SULTAN QABOOS UNIVERSITY HOSPITAL
NURSING DIRECTORATE

CORE STANDARDS OF PATIENT CARE
MATERNAL/CHILD / MEDICAL/ SURGICAL/ ONCOLOGY
Care of Patient

I. Patient Assessment / Patient Problem

A. The patient can expect that his / her health status be Assessed in a comprehensive, systematic and continuous manner throughout his/her stay in Sultan Qaboos University Hospital.

1. An initial brief assessment is performed by the Nurse for newly admitted and in hospital transferred patients within 30 minutes of arrival to A&E, OPD or Unit. The assessment will include, but is not limited to, level of consciousness, general appearance, chief complaint and treatments in progress, such as infusing intravenous fluids.

2. The patient has a complete health history and Physical examination by a nurse within four hour's of admission to the unit for adult patients & within two hours for pediatric patients.

3. From the initial assessment on admission, problems are identified and documented in the Clinical Notes (EPR).

4. A full physical assessment is done within first two hours of every shift.

5. Patients are weighed on admission, weekly or more frequently or as required.

6. Temperature, pulse, respirations, blood pressure and pain level will be recorded at a minimum of every fours hours or more frequent as required and as the patient's condition dictates.

7. All pre-operative routines and procedures will be explained to the patient & documented may include: diagnostic tests, X rays, blood tests, NPO Status.

8. The nurse will follow the procedure checklist when preparing a patient for surgery / procedure and ensure all care are performed and documented.

Continuation:

9. All immediate post operative patient have temperature, blood pressure, pulse, respirations, oxygen saturation and pain monitored hourly for four hours. If stable observations will be recorded four hourly for 24 hours or as required.

10. In immediate post operative phase, drainage tubes and procedural site's will be assessed & documented according to the wound care guideline's , hourly for first 24 hours.

B. The patient can expect that his/her health data is analyzed and used to guide the planning of care:

1. Initial patient problems are identified within four hours of admission and documented in the Clinical Notes(EPR).

2 . A plan of care is formulated, reviewed and revised at a minimum of once each shift, and when the patients condition changes.

C. The patient's physiological, behavioral and self –reporting indicators of pain will be assessed, documented and treated according to the patient's individual needs. This will be done in the following ways:

1. Immediately upon admission to the unit.

2. Before and following analgesia administration

3. A minimum of every four hours and according to specific nursing care standards for pain management.

II. PLANNING OF PATIENT CARE:

A. The patient can expect that his/her care requirements are assessed, planned, implemented and evaluated systematically by every staff.

1. The patient can expect that his/her nurse develops and documents an individualized plan of care.

2. The implementation of the plan of care is reflected in the Clinical Notes - EPR.

3. The plan is evaluated every shift and updated as necessary.

B. The patient can expect that the nursing plan of care is coordinated by a staff and integrated with the care provided by other members of the multidisciplinary team.

C. The patient can expect that the process of care promotes continuity through the assignment of the same nurse when possible.

Continuation:

D. The patient/family can expect to be involved in the process of planning care.

1. Goals of treatment are clarified.
2. Tests and procedures are explained prior to being carried out.

E. In all situations where patient care is delegated to another nurse e.g. tea and lunch breaks, a bedside report will include:

1. A brief history of the patient.
2. Body systems status report.
3. Location of invasive lines.
4. Status of physician order or treatment.

F. In all situations ensure continuity of care and comfort for the Palliative/End of Life patient by:

1. Verifying of resuscitation status.
2. Eliminating unnecessary tests and procedures i.e. laboratory works, daily weighs and vital signs in collaboration with the physician.
3. Minimizing unpleasant stimuli e.g. excessive noise.
4. Organizing nursing care to provide uninterrupted periods of rest.
5. Identifying key family member/caregiver for decision-making purposes.
6. Informing patients and/or family/caregiver of changes in care, as appropriate.
7. Clarifying & documenting the family's desired level of participation in the patient's physical care and involvement as appropriate

III. Psychosocial/Cultural/Religious Needs of the Patient:

A. The patient/family/caregiver can expect support of their psychosocial, cultural and religious well-being using the following interventions:

1. Recognizing the patient and family as the focus of care.
2. Utilizing translators when necessary to enhance communication, clarify goals of treatment, and identify the patients/families needs and/or preferences.
3. Providing an environment that continuously allows the patient/family/caregiver to practice their spiritual, cultural and religious needs.
4. Referring to other departments based on assessment of needs, e.g.Social Services, Patient Relations.
5. Supporting the family/caregiver through the patient's illness, treatment process, death and their bereavement.

Continuation:

IV. Physical Needs of the Patient:

A. The patient can expect assessment and monitoring of physiologic function for the following body systems:

1. Neurological: A neurological assessment will be performed and documented as part of the physical assessment.

2. Cardiovascular: A cardiovascular assessment will be performed and documented as part of the physical assessment.

3. Respiratory: Nursing care will include the assessment through auscultation of the lungs for normal and abnormal breath sounds every shift which is documented in the Clinical Notes (EPR)

   a. Patients requiring oxygen therapy will have oxygen saturation levels recorded and documented along with vital signs, or more frequently if ordered or the patient's condition changes.

   b. Tracheostomy Care will follow the instructions outlined in the appropriate Work Instructions.

   c. Chest tube care will follow the unit's work instruction.

4. Integumentary/Musculoskeletal:

   a. The pressure ulcer risk assessment tool will be completed and Documented for all patients, on admission, weekly, on transfer from Another unit or with any changes in the patient's condition. Skin care Guidelines will be followed according

   b. Patients on pressure reducing surfaces will have one sheet placed between their skin and the surface, unless the patient is incontinent, in which case there should be no more than one draw sheet and one incontinent pad.

   c. Wound Care documentation needs to be reviewed at the beginning of each shift. The nursing care plan will be reviewed as per Physician Order/Wound Care guidelines

5. Gastrointestinal and Genitourinary/Reproductive:

   a. Feeding tube placement is verified at the beginning of each shift and prior to administering feeds, nasogastric medications or flush for patency (do not flush for patency on neonates). Findings are documented in the Clinical Notes – (EPR)

   b. Feeding tubes are aspirated for gastric residual prior to intermittent tube feedings and every four hourly for continuous tube feedings. The residual amount is documented in the intake and output section of the Clinical Notes – (EPR) e.g. type, color and amount.

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Continuation:

C. Feeding tubes are flushed with water every four hours, except neonates. Feeding tubes are flushed before and after medication administration.

i. All drainage tubes present are checked every shift. All drainage from tubes will be documented in the intake and output section of the Clinical Notes – (EPR)e.g. type, color ad amount.

D. The bag/syringe shall not contain no more than four (4) hours of enteral feed. Feeds should be administered at room temperature.

E. Nasogastric drainage tubes are changed to silastic feeding tubes when feeds are started and changed every 30 days with confirmation of position obtained prior to feeding.

F. Nasogastric tubes are secured to ensure placement and skin integrity. Findings are documented in the Clinical Notes – (EPR)

G. Transparent Nasogastric tubes are changed every seven (7) days. The date and time of change are documented in the Clinical Notes – (EPR)

H. Tube feeding bag's or syringes are changed every 24 hours with date and time of change written on the bag/syringe.

I. Patients receiving bolus NGT feedings are not left unattended during feedings.

J. During continuous NGT feeding and post bolus NGT feeding the patient is positioned prone or onto the right side with Head of Bed elevated whenever possible.

K. To support caloric requirements, an accurate intake and output must be recorded and documented in the Daily Nursing Record.

L. Peri-care is done with the daily bath and after a patient is incontinent.

M. In the post-operative phase, the nurse will monitor all of the patient's intake and output, and as physician's orders.

N. Urinary drainage bags are emptied at the end of each shift and PRN.

O. If an indwelling urinary catheter is required for more than two weeks, this must be replaced with a silastic catheter and changed every 30 days.

P. Urinary catheter tubes are secured appropriately to the thigh.

Q. Catheter care is performed using clean a technique with soap and water every shift and prn.

Continuation:

6. Endocrine:

   a. Nurses will follow physician's orders for monitoring of blood glucose for non-insulin and insulin dependent diabetic patients.
   b. Nurses will follow physician's pre-printed insulin orders for patients requiring IV insulin.

7. Intravenous Infusions:

   a. IV infusions will be checked and verified against the physician's order at the beginning of each shift.
   b. All lines must be labeled and dated and changed as per policy.
   c. All medication infusions must be verified at the start of each shift by the incoming nurse.
   d. The distal ends of all tubing are clearly and boldly labeled on patients to identify *types* of solutions e.g. TPN, Lipids, or Heparin, *and* access site e.g. central venous, peripheral or epidural.

B. The patient can expect that infection control and preventative measures are implemented according to the Infection Control Policies and the Infection Control Policies.

C. The patient can expect that safety needs are addressed:

1. Stretcher, bed and crib side rails must be up at all times.
2. The patient must wear an identification bracelet at all times. This must be verified by the incoming nurses at the start of each shift.
3. All bedside emergency equipment is available, checked and functioning at the beginning of each shift, e.g. suction, and oxygen set up.
4. Pediatric patients will be supervised in designated playing areas.
5. Medications, hazardous supplies and cleaning materials are kept out of reach for all patients.
6. Pediatric patients will be transported safely in an appropriate bed, crib, stretcher or wheelchair. Parents wishing to carry their child must be seated in a wheelchair.
7. Silicone urinary catheters are used for patients who are sensitive to Latex

D. The patient/family can expect that personal hygiene is supported:

1. A complete bed bath or shower and linen change are done as required.
2. Head and body are checked for lice and nits on admission and every shift as per physical assessment. Treatment ordered, given and documented.
3. Oral care is done PRN.

V. Patient Education/Discharge Planning:

A. The patient/family can expect education that supports their transition towards self-care, and adaptation to their health/illness/condition.

Continuation:

1. The nurse collaborates with other services e.g. Health Educators, in the assessment, implementation and documentation of all teaching and provision of appropriate education materials.

2. To minimize post-op complications, the patient will receive pre-op education of the following:

   a. Incentive spirometry

   b. Deep breathing and coughing exercises

   c. Positioning to relieve pressure

B. The patient/family can expect that an individualized discharge plan is assessed, established and implemented.

1. Discharge planning is initiated within 24 hours of admission and documented on the Admission/Discharge Database. Prior to discharge, the nurse will complete the discharge checklist.

2. A Nursing Discharge Summary is completed on all patients that are being transferred to another facility.

3. Discharge planning demonstrates multidisciplinary collaboration i.e. Social Worker, Patient Relations.