Emergency Department.

    A. Vital signs will be accomplished on all Emergency Department patients, regardless of complaint.

    B. All information on Emergency Department Record is to be completed, including arrival condition, complaint, allergies, doctors orders and treatment, disposition of patient, condition on discharge, instructions given to patient,' and directions given for follow-up care. Be sure and include who left with the patient and how patient was transported home. Consent must be obtained on Emergency Department Record in designated place prior to treatment of patient.

5. EMERGENCY CARE WHEN CONSENT CANNOT BE OBTAINED : In the event consent cannot be obtained from the patient, patient's legal guardian or closest available kin, emergency care may be given in and for the extent of the emergency as determined by the attending physician with a consultation if time permits.

6. PROVISION OF CARE TO MINOR NOT ACCOMPANIED BY PARENT OR GUARDIAN OR AN UNACCOMPANIED UNCONSCIOUS PATIENT:

   A. Attempt to notify parent or guardian of minor, and next of kin of unconscious patient. If unable to do so, determine whether treatment is immediately required and necessary to prevent deterioration or aggravation of patient's condition.

   B. Assess the possibilities of obtaining written consent, weighted against the possibility that a delay would jeopardize the health of the patient.

   C. Obtain medical consultation as to the existence of the emergency.

   D. Physician in attendance will assume responsibility of treatment given.

   E. Chart medical reasons for immediate treatment.

SUBJECT: FUNCTION AND POLICY FOR THE EMERGENCY DEPARTMENT

Operational strategy of these emergency care areas centers around the trained nurse, Traditional responsibilities of the nurse must be considerably enlarged. In the absence of a physician, the nurse must be able to assess major medical emergencies, and institute corrective procedures if an optimum number of patients are to be salvaged. The nurse will notify the physician at the onset of an emergency and take any appropriate orders, If the nurse cannot leave the patient, an alternate employee will inform the physician or his designate.

The licensed nurse performs the authorized procedures upon:

A. The direct order of a licensed doctor, or

B. Pursuant to standing procedures already established.

The criteria for the framework of preparation and practice shall be reproduced in writing and made available to the entire medical and nursing staff. The criteria shall be composed by a committee consisting of representative/s from the medical staff and nursing service administration.

SUBJECT: GUIDELINES FOR EMERGENCY DEPARTMENT PHYSICIAN'S FEES

THIS INSTRUCTION PROVIDES GUIDELINES FOR THE EMERGENCY DEPARTMENT PHYSICIAN AND EMERGENCY DEPARTMENT PERSONNEL CONCERNING CHARGING THE PATIENT WHEN ATTENDED BY THE EMERGENCY DEPARTMENT PHYSICIAN.

PURPOSE

1. To establish the criteria for Emergency Department Physician's fees.

PROCEDURES

1. Brief Exam

    A. This charge will be utilized for patients who require; : a brief exam, oral medications or injections.

    B. This charge would not be utilized for patients who require; laboratory exams, x-rays or sutures.

2. Limited Exam

    A. This charge will be utilized for patients who require; sutures (less than five), no more than two laboratory (such as CBC, UA) and no more than one x-ray.

3. Intermediate Exam

    A. This charge will be utilized for patients who require; sutures (5-15), any minor procedures (such as pelvic exam), multi laboratory exams and or x-rays, eye exam, foreign body removal, splints (small), minor burns, cardiac monitor, oxygen.

4. Extensive Exam

    A. This charge will be utilized for patients who require extensive diagnostic care such as; codes, major burns, splints (large), extensive suturing, cardiac monitor, EKG, oxygen.

SUBJECT: EMERGENCY DIVERSION OF PATIENTS

POLICY: Policy is written on procedures for the emergency diversion of patients.

PROCEDURE

1. Notify Administration and readily discharge or admit patients in Emergency area.
2. Notify patient's physician.
3. Notify ambulance services that until further notice patients should be diverted to other hospitals.
4. Ambulatory patients will be referred to physician's offices, or clinics.
5. Obstetric patients will be referred to other area hospitals or County Hospital as indicated.
6. All Emergency Department rooms will he closed except rooms 11 and 12.
7. Back up stock and supplies on hand in the department will be utilized.

SUBJECT: NURSING SERVICE AND OTHER STAFF COVERAGE

1. A head nurse plans and coordinates emergency service care, and takes part in activities concerned with emergency service.

2. A registered nurse is in charge within the emergency area at all times.

3. Sufficient RN and LVN personnel are permanently assigned and scheduled for nursing coverage.

4. Ancillary personnel (nurse assistants, clerical, ward clerks, aides and orderlies) is scheduled on a regular basis to provide sufficient coverage.

THE PEOPLE UNDER OUR CARE

Their daily lives altered by the trauma of illness, injury, neglect, separation, senility or isolation, the people under our care come to us. It is in our power to quiet their fear, ease their suffering, aid healing, and provide a temporary haven and family. Each of us has been blessed with the heart, skills, and training to do so. Never forget that the "patients" referred to clinically throughout this text are people who, like each of us, are imperfect, yet always deserving of our concern, our respect, and our professionalism.

Ours is a special trust. Let us always be worthy of it.

THE PATIENT'S BILL OF RIGHTS

1. The right not to be denied treatment or accommodations that are available and medically necessary on the basis of such considerations as race, color, creed, age, sex, national origin, or handicap.
2. The right of Privacy.
3. The right to respectful care.
4. The right to be informed about his/her condition.
5. The right to have his/her questions answered honestly.
6. The right not to be deceived.
7. The right to participate in decisions concerning his/her care.
8. The right to refuse treatment.
9. The right to confidential medical records.
10. The right to request hospital services.
11. The right to know how this hospital is connected professionally with others.
12. The right to be advised of experimentation affecting his/her care.
13. The right to expect continuity of care.
14. The right to examine his/her bill.
15. The right to retain his individuality and not be judged for his/her decisions which may be contrary to beliefs of others.

PATIENT'S BILL OF RIGHTS

It is imperative for all employees of General Hospital to recall that the primary reason for the hospital's existence is serving the human and physical needs of our patients. This cardinal goal should never be lost sight of in the day to day running of the hospital. Our patients are entitled to and must receive equitable and humane treatment at all times. More specifically, each individual person who is hospitalized and/or treated at General hospital should receive the same consideration, courtesy, and compassion that we would want to be extended to ourselves or one of our family members.

In order to be consistent with this principle, it is apparent that no patient can be denied any form of treatment solely on the basis of his economic status, race, sex, or creed. All treatments which are available at General Hospital should be available to all patients who might exhibit a need for such treatment. Likewise, accommodations, facilities and treatments available in the hospital cannot be assigned on a partial basis but must be assigned on the demonstrated needs of the patients themselves.

Inherent in the concept of humane treatment is the need for privacy of all patients. Too often we become callous after long experience at our jobs and forget that physical modesty does not desert the patient at the hospital door. It cannot be too often or strongly stated that we should treat our patients as we ourselves would wish to be treated. Patient privacy should extend beyond physical matters to such matters as patient records and information. Access to patient records is limited to a Strict need to know basis. Information should never be disseminated unnecessarily even within the hospital. It should certainly not be disseminated to persons outside the hospital. This privacy of information is both a legal as well as a humanitarian consideration and the persons spreading information promiscuously places himself and the hospital in severe legal jeopardy.

Each patient admitted to General hospital is admitted by a particular physician who maintains responsibility for that patient unless it is specifically transferred to another physician. Very ill or confused patients may have difficulty,ascertaining who is primarily responsible for their care. Certainly each patient is entitled to know who is the "Captain of the Ship" where their care is concerned and if confusion arises in this regard in the patient's mind, the physician in charge should be asked for clarification.

Patients are entitled to discuss their case with their primary physician. While this is the responsibility of the physician involved, where a Patient may seem confused or uncertain of his situation, an employee of the hospital may and should communicate this uncertainty to the attending physician so that he may assure adequate communication with the patient regarding their problems.

Should any clinical training program or any program involved in gathering a research data be carried out in the hospital, patients should be informed that their participation in such program is strictly on a voluntary basis. This would not extend to such routine hospital programs as obtaining cultures for infectious control programs, since this is not a strictly research project. However it would extend to organized programs of research where data is being obtained as part of a clinical study.

SUBJECT: THE DYING PERSON'S BILL OF RIGHTS

1. I have the right to be treated as a living human being until I die.
2. I have the right to maintain a sense of hopefulness however changing its focus may be.
3. I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this may be.
4. I have the right to express my feelings and emotions about my approaching death in my own way.
5. I have the right to expect continuing medical and nursing attention even though "cure" goals must be changed to "comfort" goals.
6. I have the right to participate in decisions concerning my care.
7. I have the right not to die alone.
8. I have the right to be free of pain.
9. I have the right to have my questions answered honestly.
10. I have the right not to be deceived.
11. I have the right to have help from and for my family in accepting my death.
12. I have the right to die in peace and dignity.
13. I have the right to retain my individuality and not be judged for my decisions which may be contrary to beliefs of others.
14. I have the right to discuss and enlarge my religious and or spiritual experiences, whatever these may mean to others.
15. I have the right to expect that the sanctity of the human body will be respected after death.
16. I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

SUBJECT: EMERGENCY DEPARTMENT MINISTRY

As we all know, emergency departments are patient-oriented. An acute trauma patient is brought into the emergency department and the staff swings into action. The most urgent need and task is stabilizing the condition of the patient. The patient suffering acute illness and/or trauma needs not only medical support but also emotional support because of the fear of the crisis. Physicians and nurses and chaplains provide this support by establishing rapport with the patient and by being calm and confident in the patient's presence. However, due to the limitations of time and the imposition of a crisis that has to be diagnosed and treated, the family is shuttled aside in providing emergency medical care. And yet, families have fears as well as the patient and justifiably so. The point to be made here is the stabilization of the family.

What does it mean to stabilize the family? Speaking in religious terms one might say that the family reflects a disintegration of their cosmic world. The crisis they are in has so undated them that they are overwhelmed. Quite literally, their world is falling apart around them. To stabilize them means to help them to reinforce or shore up their life structures through the crisis, and then continue to function after the crisis has climaxed. It is my belief that as the Medical team begins to stabilize the condition of the patient, the chaplain should stabilize the family, where stabilizing the patient may not be appropriate for a number of reasons.

The chaplain is involved in this stabilization because he is trained to work with people who are experiencing a significant loss or possible loss. In other words, the chaplain acts as a bridge-person. He acts as a go-between for God and man, but in the institutional setting of the hospital, his role takes on another dimension. He acts as a liaison between the family and the hospital--the patient, doctors, and nurses.

In regards to the individual patient in the emergency department, they are people who are in some type of stress. They may have all kinds of psychic needs to displace, for example: anger, frustration, bitterness; and they may displace these upon the emergency department personnel. They have this need because they are human. And whereas the hospital stands in the idealistic position to catch such negative reactions of patients. Thus, on behalf of the hospital, the chaplain has the ministry to persons that will allow the negative emotions to be expressed in a manner that will be appropriate. This type of ministry is performed by engaging the person in conversation at the level that through ventilation or catharsis those negative feelings will surface appropriately.

But ministry of the chaplain does not deal solely with the negative; it relates to the positive as well. It is a ministry to help the person to work with the positive side, the strengths that he has, and the life-orientated thrust of being human. In this regard, ministry takes on the dimension of helping persons to be expressive, by being neutral, accepting, and supportive. In other words, ministry here is helping one to come to terms as a person with reality and the future. Another way of putting this is a ministry in the reduction of anxiety.

SUBJECT: PASTORAL CARE

General Hospital provides professionally trained health care chaplains to meet the emotional and spiritual needs of the patients, their relatives, and hospital personnel. These professionals function as catalysts in the healing process of those who are frightened, discouraged, lonely, angered or overwhelmed, by individual counseling and by promoting and supporting an atmosphere of compassionate care and concern.

The key function of the department is to provide that part of total care which aims at meeting the spiritual and emotional needs of the patient, precisely as they relate to the patient's present medical condition, The philosophy of the department flows from the belief that health care service continues and extends the healing mission of Christ. Regard for the spiritual dimension of the person is intrinsic to the provision of health care which endeavors to respond to the needs of the whole person.

The Pastoral Care Department consists of a Director/Chaplain, Associate Chaplain, Pastoral Associate, and Sister Visitor. A chaplain is scheduled on-duty to cover the three shifts. The switchboard has a copy of which chaplain is on-duty.

Sacraments are provided upon request. Mass is celebrated in the hospital chapel: Monday thru Friday at 6:15 a.m,, and again at 11:00 a.m. on Tuesday, Wednesday and Thursdays. The weekend Mass (Saturday and Sunday) is at 11:00 a.m. On the first Saturday of the month a memorial mass is offered for all those who have died in the hospital the previous month.

Members of the Pastoral Department may be beeped through the switchboard.

SUBJECT: PROCEDURES NOT ALLOWED IN THE EMERGENCY DEPARTMENT

POLICY: Certain procedures are not allowed to be performed in the Emergency Department.

PURPOSE

1. To define the scope of treatment provided in the Emergency Department.

PROCEDURE

1. The Medical Director, in conjunction with the Chief of Staff, shall prepare a list of all approved special procedures for the Emergency Department. The approved list of treatment procedures shall be prominently displayed at all times in the Emergency Department.

2. Certain general and specific procedures will not be allowed in the Emergency Department without the prior consent of the Medical Director or the Chief of Staff. Specific excluded procedures include:

    A. Prolonged diagnostic procedures such as endoscopy.

    B. Surgical drainage of large abscesses.

    C. Vasectomies.

    D. Delivery of obstetrical patients except in precipitous delivery.

    E. Complicated repair of lacerations requiring general or spinal anesthesia.

    F. Definitive treatment of compound fractures.

3. Medical Staff members may schedule and perform minor surgical procedures in the Emergency Department, such as excision of skin lesion, minor tissue biopsies, etc., provided these procedures do not interfere with the efficient delivery of care to emergency patients.

SUBJECT: LIMITATION OF PROCEDURES ALLOWED IN THE EMERGENCY DEPARTMENT

POLICY: Certain procedures are not allowed to be performed in the Emergency Department.

PROCEDURE

1. All procedures which because of their locality, difficulty, or length of time required and which may constitute a distinct hazard to the life or health of the patient or personnel, or which are prone to complications related to function, healing or infection if not performed in a controlled, isolated area, such as an operating room, if time and personnel permit, should not be carried out in the Emergency Department.

2. No general anesthetic gases are to be used in the Emergency Department.

3. Examples of the types of procedures not to be carried out are:

    A. Repair of a flexor tendon

    B. Opening of a joint

    C. D&C

    D. Extreme debridement of burns

    E. Extensive repair of tendons

4. Explosive-type cleaners are not allowed in the Emergency Department. Nonexplosive-type hand cleaners will be used for the removal of grease, gasoline, etc., from patient's site of injury.

5. Procedures such as proctoscopy, enemas, etc. will be done in a treatment room designated by the nursing supervisor.

SUBJECT: SURGICAL PROCEDURES AND THE USE OF ANESTHESIA

PURPOSE

1. To define surgical procedures which shall not be performed in the Emergency Department.

POLICY

There will be no elective surgery performed in the Emergency Department which requires general or regional anesthesia.

SUBJECT: LIMITATION OF PROCEDURES ALLOWED IN THE EMERGENCY DEPARTMENT

POLICY: Certain procedures are not allowed to be performed in the Emergency Department.

The Emergency Department is established, equipped and staffed to provide acute emergency care. Cases of the following nature will not routinely be treated in the Emergency Department:

1. Elective surgical procedures.

2. Diagnostic work-up for patients that are not to be admitted to the hospital.

3. Admitting of routine patients to patient care units.

SUBJECT: MEDICAL STAFF PROCEDURES WHICH MAY NOT BE PERFORMED IN THE EMERGENCY DEPARTMENT

POLICY: Certain procedures are not allowed to be performed in the Emergency Department.

1. Cases involving general anesthesia are not performed in the Emergency Department.

2. Generally, lengthy procedures requiring more than 30-60 minutes to perform are not performed in the emergency Department. Those cases be immediately and readily transferred to another area for further care.

SUBJECT: PROCEDURES NOT PERFORMED IN THE EMERGENCY DEPARTMENT

POLICY: Certain procedures are not allowed to be performed in the Emergency Department.

PURPOSE

1. To delineate procedures which may jeopardize patient safety.

PROCEDURE

The following procedures will not be performed in the Emergency Department:

1. Any outpatient surgery.
2. Any procedure requiring general anesthesia.
3. Cervical Biopsies.
4. D&C.
5. Diagnostic work-up or procedures.
6. Dislocated fractures needing general anesthesia.

SUBJECT: PROCEDURES NOT PERFORMED IN THE EMERGENCY DEPARTMENT

POLICY: Certain procedures are not allowed to be performed in the Emergency Department.

Procedures not to be performed on Emergency Department patients:

1. Spinal or regional anesthesia.
2. Arterial lines.
3. I & D of deep infections.
4. Lumbar Puncture.
5. Swan-Ganz Catheters.
6. Bone Marrow Aspiration.
7. Repairs of nerve, tendon, or arterial wounds.
8. Diagnostic biopsies of lymph nodes, pleura, kidney or thyroid.

SUBJECT: SURGICAL PROCEDURES AND THE USE OF ANESTHESIA

POLICY: Policy is written concerning the performance of elective surgery in the Emergency Department.

PURPOSE

1. To define surgical procedures in the Emergency Department.

GENERAL INFORMATION

1. There will be no elective surgery performed in the Emergency Department which requires general or regional anesthesia.

2. Procedures not allowed in Emergency Department.

   A. Elective surgery is not to be performed in the Emergency Department.

   B. General Anesthesia.

   C. Laparotomy.

   D. Lymph node biopsy or excision.

   E. Tendon sutures.

   F. Nerve suture.

   G. Bronchoscopy.

   H. Craniotomy, except for emergency bur holes.

   I. Compound fractures reduction.

   J. Swan Ganz Catheter insertion.

   K. Elective cardioversion.

   L. Elective pacemaker insertion.

   M. Procedures on inpatients.

3. None of these disallowed procedures are intended to prevent there use in resuscitation and other emergency lifesaving situations.

SUBJECT: ANESTHESIA IN THE EMERGENCY DEPARTMENT

Only local anesthesia may be used in the Emergency Department. Those patients requiring general anesthesia must be taken to surgery unit for the procedure.

SUBJECT: ANESTHESIA

POLICY: Policy is written concerning the use of anesthesia in the Emergency Department.

Types of anesthesia administered in the Emergency Department:

1. Local anesthesia.
   The infiltration of a local anesthetic agent may be done in the Emergency Department by the attending physician.

2. Block anesthesia.
   Axillary, digital and paracervical block anesthesia may be administered in the Emergency Department by an anesthetist or the attending physician.

3. General Anesthesia.
   General anesthesia may be administered by an anesthetist in the Emergency Department within the following guidelines:

   A. No emergency patients in the area.

   B. Nonflammable product utilized.

   C. To perform a closed reduction of fracture, manipulation of a dislocated joint, or pediatric procedure, i.e., foreign body in the eye, nose, etc.

   D. Anesthetist continuously in attendance from onset of anesthesia through completion of the procedure.

   E. In the event the anesthetist requests post-anesthesia recovery, the recovery room nurse may be called in to recover patient.

   F. Portable oxygen and suction continuously available at the bedside.

   G. Attending physician examines patient and writes discharge orders and instructions.

SUBJECT: CHANGE OF SHIFT REPORT

POLICY: A change of shift report will be given by nursing personnel at each shift change.

PURPOSE

1. To provide continuity of patient and/or family care.

2. To provide charge nurse with information for level of care needed for assignments.

GENERAL INFORMATION

1. All off-going nursing personnel will give a change of shift report to the assigned on-coming nursing personnel.

2. The charge nurse is responsible for assuring that late or newly assigned personnel receive report.

PROCEDURE

1. The off-going nurse will provide the following information:

    A. Patient name, room number, complaint/diagnosis and assessment of patient problems and/or needs.

    B. Procedure(s) completed and/or pending.

    C. The name of attending physician will be given for each patient.

    D. New physician orders.

    E. Laboratory orders/results completed and/or pending.

SUBJECT:

POLICY:

PURPOSE

1.

2.

GENERAL INFORMATION

1.

2.

PROCEDURE

1.

SUBJECT: MEDICAL DIRECTOR OF THE EMERGENCY DEPARTMENT

1. Medical Director

    A. Medical care in the Emergency Department shall be under the full-time direction of an emergency physician appointed by the Medical Staff.

    B. The Chairman of the Emergency Department shall act in this capacity when the Medical Director is unavailable.

    C. When the Chairman of the Emergency Department is also unavailable, members of the Executive Staff Committee, as available, shall act as Medical Director.

2. Qualifications of the Medical Director

    A. Must be a member of the active Medical Staff.

    B. Must have at least three years of training and/or experience in a specialty appropriate (as determined by the Medical Staff) to the care and treatment of emergency patients.

    C. Must have credentials reflecting training and experience as well as evidence of medical competence.

3. Responsibilities of Medical Director

    A. Has the authority and responsibility for implementing established policies and for providing overall direction of physicians in the continuing operation of the Emergency Department.

    B. Assures that the quality, safety, and appropriateness of emergency patient care are monitored and evaluated and that appropriate action based on the findings of review activities is taken.

SUBJECT: CREDENTIAL FILES OF THE EMERGENCY DEPARTMENT PHYSICIANS

1. The credential files of all physicians with Emergency Department pprivileges shall reflect their training and experience in emergency medicine and evidence of current competence.

2. The Executive Committee of the Medical Staff shall annually review the Credential Files to ensure compliance.

SUBJECT: PART-TIME EMERGENCY DEPARTMENT PHYSICIANS

1. All physicians providing emergency services shall be a Member of the active Medical Staff.

2. All physicians providing emergency services shall be granted Medical Staff privileges in accordance with the Medical Staff Bylaws.

3. Scheduling of Emergency Department physician coverage shall be under the direction of the Medical Director.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: GENERAL INFORMATION

MEDICAL DIRECTOR PROGRAM

The foundation of management and quality assurance in the Emergency Department is the efficient conduct of the Medical Directors' Program.

APPOINTMENTS

A Medical Director is appointed for the Emergency Department at General Hospital. The Medical Director is responsible for the administration and supervision of the Emergency Department. Responsibility for the appointment of a medical Directors rests with the Administrator and the Medical staff. Once an individual has been appointed to the position of Medical Director, formal communications of this appointment are sent to the hospital administration, medical staff, and the Emergency Department physicians.

QUALIFICATIONS

Basic qualifications of Medical Directors include:

1. Career orientation to emergency medicine.
2. Extensive training and/or experience in emergency medicine.
3. The acceptance of administrative responsibilities.
4. Board eligibility or certification in emergency medicine or a related field.
5. Three or more years of formal experience in emergency medicine.
6. Demonstrated communication and administrative skills.

REPORTING STRUCTURE

The Medical Director shall report to the Medical Staff's Chairman of the Emergency Department.

DUTIES AND RESPONSIBILITIES

1. **Staff and Committee Meetings.**
   The Medical Director shall be responsible for the attendance at regularly scheduled medical staff and appropriate staff committee meetings relative to the efficient function of the emergency department. The Medical Director shall also attend any other meetings relative to the emergency department upon the request of the hospital administrator or the Emergency Department Chairman.

2. **Physician Orientation.**
The Medical Director shall be responsible for the initial orientation of new Emergency Department physicians at General Hospital. The orientation procedure shall follow the formal written Physician Orientation Procedure and Checklist of the Emergency Department.

3. **Physician Evaluation.**
The Medical Director shall continuously assess and evaluate the performance of the Emergency Department physicians at General Hospital. Each Emergency Department physician shall be evaluated through completion by the Medical Director of a Physician Evaluation Report form. The Physician Evaluation Report shall be conducted annually for established Emergency Department physicians and within sixty days of the initiation of services of newly scheduled physicians.

QUALITY ASSURANCE PROGRAM

The Medical Director shall be primarily responsible for the implementation and ongoing maintenance of the Quality Assurance Program.

1. **Joint Commission of Accreditation of Healthcare Organizations.**
The Medical Director is responsible for ensuring that the standards of the Joint Commission of Accreditation of Healthcare Organizations are met relative to the Emergency Department.

2. **Policy and Procedure Manual.**
A policy and procedure manual consistent with the established policies and procedures of the Joint Commission of Accreditation of Healthcare Organizations shall be maintained by General Hospital in the Emergency Department at all times. The Medical Director shall be responsible for ensuring that this manual is updated as appropriate and that the Emergency Department policies and procedures are adhered to by emergency department personnel.

3. **Chart Audits.**
The foundation of the Quality Assurance program involves the auditing of the clinical performance of Emergency Department physicians on a regular basis. The Medical Director is responsible for performance of the chart audit on a regular basis. The results are to be reported to the medical staff through the emergency department committee. The specifics of the Chart Audit are in the appendix.

4. **Patient Complaints.**
It is the responsibility of the Medical Director to evaluate all Emergency Department patient complaints. The Medical Director shall complete the patient complaint form and forward it to the Chairman of the Emergency Department committee.

5. **Physician Complaints.**
   It is the responsibility of the Medical Director to evaluate any and all complaints relative to the personal or professional performance of the Emergency Department physicians. The Medical Director shall complete the physician complaint form and forward it to the Chairman of the Emergency Department committee.

EDUCATION PROGRAM

The Medical Director shall be responsible for the coordination of the Emergency Department educational programs for physicians and other medical personnel. ACLS and formal nurse education programs shall be included in the Emergency Department educational program. The Medical Director shall also be responsible for the conduct of regularly scheduled in-service education lectures and demonstrations in the Emergency Department.

COMMUNITY RELATIONS

The Medical Director should represent General Hospital and the Emergency Department at community activities. The Medical Director is encouraged to schedule appearances at local civic organizations and club meetings for the purpose of presenting topics and information relative to emergency medicine and General Hospital's Emergency Department.

DIRECTOR'S REPORTS

The Medical Director is responsible for the completion on a monthly basis of a Medical Director's report.

GENERAL INFROMATION

This manual is designed to help physicians in the daily activities in the Emergency Department. This manual will also help to orient new physicians concerning General Hospital's expectations and operations. The manual is not intended to carve in stone the practice of medicine. Medical care will be judged through peer review, either by fellow Emergency Physicians or properly constituted hospital medical staff committees.

You are expected to read this entire manual and the Hospital's Emergency Department Policy and Procedure Manual. All questions concerning any part of this manual should be directed to the Emergency Department Medical Director. Suggestions for additional policies or needed changes should also be directed to the Emergency Department Medical Director.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: RESPONDING TO ALL TRUE EMERGENCIES

1. Judgement as to what constitutes a true emergency is to be made by the emergency physician.

2. It is the duty of the emergency physician to respond and treat all true emergencies.

3. The physician should always respond if a nurse requests that the emergency physician see a patient.

4. Patients waiting on a private physician.

    A. Any patient who appears to be in difficulty should be seen by the emergency physician immediately.

    B. Document reasons for the intervention, physical findings, and history.

    C. General Hospital rules concerning length of stay for a patient in the Emergency Department waiting for a call from the private physician is usually 20 to 30 minutes. The time of first call to the private physician and the decision to turn the case over to the Emergency Department physician should be recorded by a nurse.

    D. All care rendered by the emergency physician prior to transfer of care to the private physician must be documented.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: DOCUMENTATION

1. Produces a complete record of each patient's visit
2. The best malpractice insurance is a well documented emergency department record.
3. Complete records are often needed by:
    A. Follow-up physicians.
    B. Another emergency physician.
    C. An audit committee.
    D. Billing office.
4. It is essential that documentation provide:
    A. What was occurring with the patient.
    B. The diagnosis and treatment.
    C. The disposition and instructions to the patient.
5. The rules and regulations of a number of agencies govern the documentation of emergency department patient records.
    A. Medicare.
    B. Medicaid.
    C. Joint Commission on Accreditation of Healthcare Organizations.
    D. General Hospital Bylaws.

6. General Documentation:

   A. Recording the important information concerning the current problem.

   B. Recording the pertinent positive and negative findings in the history and physical with respect to the patient's problem.

   C. All treatments and medications given in the Emergency Department.

   D. All prescriptions with medication doses, frequency and route of a administration.

   E. The disposition of the patient, including follow-up instructions, and condition on discharge.

   F. Discharge notes should include words such as "improved", "worse", "poor", "fair", etc.

   G. The physician signature on the chart in all of the proper places.

7. Specific Documentation:

   A. Patient identification:
      1. If unable to obtain, document the reason.

   B. Time and Means of Arrival:
      1. "9 AM, ambulatory", "7 PM, ambulance".

   C. Signed Consent for Treatment:
      1. If unable to obtain, document the reason.

   D. Pertinent History of the Illness:
      1. Any discrepancy between the clerk's history, the nurse's history, and the physician's history must be clarified on the record.
      2. Ambiguities or multiple meanings to a patient's statements must be clarified on the record.
      3. Both pertinent positive and negative responses must be recorded.

E. Vital Signs:
   1. At least one set of complete vital signs (blood pressure, pulse, respiration and temperature).
   2. When a patient is critical, multiple recording of the vital signs are required.

F. Pre-Hospital Care:
   1. Care given by others, including EMS, should be documented by reviewing their records or if none, documented in the Emergency Department records.

G. Diagnostic and Therapeutic Orders:
   1. All orders for tests must be documented on the chart.
   2. The results of tests must be recorded by the physician.
   3. The interpretation of all electrocardiograms must be recorded by the physician.
   4. The physician must write all medication orders. Verbal orders should be used only during extreme emergency circumstances and then written as soon as possible.

H. Clinical Observations including Results of Treatment:

I. Reports of Procedures, Tests and Their Results:
   1. Laboratory results and x-ray interpretation should be recorded on the chart by the physician.

J. Diagnostic Impression:
   1. Based on the recorded history and the physical, the emergency physician must record a diagnosis.
   2. Do not record a symptom as a diagnosis. "Diarrhea" is not a diagnosis.
   3. Record all diagnoses that are found.

K. Disposition:
   1. All treatment given.
   2. Final disposition.
   3. Condition at admission, discharge, or transfer.
   4. Instructions to the patient or his family or both.
   5. Follow-up care instructions.
   6. Documentation of to whom and mode of transfer should be made on all patients that are transferred.
   7. Documentation of times of calling or notification of the admitting physician.

L. Leaving Against Medical Advice:
   1. All patients leaving the Emergency Department against medical advice (AMA) should sign an AMA form. The form documents reasons for leaving and any explanation given to the patient concerning possible consequences.
   2. All patients refusing to sign the AMA form will have will have this documented on the form and on the chart.

M. Notification of Staff Physicians:
   1. Discussions with staff physician should be documented including the time and condition of the patient.
   2. Document the physician's refusal to admit the patient.
   3. Document steps taken to get the patient admitted.

N. Allergies and Medication:
   1. Do not prescribe any medications until any allergies have been documented.
   2. Do not prescribe any medications until any current medications the patient is taking has been documented.

O. Tetanus Immunization Status:
   1. Tetanus immunization should be documented.

P. Reportable Cases:
   1. A list of reportable cases is in the policy and procedure manual.
   2. All reportable cases should be carefully documented.
   3. Document all required reporting to the proper authorities.

Q. Lacerations:
   1. Length.
   2. Location.
   3. Depth.
   4. Cause.
   5. Time of injury.
   6. Injury or lack of injury to underlying structures such as nerves or tendons.
   7. Possibility of foreign bodies.
   8. Probing or x-raye of the wound if done to investigate the possibilityof a foreign body.
   9. The number of sutures.
   10. The type of cleansing used on the wound.

11. The type of dressing used on the wound.
12. Debridement of wound.
13. Revision of the wound edge.
14. Contamination of the wound.

R. Orthopedic injuries:
1. The mechanism of injury.
2. The time of injury.
3. Location of injury.
4. The neurovascular status of the injured part before and after manipulation or cast/splint application.
5. Splints applied and type.
6. Instructions to elevate, apply ice or heat, etc.
7. Observation of neurovascular status.
8. Cast checked by a physician within 24 hours.
9. Manipulation of the fracture.
10. Anesthesia used.
11. Use of cervical collars or sand-bagging of neck injuries.
12. Complete neurological examination.
13. Results of post reduction x-rays.

S. Intravenous Therapy:
1. Intravenous fluids.
2. Intravenous medications.
3. Venipunctures.
4. Arterial punctures.

T. Anesthesia:
1. Type (local or topical).
2. Location.
3. Amount.

U. Eye Injuries:
   1. Visual acuity.
   2. Mechanism of injury.
   3. Location of injury on the eye.
   4. Medications used.
   5. Removal or attempted removal of foreign matter.
   6. Instrument of removal (wet cotton tip applicator, spud, needle, etc.)
   7. Irrigation.
   8. Irrigation, type of solution, number of minutes, volume used and beginning and end point pH if a chemical burn.

V. Burns:
   1. Location.
   2. Degree (depth).
   3. Size.
   4. Percentage of body surface area (BSA).
   5. Treatment.
   6. Disposition.

W. Nosebleed:
   1. Cause.
   2. Location.
   3. Treatment.

X. X-Ray Interpretation:
   1. Documentation of the x-ray interpretation with notation if interpretation is by the emergency physician or the radiologist.

Y. Time Spent:
   1. Document unusual amounts of time spent with the patient.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: DICTATION

Complicated medical cases, or cases of criminal or civil significance such as major trauma, gunshot wounds, prolonged cardiopulmonary resuscitation or similar cases should be documented in greater detail than can be put on an Emergency Department chart by dictating an emergency department note on the hospital's dictating lines. Request at the end of the dictation that a copy be sent to the Emergency Department physician at his mailing address.

The hospital provides a third party to accept and transcribe confidential dictations in cases of possible medicolegal significance such as patients who threaten suit, or other dictation which the physician does not wish to give over hospital lines. Only the physician will receive the transcription and the tape will be erased. All such dictations will remain strictly confidential.

In addition to medicolegal cases, the physician may also dictate such matters as breakdowns in nursing relationships or problems with administration.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: PRODUCTIVITY IN THE EMERGENCY DEPARTMENT

These general suggestions to aid in professional atmosphere, public relations, and to help handle patient flow are listed as suggestions and are subject to the judgement of the Emergency Department physician.

1. See patients as soon as possible after their registration has been completed. If the wait has been long, apologize for the inconvience.

2. Read the chart before entering the room.

3. Verify the patient's name.

4. Don't duplicate information already obtained by the clerk and nurse except to confirm or clarify that information.

5. Write the information on the chart as it is obtained from the patient, being careful to assure the patient that you are concerned and listening. Look interested. Make eye contact.

6. Touch the patient. Laying hands on the patient is itself therapeutic. In some complaints, such as an ankle injury, the patient can be examined while the history is being taken. Also wash your hands in the patient's room before you examine the patient.

7. Try to take care of the patient in a single encounter. Ask if there is any other problem you should know about. In a case requiring other tests, if possible explain the two most likely options based on possible test results and the expected treatment during the first encounter. When the tests results are back, informing the patient of the results, answering questions, and making a disposition should take less time during the second encounter.

8. Treat patients with simple problems, such as a sore throat, between more involved problems such as lacerations. An example would be treating a simple sore throat while a laceration is being cleaned and the nurse is obtaining the initial history.

9. If possible, medicate patients early for pain. The patient will be much less demanding during the wait.

10. Use the triage nurse or the charge nurse, in whom you have developed trust in their judgement and the protocols, to begin tasks which must be done. An example would be to splint simple injuries and sprains and forward them to x-ray before you see them. These tasks should only be delegated if patient volume will keep the physician from seeing them promptly.

11. Let the nurses collect a clean catch urine for possible urinalysis and a culture and sensitivity routinely in a woman with a urinary tract complaint. Even if not needed later, it saves time to get it early and the specimen can be dumped if not needed.

12. When having blood drawn from a patient who may need further tests or will be admitted, have the lab draw an extra serum tube.

13. Be decisive. After examining the patient try and decide all the tests and information you need to make a disposition of the patient. This eliminates having to order other tests or x-rays after awaiting results for the initial tests.

14. After it is clear that a patient is going to be admitted, complete only what is necessary to prepare the patient for safe transport to the floor. All tests and initial studies do not have to be completed in the Emergency Department.

15. Spend time to save time when necessary. A few minutes spent explaining a procedures may save time calming and explaining the procedure to the patient later.

16. Policy should be written to limit the Emergency Department physician's time spent on the telephone. Ask the clerks and nurses to screen your calls, take messages for call back at a quieter time, etc.

17. Open displays of anger such as yelling at nurses and getting angry at patients are disruptive. Problems with a staff member, nurse, or other personnel should be discussed in private at a convient time.

18. One of the physician's least used time saver is to do it yourself. Often it will be quicker to do things yourself, such as setting up a suture set, cleaning a wound, or putting on a bandage, rather than wait for the nurse to perform the task.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: ROUTINE ORDERS

Approved "standing orders" are to be used in the admission of patients from the Emergency Department whenever those orders are applicable. For instance, CCU, ICU, Neurological or other preprinted order sheets should be used wherever possible by the emergency physician.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: RAPE EXAMINATION

All patients presenting to the emergency physician alleging rape will be examined using the rape kit. The hospital's policy and procedure manual contains the information necessary to care for patients alleging rape. It is imperative that the written policy and procedure be followed. Generally:

1. Evidence should be collected in the proper manner and specimens labeled and sealed.

2. The evidence and specimens will be delivered directly to a policeman or will be given to the patient for delivery to a policeman.

3. The physician should examine the whole patient and document bruises, lacerations, etc.

4. The history should be carefully documented and the diagnosis, "alleged rape" recorded with other diagnoses as appropriate.

5. The patient should be given referral to the proper county agency or private physician for follow-up.

6. Document that the police are aware of the alleged rape.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: FRACTURE OR SUSPECTED FRACTURE FOLLOW-UP

1. All patients with musculoskeletal injuries and complaints should receive proper initial evaluation and treatment and then referred for follow-up by either their family doctors or the appropriate physicians from the back-up roster.

2. Detailed prolonged instructions on future care should be avoided.

3. All orthopedic injuries should be re-examined within 24 to 48 hours. If the follow-up physician is unavailable the patient should be instructed to return to the emergency department at the appropriate time.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: ATTEMPTED SUICIDES

1. Must be admitted for treatment or have arrangement for supervision and proper psychiatric follow-up.

2. If the patient is to be released to family members, they must be properly instructed in observing the patient and the instructions documented. If the patient is released, a follow-up physician, either the family doctor or psychiatrist, should see the patient within 24 hours.

3. If the patient is transferred to another hospital, all of the usual notifications and documentation is to be completed.

4. In no case is a patient judged to be suicidal to be released to himself. If necessary, the patient should be committed under temporary custody in accord with state law and hospital policy.

SUBJECT: EMERGENCY DEPARTMENT PHYSICIAN MANUAL: PATIENT WITH SUSPECTED MYOCARDIAL INFARCTION

1. Patients are to be evaluated clinically and a decision of admission or non-admission made. The decision of admission is to be made on clinical grounds with ancillary studies used only as support. In no case is any "chest pain" patient to be discharged on the basis of "normal EKG" or "normal cardiac enzymes".

2. The condition of the patient at transfer to the CCU should be recorded.

3. All patients being transported to the CCU will have an IV, oxygen, and will be on a monitor.

EMERGENCY DEPARTMENT PHYSICIAN'S RECORD

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____ **SEX:** M / F
INFORMANT: []patient []spouse []sibling []interpreter []other: _____ []Family present []No history available
DATE: _____ **TIME:** _____ **PATIENT'S PHYSICIAN:** _____

PRESENTATION

CHIEF COMPLAINT / PRESENT ILLNESS CC1 Location CC2 Quality CC3 Severity CC4 Duration CC5 Timing CC6 Context CC7 Modifying Factors
CC8 Associated Signs And Symptoms []CC9 Status of three or more chronic or inactive conditions documented.

[]Nursing Record and Vital Signs Reviewed

[]See Physician Continuation Notes

TREATMENT

(T1A)**LAB /** (T1B)**X-RAY / MEDS, & TREATMENTS**	**ORDERED/DONE/COMPLETED**	(T2)**ANALYSIS AND RESPONSE**
(T1C)[]EKG []CARDIAC MONITOR		
[]CXR []ABD XRay		
[]CBC		
[]LYTES []RENAL []GLUCOSE		
[]LIVER		
[]AMYLASE/LIPASE		
[]U/A []FOLEY		
[]CARDIAC ENZYMES		
[]IV		
[]IV		
[]O2 []ABG (T3)[]OLD RECORDS (also see PH2)		(T4)[]DIRECT VISUAL & INTERPRETATION IMAGE, TRACING, SPECIMEN

(T5)PHYSICIAN CONSULTATIONS: _____ (T6)[] Discussion with radiologist (T7)[] Discussion/History with family
(T8)NOTIFICATION: []Social services []Protective services []Justice of the peace []Animal control []Poison control []Law enforcement []Patient representative

DIAGNOSIS

DIFFERENTIAL DIAGNOSIS: _____

DIAGNOSIS	**STATUS**	**DIAGNOSIS**	**STATUS**
1.		4.	
2.		5.	
3.		6.	

STATUS: (A) Improved **(B)**Well Controlled **(C)**Resolving **(D)**Resolved **(E)**inadequately Controlled **(F)**Worsening **(G)**Failing to change as expected.

DISPOSITION

Prescription(s): _____

Other: _____

[] Instruction Sheet Given On: _____

[] Released [] Admitted [] Observation [] DOA []Expired [] AMA

[] Follow up with (physician/specialist) on: [] Return to Emergency Department if any problems before follow up.

[] Transferred to: _____ by Private Car / Ambulance / Helicopter / Other.

Attending/Staff Physician notified of disposition: [] Yes [] No Name: _____ Time: _____

Discharge: Date:_____ Time:_____ **Condition**: []Stable []Good []Fair []Poor []Critical

Method:[]Walk []Carried []Crutches Wheelchair []Stretcher **Accompanied by**:[]Self []Family []Friend []Parent []Other: _____

_____ _____ _____
Print Physician's Name Physician's Signature Date

MEDICATIONS: []See Other Notes

ALLERGIES: []No Known Allergies []See Other Notes

Problem Focused: one to five elements. Expanded Problem Focused: at least six elements. Detailed: at least twelve elements.

Comprehensive: at least one element from each systems/body areas and all elements in systems/body area identified with "!".

CARDIOVASCULAR - P H Y S I C A L E X A M - CARDIOVASCULAR

(any 3 of A1 to A7 counts as 1 element)

!A CONSTITUTIONAL A! []See Other Notes

A1 **SITTING BP** _____ / _____ **STANDING BP** _____ / _____ A2 **SUPINE BP** _____ / _____

A3 **P** _____ A4 **R** _____ A5 **T** _____ (C / F) A6 **HT** _____ A7 **WT** _____ (lbs / kg)

A8 **GENERAL APPEARANCE:**

A9 COMMUNICATION ABILITY: Quality of Voice:

B HEAD AND FACE B []Normal

B1 INSPECTION HEAD & FACE:

B2 PALPATION/PERCUSSION FACE: []sinus tenderness

B3 SALIVARY GLANDS:

B4 FACIAL STRENGTH:

C EYES C []Normal

C1 VISUAL ACUITY:

C2 VISUAL FIELD:

C3 OCULAR ADNEXAE: Lids: Lacrimal Glands & Drainage: Orbits: Lymph Nodes:

C4 **CONJUNCTIVAE & LIDS:** []xanthelasma

C5 PUPILS AND IRISES: Shape: Reaction: Size: Morphology:

C6 OPTHALMOSCOPIC EXAM: []C12 done without pupil dilation

C7 OCULAR MOTILITY: Primary Gaze Alignment:

C8 SLIT LAMP EXAM CORNEAS: Epithelium: Stroma: Endothelium: Tear Film:

C9 SLIT LAMP EXAM ANTERIOR CHAMBERS: Depth: Cells Flare:

C10 SLIT LAMP EXAM LENSES: Clarity: Anterior & Posterior Capsule: Cortex: Nucleus:

C11 INTRAOCULAR PRESSURE:

C12 DILATED PUPILS OPTHALMOSCOPIC EXAM:

C12a OPTIC DISCS: Size: C/D Ratio: Appearance:

C12b POSTERIOR SEGMENTS: Retina: Vessels:

D EARS, NOSE, MOUTH AND THROAT D []Normal

D1 EXTERNAL EARS & NOSE:

D2 OTOSCOPIC: Pneumotoscopy: []normal tm motility

D3 HEARING: Whispered Voice: Finger Rub: Tuning Fork:

D4 NASAL EXAM: Mucosa: Septum: Turbinates:

D5 **LIPS, TEETH, GUMS, & PALATE:**

D6 **OROPHARYNX:** []pallor. []cyanosis. []normal moisture. Oral Mucosa: Tongue: Tonsils:

D7 PHARYNGEAL WALLS AND PYRIFORM SINUSES:

D8 MIRROR EXAM OF LARYNX: Epiglottis: Vocal Cords: Mobility of Larynx:

D9 MIRROR EXAM OF NASOPHARYNX: Mucosa: Adenoids: Eustachian Tubes: Posterior Oropharynx:

(mirror exam not required in children)

E NECK E []Normal

E1 NECK:

E2 **THYROID:** E3 **JUGULAR VEINS:**

!F RESPIRATORY F! []Normal

F1 **LUNG AUSCULTATION:** []normal breath sounds []rales []rhonchi []wheezes

F2 **RESPIRATORY EFFORT:** F4 CHEST INSPECTION:

F3 CHEST PERCUSSION: F5 CHEST PALPATION:

!G CARDIOVASCULAR G! []Normal

G1 **PALPATION OF HEART:**

G2 **AUSCULTATION OF HEART:**

G3 **PERIPHERAL VASCULAR SYSTEM:** []edema []varicosities []tenderness Pulses: Temperature:

G4 **CAROTID ARTERIES:** []no bruits G7 BLOOD PRESSURE: RT LEG LT LEG

G5 **FEMORAL ARTERIES:** G8 **ABDOMINAL AORTA:**

G6 **BLOOD PRESSURE:** RT ARM LT ARM G9 **PEDAL PULSES:**

H CHEST (BREASTS) H []Normal

H1 APPEARANCE:

H2 PALPATION BREASTS & AXILLAE:

!J GASTROINTESTINAL (ABDOMEN) J! []Normal

J1 **ABDOMEN:** []no masses []nontender []normal bowel sounds

J2 **LIVER & SPLEEN:** []not enlarged

J3 HERNIA: []absent []present

J4 ANUS, PERINEUM, & RECTUM:

J5 **STOOL OCCULT BLOOD:** []negative []positive

K GENITOURINARY K []Normal

MALE

K1 ANUS & PERINEUM INSPECTION:

K2 SCROTUM:

K3 PENIS:

K4 EPIDIDYMIDES:

K5 TESTES:

K6 URETHRAL MEATUS:

K7 DIGITAL RECTAL

K7a PROSTATE GLAND:

K7b SEMINAL VESICLES:

K7c SPHINCTER TONE: HEMORRHOIDS: RECTAL MASSES:

FEMALE

K8 DIGITAL RECTAL EXAM

K8a SPHINCTER TONE: HEMORRHOIDS: RECTAL MASSES:

K9 PELVIC EXAMINATION

K9a EXTERNAL GENITALIA:

K9b URETHRA:

K9c URETHRAL MEATUS:

K9d BLADDER:

K9e VAGINA:

K9f CERVIX:

K9g UTERUS:

K9h ADNEXA/PARAMETRIA:

K9i ANUS AND PERINEUM:

L LYMPHATIC L []Normal

L1 NECK PALPATION:

L2 AXILLAE PALPATION:

L3 GROIN PALPATION:

L4 OTHER:

M MUSCULOSKELETAL M []Normal

M1 **BACK:** []kyphosis []scoliosis

M2 **GAIT & STATION:** []able to exercise

M3 JOINTS, BONES, & MUSCLES/TENDONS

M3a HEAD & NECK

INSPECTION/PALPATION:

RANGE OF MOTION: []pain []normal

STABILITY:

M3aa **MUSCLE STRENGTH & TONE:**

M3aa []atrophy []abnormal movements

M3b SPINE, RIBS, & PELVIS

INSPECTION/PALPATION:

RANGE OF MOTION: []pain []normal

STABILITY:

M3ba MUSCLE STRENGTH & TONE:

M3ba []atrophy []abnormal movements

----------PROGRESS / RECHECKS (include time)**----------**

N EXTREMITIES N []Normal

N1 JOINTS, BONES, & MUSCLES

N1a RIGHT UPPER EXTREMITY

INSPECTION/PALPATION: []clubbing []cyanosis []ischemia

RANGE OF MOTION: []pain

STABILITY:

N1aa MUSCLE STRENGTH & TONE: []atrophy []abnormal movement

N1b LEFT UPPER EXTREMITY

INSPECTION/PALPATION: []clubbing []cyanosis []ischemia

RANGE OF MOTION: []pain

STABILITY:

N1ba MUSCLE STRENGTH & TONE: []atrophy []abnormal movement

N1c RIGHT LOWER EXTREMITY

INSPECTION/PALPATION: []clubbing []cyanosis []ischemia

RANGE OF MOTION: []pain

STABILITY:

N1ca MUSCLE STRENGTH & TONE: []atrophy []abnormal movement

N1d LEFT LOWER EXTREMITY

INSPECTION/PALPATION: []clubbing []cyanosis []ischemia

RANGE OF MOTION: []pain

STABILITY:

N1da MUSCLE STRENGTH & TONE: []atrophy []abnormal movement

N2 **DIGITS & NAILS (INSPECTION AND/OR PALPATION):** []clubbing []cyanosis []ischemia

P SKIN P []Normal

P1 ECCRINE & APOCRINE GLANDS (INSPECTION):

P2 HAIR (INSPECTION): Scalp: Eyebrows: Face: Chest: Pubic: Extremities:

P3 **SKIN & SUBCUTANEOUS TISSUE (INSPECTION AND PALPATION)** SKIN TURGOR: []normal []decreased

P3a HEAD AND NECK:

P3b CHEST, BREASTS, & BACK:

P3c SPINE, RIBS AND PELVIS:

P3d ABDOMEN:

P3e GENITALIA:

P3f RIGHT UPPER EXTREMITY:

P3g LEFT UPPER EXTREMITY:

P3h RIGHT LOWER EXTREMITY:

P3i LEFT LOWER EXTREMITY:

P3j SCALP PALPATION:

R NEUROLOGIC R []Normal

R1 CRANIAL NERVES:

1st-Smell: []normal

2nd-Visual acuity, Visual fields, Fundi: []normal

3rd 4th 6th-Pupils, Eye movements: []normal

5th-Facial sensation, Corneal reflexes: []normal

7th-Facial symetry, Strength: []normal

8th-Hearing with tuning fork, Whispered voice: []normal

9th to 10th-Uvula elevation, Gag reflex: []normal

11th-Shoulder shrug strength: []normal

12th-Tongue protrusion: []normal

NOTES:

R2 ATTENTION SPAN AND CONCENTRATION:

R3 LANGUAGE: []naming objects normally []repeating phrases normally []spontaneous speech

R4 FUND OF KNOWLEDGE: []current events normal []past history normal []vocabulary normal

R5 COORDINATION: []finger/nose normal []heel/knee/shin normal []fine motor normal

RAPID ALTERNATING MOVEMENTS: []upper extremities normal []lower extremities normal

R6 DEEP TENDON REFLEXES: []babinski negative []babinski positive

R7 SENSORY EXAM: []touch normal []pin normal []vibration normal []proprioception normal

!S (NEUROLOGICAL / PSYCHIATRIC S! []Normal

S1 JUDGEMENT & INSIGHT:

S2 **MENTAL STATUS**

S2a **ORIENTATION:** []time []person []place

S2b MEMORY: []recent memory normal []remote memory normal

S2c **MOOD & AFFECT:** []depression []anxiety []agitation []hypomania []lability

S3 ASSOCIATIONS: []loose []tangential []circumstantial []intact

S4 THOUGHT PROCESSES: []logical []illogical []tangential

Rate Of Thoughts: Abstract Reasoning: Computation:

S5 SPEECH: Rate: Volume: Articulation: Coherence: Spontaneity:

S6 ABNORMAL THOUGHT: []hallucinations []delusions []preoccupation with violence

[]homicidal ideation []suicidal ideation []obsessions

THIS IS THE LAST PAGE OF THE SAMPLES.

THE BOOKMARKS BELOW THIS PAGE DO NOT FUNCTION. THEY ARE ONLY A REFERENCE OF SUBJECTS FOR VARIOUS POLICIES AND PROCEDURES.

THE COMPLETE REFERENCE SOURCE VERSION IS AVAILABLE FOR USE IN DEVELOPING OR UPDATING EMERGENCY DEPARTMENT POLICIES & PROCEDURES.

NOW YOU HAVE HELP IN UPDATING YOUR EMERGENCY DEPARTMENT POLICIES, PROCEDURES, AND PROTOCOLS! (POLICIES CAN ALSO BE USED TO UDATE CLINIC, PHYSICIAN'S OFFICE, CRITICAL CARE UNITS, AND NURSING HOME POLICIES AND PROCEDURES.)

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A PARTIAL LISTING OF SOME OF THE MANY HOSPITAL POLICIES AND PROCEDURES MANUALS THAT CAN BE FOUND THROUGHOUT HOSPITALS: General Nursing Policy & Procedure Manual, Trauma Protocols, Emergency Department Policies and Procedures, Orientation Manual, Patient Care Manual, Infection Control Policy and Procedure Manual, Medical Staff Bylaws Rules & Regulations, Environmental Care Plans, Disaster Plans, Evacuation Plans, Tornado Plans, Hurricane Plans, Pharmacy Policies and Procedures, Dietary Policies, Surgery Policies, Administration Policies, Exposure to Blood Bourne Pathogens Plan, Emergency Preparation Manual, Radiation Policies and Procedures.

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The digital age is here! Everything from video & audio to medical records are rapidly converting to the new digital format. Don't be left behind in regards to your numerous policy, procedure & protocol manuals, department manuals, employee manuals, orientation information manuals, etc. Many hospitals still have multiple printed copies of hospital departmental policy, procedure, and protocol manuals scattered throughout the hospital. Maintaining these numerous manuals can be a major problem. Finding specific policies, dealing with missing pages, replacing damaged pages, performing updates, and distributing to departments can all result in time consuming and frustrating situations. Conversion will solve these problems. **It is time to convert all your multiple hospital policy and procedure manuals to the digital format and place them on one CD-ROM Disk!**

Usually there are very large policy and procedure manuals in every hospital department. The printing and upkeep of these manuals are not cost effective and can be difficult to maintain and distribute. Compare that labor intensive and cumbersome process to the use of **a single CD-ROM Disk that would contain your hospital's entire collection of policy and procedure manuals**. Copies of this CD-ROM Disk could be kept in each department as well as distributed to department directors. It would also allow easy computer network access as well as simple updates, upgrades, and distribution. The cost of doing nothing now will continue to rise. A conversion to this digital format would more than pay for itself by greatly reducing your future paper costs, printing costs, and hospital staff time spent searching, updating, and managing specific policies, procedures, and protocols. Easy access to all these manuals can also reduce liability risks.

We are currently performing conversions of hospital policy and procedure manuals from paper to digital format. If you would like to include your hospital's policy and procedure manuals in our next conversion process, please let us know. We will be able to convert from the actual printed policies or from the computer disk text files that some hospitals use. Our conversion will allow searching for individual words or topics in all your policy and procedure manuals. The digital format is such that any of your hospital staff could use the computer to find and view the policy and procedure manuals.

You may want to discuss the merits of this conversion with your Data Processing Director and/or Administrator. Also, keep in mind that only a limited number of hospitals will be accepted for the next conversion period so that we can provide each hospital with personalized priority service. Conversions will be performed in the order that each hospital signs up for this service. Therefore, you may want to make a decision on this offer as soon as possible. Please contact us for additional information without any obligations. **You can call our company at (979) 345-3236 Monday thru Friday from 10am to 4pm CST for additional information.**

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