DEDER GENERAL HOSPITAL

NURSING CARE PROTOCOL

PREPARED BY*: *HSQU

DEDER, EASTERN ETHIOPIA

JULY 2016 E.C

PROTOCOL APPROVAL SHEET

NAME OF PROTOCOL*: *NURSING CARE PROTOCOL

PREPARRED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Abdi Tofik (BSc, MPH)	Health Service Quality Director (HSQD)	
2	Abdella Aliyi (BSc MW)	HSQ Officer and Reform f/person	
3	Redwan Sharafuddin (BSc Pharm)	HSQ Officer	

APROVED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Nureddin Yigezu (BSc, MPH)	Chief Executive Officer (CEO)	
2	Dr. Derese Gosa (MD)	Medical Director	
3	Dr. Isak Abdi (MD, G/Surgeon)	OR Director & SaLTS Team leader	

THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C

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1. Introduction

This protocol outlines the standards of nursing care that must be adhered to by all nursing staff within the **Deder General hospital.**

2. Objective:

To establish standardized guidelines for the provision of nursing care to ensure consistent, safe, and high-quality care for all patients throughout the hospital.

3. Scope:

This protocol applies to all nursing staff, including Professional Nurse, Diploma Nurse, Level IV Nurse, and other personnel involved in patient care.

4. PROCEDURE:

4.1. Patient Admission:

4.1.1. Initial Assessment:

- Upon admission, the assigned nurse must conduct a comprehensive assessment, including:
    - **Vital signs**: temperature, blood pressure, pulse, respiratory rate.
    - **Pain assessment** using appropriate pain scales.
    - Allergies and sensitivities.
    - Review of medical history and current medications.
    - Psychosocial assessment, including mental health status and support systems.
    - Risk assessments, including fall risk, pressure ulcer risk, and infection risk.
- Document all findings in the patient's Chart or electronic medical record (EMR) promptly and accurately.

5.1.2. Care Planning:

- Develop an individualized nursing care plan based on the initial assessment, in collaboration with the patient, their family, and the healthcare team.
- **The care plan should include:**
    - Nursing diagnoses based on assessment findings.
    - Specific, measurable goals for patient outcomes.

- Nursing interventions designed to achieve the goals.
- Criteria for evaluating the effectiveness of the interventions.

- The care plan must be reviewed and updated regularly, particularly when there are changes in the patient's condition.

5.2. Patient Care:

5.2.1. Medication Administration:

- Medications must be administered in accordance with the "five rights" of medication administration: right patient, right drug, right dose, right route, and right time.
- Verify patient identity using at least two identifiers (e.g., name, date of birth) before administering any medication.
- Document all medications administered, including the time, dose, route, and any patient reactions.

5.2.2. Monitoring and Documentation:

- Continuously monitor the patient's condition, including:
  - ✓ Regular vital signs monitoring as per the care plan or physician orders.
  - ✓ Monitoring fluid intake and output.
  - ✓ Regular pain assessments and management.
  - ✓ Observing for signs of complications or deterioration.
- All observations, nursing interventions, and patient responses must be documented in the EMR promptly and accurately.

5.3. Patient Education:

Provide patient education on their condition, treatment plan, medications, and any necessary lifestyle modifications.

- Tailor education to the patient's level of understanding, language, and cultural background.
- Document all educational interventions and the patient's level of understanding in the EMR.

5.4. Patient Hygiene and Comfort:

- ☞ Assist patients with personal hygiene, including bathing, grooming, oral care, and toileting, ensuring dignity and comfort.
- ☞ Regularly assess and address skin care needs, particularly for immobile patients, to prevent pressure ulcers.
- ☞ Ensure the patient's environment is clean, safe, and conducive to healing.

5.5. Mobility and Fall Prevention:

- ➢ Assess each patient's mobility level and fall risk upon admission and regularly thereafter.
- ➢ Implement fall prevention measures, such as bed alarms, non-slip socks, and assistance with ambulation.
- ➢ Encourage and assist patients with mobility as appropriate to their condition and care plan.

5.6.Communication and Collaboration:

5.6.1 Shift Handover:

- At the end of each shift, provide a detailed handover to the incoming nursing staff, using a standardized format such as SBAR (Situation, Background, Assessment, Recommendation).
- Include updates on patient status, recent changes in condition, ongoing care needs, and any pending tests or procedures.

5.6.2. Interdisciplinary Collaboration:

- Collaborate with other healthcare professionals, including physicians, therapists, social workers, and dietitians, to ensure comprehensive care.
- Actively participate in interdisciplinary rounds and care planning meetings, contributing nursing perspectives and advocating for the patient's needs.

5.7. Discharge Planning:

5.7.1. Discharge Assessment:

- Initiate discharge planning upon admission, assessing the patient's needs for post-discharge care, such as home health services, medical equipment, or follow-up appointments.
- Collaborate with the discharge planning team to ensure all necessary services are arranged before the patient leaves the hospital.

5.7.2. Patient and Family Education:

- Provide clear, comprehensive instructions to the patient and family regarding post-discharge care, including medication management, wound care, dietary restrictions, and activity limitations.
- Ensure that the patient and family understand potential signs of complications and when to seek medical help.
- Document all discharge instructions and the patient's understanding in the EMR.

5.8. Documentation:

- Complete a discharge summary, including all care provided during the hospital stay, patient's condition at discharge, and follow-up care plans.
- Ensure a copy of the discharge summary is sent to the patient's primary care provider and any other relevant healthcare professionals.

5.9. Infection Control:

5.9.1. Hand Hygiene:

✓ Perform hand hygiene before and after patient contact, before performing any aseptic procedures, and after exposure to bodily fluids or contaminated surfaces.

✓ Use alcohol-based hand sanitizer or soap and water according to hospital guidelines.

5.9.2. Personal Protective Equipment (PPE):

- Use appropriate PPE based on the patient's condition and the type of care being provided (e.g., gloves, masks, gowns).
- Follow the hospital's infection control guidelines for the proper use, removal, and disposal of PPE.

5.9.3. Environmental Cleaning:

- Ensure that patient rooms and common areas are regularly cleaned and sanitized, especially high-touch surfaces.
- Work with housekeeping staff to maintain a clean and safe environment for patients.

5.10. Emergency Response:

5.10.1. Recognizing and Responding to Emergencies:

- Be vigilant for signs of medical emergencies, such as respiratory distress, chest pain, sudden changes in consciousness, or severe pain.
- Initiate emergency protocols immediately, including calling a code, starting CPR, or administering emergency medications as appropriate.

5.10.2. Documentation and Reporting:

- Document all actions taken during an emergency, including the patient's response and outcomes.
- Report the emergency to the appropriate supervisor and complete any required incident reports.

5.11. Compliance Monitoring:

5.11.1. Audits and Evaluations:

- The hospital's Nursing Audit team will conduct regular audits of nursing care practices, including documentation, medication administration, and infection control compliance.
- Audit results will be reviewed with nursing staff, and areas for improvement will be identified.

5.11.2. Performance Improvement:

- Implement performance improvement initiatives based on audit findings to address any identified gaps in care.
- Provide ongoing education and training to nursing staff as needed to ensure continuous improvement in patient care.

5.12. Education and Training:

5.12.1. Orientation:

- All new nursing staff must complete a comprehensive orientation program that includes training on hospital protocols, infection control, emergency response, and documentation standards.

5.12.2. Continuing Education:

- Nurses are required to participate in continuing education programs to stay current with best practices, new technologies, and updates in hospital policies.
- Specialty training will be provided for nurses working in specific areas, such as intensive care, emergency, or pediatrics.

6. Responsibilities:

- Responsible for comprehensive patient assessment, care planning, medication administration, and coordination with the healthcare team.
- Assist in providing patient care, monitoring patients, and performing nursing procedures.
- Perform patient care tasks, such as hygiene, mobility, and feeding.

7. Review and Updates:

This protocol will be reviewed annually by the Nursing Leadership Team and updated as necessary based on audit findings, staff feedback, and changes in clinical practice guidelines.

8. References:

- Nursing Best Practice Guidelines
- Hospital Infection Control Manual
- Patient Safety and Quality Improvement Protocols