CHAPTER 2
Introduction to Nursing Protocols

I. INTRODUCTION

The Nursing Protocols contained in this volume were developed to provide nursing personnel with guidelines for assessment and management of common health conditions among the California Department of Corrections (CDC) patient population. These are the only protocols authorized by Health Care Services Division for use within CDC.

II. ORIENTATION AND TRAINING

After receiving training in physical assessment and orientation regarding their use, the protocols may be used by the nurse. Documentation regarding training shall be placed in each nurse's personnel file and the proof of practice binder.

An assessment program shall be included in the nursing services program to ensure competency in the protocols approved for use in the facility. Periodic inservices, skill checks, and reviews shall be conducted by a Supervising Registered Nurse, or designee, so that nurses maintain baseline competencies with regard to physical assessment and use of nursing protocols. These shall be performed quarterly, or sooner if indicated. The review shall consist of the more frequently used or most problematic protocols. Staff shall receive positive as well as constructive feedback, and retraining provided when necessary.

III. USE OF NURSING PROTOCOLS

Nursing Protocols are to be made available to nursing personnel in the emergency treatment area and areas where clinical activities are conducted. The protocols serve as guidelines for sound nursing practice and shall be used during nursing triage. The nursing assessment flow sheets provide structure to the assessment process; however, professional judgment is used to determine what additional information shall be collected to make an assessment. Regardless of the presenting complaint, abnormal vital signs shall always be noted and referred if necessary.

Nurses shall always practice within their licensure, training and experience when using protocols. When in doubt about the assessment and management of a patient, it is best to refer to an advanced level provider for evaluation.

IV. CONDUCTING AN ASSESSMENT

Nursing staff shall not conduct an assessment at the cell front. This results in a reduced type of medical contact with cursory exams through the cell doors, incomplete physical examination, insufficient privacy and no vital signs.

To prevent this occurrence, the Health Service Request form (CDC 7362) shall be used by patients to request services for primary care. Primary care encounters shall be conducted with the health record present, in an adequately equipped room, which affords privacy and access to hand washing facilities. The only reason to engage in an exchange of medical

information through the cell front is a patient declared emergency. These may be briefly assessed for the urgency of the complaint. If urgent, the patient shall be taken to an examination room for evaluation and a complete assessment performed, including vital signs.

V. NURSING DIAGNOSIS

According to the North American Nursing Diagnosis Association (NANDA) the nursing diagnosis is a "clinical judgment about individual, family, or community responses to actual or potential health problems or to life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable." The term nursing diagnosis implies the identification of a patient's problem and the treatment that a **NURSE** can legally manage. These are the basic guidelines for ensuring that the diagnostic statement is correct:

- Use proper terminology that reflects the patient's ***nursing*** needs.
- Make each statement concise so that other health team members easily understand it.
- Use the most precise words possible.
- Use a problem-cause format, stating the problem and its related cause.

The phrase "alteration in comfort" as a stand-alone nursing diagnosis provides no useful information regarding the assessment of the patient. A more specific nursing diagnosis shall be used such as "Post operative pain."

VI. MULTIPLE COMPLAINT PATIENTS

A common problem for nursing staff is to decide which protocol to use for patients with multiple complaints. A miscellaneous complaint assessment flow sheet or a thorough progress note shall be used for documentation. The documentation shall include that which is in the guidelines for each identified patient complaint.

VII. CRITERIA FOR REFERRAL

Each protocol describes criteria for a referral.

VIII. REFERRAL OF ABNORMAL VITAL SIGNS

The nurse shall be cognizant of objective data that requires referral regardless of the presenting complaint of the patient. This is particularly relevant to abnormal vital signs. As an example, a patient presenting with athlete's foot who has a blood pressure reading of 170/122 mm/Hg shall receive an urgent (same day) referral to an advanced level provider.

Examples of criteria regarding abnormal vital signs are:

Vital Sign	**High:**	**Low:**
Temperature	>101 F	<96 F
Blood Pressure		
Diastolic	>100 mm/Hg	
Systolic	>160 mm/Hg	<90 mm/HG
Pulse	>110/minute	<50/minute
Respirations	>30/minute	<10/minute

When vital signs fall above or below the thresholds described, or anytime the nurse's professional judgment indicates, the patient shall be referred to an advanced level provider on the same day.

Vital signs shall be taken for all nursing encounters.

IX. USING THE NURSING PROTOCOL FLOW SHEETS

The nursing protocol flow sheets enable the nurse to meet all requirements of the protocol. Nurses not using these forms remain responsible for addressing in their progress notes each and every item present on the printed form.