REQUIRED NURSING DOCUMENTATION

Triage

- Arrival information- including which EMS brough the patient in
- Chief Complaint
- ED Triage Note (EXPLAIN WHY PATIENT IS HERE)
- Vital signs (EVERY TRIAGE PATIENT NEEDS A FULL SET OF VITAL SIGNS INCLUDING WEIGHT AND HEIGHT)
- Update the patients pharmacy and try to review meds as much as you can
- Pain (THIS MUST BE DONE ON EVERY SINGLE PATIENT)
    - Pain level on a scale
    - Pain type
    - Pain location
    - Pain orientation
    - Pain descriptor
    - Continuous vs intermittent
- Suicide Screening

Assessment

- Cardiac
- Respiratory
- Skin condition/color/temperature
- ED HD Fall Risk
- Then complaint based assessment

Braden

- If in Emergency Department for 4 hours
- Every shift
- Any status change
- INTERVENTIONS MUST BE PLACED IF THE BRADEN IS $\leq$18
- WE MUST BE DOCUMENTATING IF WE TURN PATIENTS/PUT WAFFLE MATTRESS ON/ HEELS UP/SPECIALTY MATTRESS

Wounds

- ALL PATIENTS STRIPPED AND SKIN ASSESSED- NO EXCEPTIONS
- Document any and all skin issues- wounds, redness, abrasions, bruises etc
- Put an allevyn on all wounds

Vitals

- Full set of vitals must be documented on every patient in ED every 4 hours
- Vitals must be documented at discharge

Pain

- Document at triage
- One hour after intervention
- Every 12 hours
- Any time patient has new pain complaint

Restraints

- Put a sticker in the restraint book and start filling out QA form when you place a patient in restraints
- Never back time restraint order
- Notes: Initiation, one hour face to face (violent only), discontinuation
- Violent restraints are charted on q15 min
- Nonviolent restraints charted on q2h
- If a patient leaves hospital by ENS- we completely discontinue our restarints (EMS uses their own.)
- FOLLOW THE FLOW SHEETS BY CHARGE NURSE AND IN RESTRAINT BINDER AND USE THE RESTRAINT REFERENCE AT THE COMPUTER- THESE ARE THERE TO HELP YOU

Blood Documentation

- Obtain a consent prior to starting blood
- Use flow sheets and always click “File”
- Pre/intra/ post transfusion vitals
- Reaction
- Amount infused

Stroke

- CALL A CODE 77 IF THE PATIENT HAS STROKE LIKE OR TIA LIKE SYMPTOMS- THIS IS NURSE DRIVEN
- Last known normal
- Blood glucose
- Reason for ANY delay
- BEFAST upon arrival
- NIHSS
- Dysphagia

Chest Pain

- Time of pain onset
- Order and perform EKG within 10 minutes
- Order and draw troponin within 60 minutes
- If STEMI- PAINT A PICTURE OF STEP BY STEP WHAT IS GOING ON

Pediatrics

- Document ACCURATE weight

- Who child is with- if not a parent or legal guardian we MUST be getting verbal consent over the phone and CHARTING IT

Pelvic/Rectal

- IF YOU WITNESS THIS CHART IT IN EPIC THAT YOU WERE AT BEDSIDE WITH THE PHYSICIAN AS A CHAPERONE

Critical Medication

- If the patient is on any CARDIAC or BLOOD PRESSURE medication these patients must BE ON A MONITOR AT ALL TIME
- Document vitals FREQUENTLY
- Chart when you adjust the drip

Heparin

- THIS IS A CRITICAL MED
- A PTT must be drawn q6h and adjusted based on the PTT result
- Read the policy based on this

Insulin Drip

- Review policy
- Blood glucose must be checked q1h

ICU/IMCU

- If transporting to these units: ICU must be taken by NURSE and patient on monitor, IMCU must be taken on monitor by NURSE OR PARAMEDIC

IF YOU DO ANYTHING- <u>CHART IT</u>. GIVE AN ICE PACK, CHART IT. GIVE SOME ICE CHIPS AND A BLANKET, CHART IT. PAINT A PICTURE OF YOUR PATIENT AND THEIR STAY IN THE ED. AN OUTSIDER LOOKING AT THE CHART SHOULD BE ABLE TO KNOW WHAT IS GOING ON. IF YOU ARE A TECH OR MEDIC AND YOU DO SOMETHING FOR A PATIENT-CHART IT. ORTHO SPLINT, CHART IT. IRRIGATION, CHART IT. <u>IF YOU DIDNT CHART IT- YOU DIDNT DO IT.</u>