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Standardized Procedure - Urgent Care - for Initiating Pre-Established Orders for Stable Patients, 30133.99

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I. PURPOSE

To provide a standardized procedure for Urgent Care (UC) Registered nurses (RN) to initiate pre-established orders for stable patients awaiting UC provider evaluation. If the patient becomes unstable at any time the provider will immediately be notified.

II. DEFINITIONS:

A. **Adult**: 18 years of age and over

B. **Anaphylaxis**: A sudden, severe, life-threatening reaction resulting from the rapid systemic release of chemical mediators from mast cells and basophils.

C. **hCG**: Urine test for presence of human chorionic gonadotropin hormone

D. **Pediatric**: 12 years of age or under

E. **RN**: Registered Nurse

F. **SpO_2**: The saturation of arterial blood with oxygen as measured by pulse oximetry, expressed as a percentage.

G. **SRS**: Sharp Rees-Stealy Medical Centers

H. **Standardized Procedure (SP)**: As defined by the California Board of Registered Nursing: "The means designated to authorize performance of a medical function by a registered nurse developed through collaboration among registered nurses, providers and administrators in the organized health care system in which it is to be used".

I. **Teen**: 13 years – 17 years of age

J. **VIS**: Vaccine Information Statement

III. TEXT:

A. **Standardized Procedure Function in UC:** Competency validated RNs working in UC may follow the SP for stable UC patients prior to provider evaluation.

B. **Circumstances under which RN may perform SP function(s**):

1. **Setting** – An RN working in the UC department at Sharp Rees-Stealy Medical Centers.
2. **Scope of Supervision** – UC physician immediately available.
3. **Patient conditions to notify provider:**
    a. The RN shall notify the UC provider immediately whenever a patient exhibits adverse reactions, or sign/symptoms develop that require immediate intervention.
    b. If at anytime the patient becomes unstable and there is no provider in the department, the RN shall call 9-1-1 and initiate the SP.

C. **RN Requirements**:

1. **Education/Training/Experience** – The UC RN shall receive UC specific education upon hire.
2. **Method for evaluating initial and ongoing competency validation of RNs**:
    a. The RN shall complete an initial and annual competency module and test in the Learning Management System (LMS). The RN must score 90% or higher to pass.
    b. An RN who successfully passes the LMS module and test shall be considered competent to follow the UC SP.
3. **Initiating the SP:** The RN shall perform and document a patient assessment to include subjective and objective information to determine the appropriateness for initiating the SP prior to provider evaluation.
    a. If at any time a patient becomes unstable and there is no provider in the department, the RN shall call 9-1-1 and institute appropriate SP.
4. **Documentation- The RN shall document the following:**
    a. SP orders initiated by the RN shall be documented in the patient's EHR as being performed per the UC SP.
    b. Prior to giving medication, the RN shall verify two patient identifiers and review patient allergies. This will be included in the documentation of medication administration in EHR.
    c. Patient's response to procedure (i.e., temperature reading 1 hour following antipyretics).
    d. If intravenous medications are administered, the intravenous medication text template shall be used to document.

D. **Method for maintaining a written record of RNs who are authorized to perform the SP:**

1. A list of competency validated RNs, who are authorized to follow this standardized procedure, shall be kept current in an electronic database that is available to SRS Nursing

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Leadership, Physician Leadership, and the Chief Clinical Operations Officer. This list shall be updated on an ongoing basis by the department supervisor or designee for RNs who successfully pass the initial and annual competency validation assessments.

E. **Location of current signed SP:**

1. The current SP can be found on the Sharp Intra-net under Policy and Procedures. A current signed copy of the standardized procedure by the Division Chief or Medical Director shall be attached to the policy in the policy database (see Attachment A).
2. A current copy of the signed SP shall be kept in each Urgent Care Department.

F. **Chart Audits:**

1. Random monthly chart audits are performed to ensure appropriate use and documentation of the UC SP. Audit results shall be kept at each site by the UC supervisor.

G. **Delegation:**

1. Licensed Vocational Nurses (LVN) working in SRS UC Centers may follow orders to perform Point of Care (POC) tests and ECGs delegated by a competency validated RN who is functioning under a SP. The RN must ensure the patient's clinical presentation meets criteria for the SP and document the order and criteria that were met in the electronic health record (EHR). SRS Scope of Practice Licensed Vocational Nurse (LVN), 30114

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IV. PROCEDURE

A. Abdominal pain and/or Dysuria:

A. Obtain a clean catch urine specimen and perform point of care (POC) urinalysis (UA).
   1. Only use approved diagnosis codes to order POC UA in Touchworks as defined in Attachment B.

B. Urine POC HCG shall be performed on all women of childbearing age (12-50 years of age). Consult provider for positive HCG or questions.

C. Male patients: Obtain a clean and dirty urine specimen for possible testing.

D. After obtaining a clean catch urine specimen, adult patients may receive 200 mg Phenazopyridine (Pyridium), by mouth, for suspected UTI. UTI symptoms may include urinary frequency, urgency, dysuria, or pressure.

B. Anaphylaxis:

A. Signs and symptoms of anaphylaxis may include:
   1. Itching and/or hives
   2. Sneezing, rhinorrhea, 'red eyes'
   3. Anxiety, flushing, tachycardia, diaphoresis
   4. Wheezing, shortness of breath, dizziness, light headedness, decreased blood pressure (BP)
   5. Sudden hoarseness, difficulty swallowing, stridor, cough

6. Nausea, vomiting, abdominal pain
7. Loss of consciousness
8. Pallor, cyanosis or clinical signs of shock

B. Immediately notify a provider if one is available. If a provider is not available / not on-site the following protocol may be initiated by an RN:
    1. For significant distress such as cyanosis, inability to speak, swelling of tongue or throat, or for loss of consciousness, initiate Code Blue procedure and call 9-1-1.
    2. **Adult**: Check vital signs (BP, HR, RR and oxygen saturation) immediately before, and continuously monitor every five (5) minutes after, giving Epinephrine via EpiPen Auto-Injector 0.3 mg intramuscularly into the thigh and 25mg-50mg Benadryl IV push (preferred method) or intramuscularly into the thigh. May repeat the Epinephrine dose, as needed, every 5-15 minutes.
    3. **Pediatric** and **Teenage Patients**: Check vital signs (BP, HR, RR and oxygen saturation) immediately before and continuously monitor every five (5) minutes after giving appropriate dosage of Epinephrine via EpiPen Auto-Injector (pt's greater than 30kg), EpiPen Jr. Auto-Injector (pt's 15-30kg) or 1:1000 concentration of Epinephrine vial (pt's less than 15kg) intramuscularly into thigh and Benadryl IV push (preferred method) or intramuscularly into thigh.
        i. Age and weight guidelines for Epinepherine and Benadryl dosages are provided in Table 1 and 2 below. May repeat the Epinephrine dose as needed every 5-15 minutes.

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C. Administer 100% oxygen via non-rebreather mask for significant distress such as cyanosis, inability to speak, swelling of tongue or throat.
D. Attempt to establish an intravenous (IV) line after initial treatment has been initiated. *DO NOT delay initial treatment to establish an IV.*
E. For adult patients, infuse normal saline solution at a rate of 1,000ml/hour (if patient has no contraindications) for systolic blood pressure less than 90 mmHg.
F. For pediatric patients, infuse normal saline solution 20ml/kg (up to max of 1000ml) IV over 1 hour.
G. **Epinephrine administration described in #3 may be repeated two (2) additional times at 5 to 15 minute intervals**. (Maximum of three treatments of Epinephrine, but only one treatment of Benadryl). Nebulized albuterol 2.5 mg in 3ml normal saline for chest tightness, shortness of breath and/or wheezing.
H. **Table 1. Pediatric and teen Epinephrine dosage:**

EPINEPHRINE IM Administration

0.01ml/kg per dose (may be repeated every 5-15 minutes up to 3 doses)

Age	Broselow Color	Weight (lbs)	Weight (kg)	IM Dose 1:1000 1mg/ml	Volume
Infants	Pink	Under 18 lbs	Under 8 kg	0.05 mg	0.07ml
	Red	18 - 20 lbs	8 - 9 kg	0.09 mg	0.09 ml
	Purple	21-25 lbs	10 - 11kg	0.1 mg	0.1 ml
Children	Yellow	26 – 31 lbs	12 - 14 kg	0.13 mg	0.13 ml
Children	White	32 – 40 lbs	15 – 18 kg	0.15 mg	0.17 ml
Children	Blue	41 - 52 lbs	19 - 23 kg	0.2 mg	0.21 ml
Children	Orange	53 - 64 lbs	24 - 29 kg	0.25 mg	0.27 ml
Adolescents	Green	65 - 79 lbs	30 - 36 kg	0.3 mg	0.3 ml
Adults	NA	≥ 80 lbs	≥37 kg	0.3 mg	0.3 ml

EPINEPHRINE AUTOINJECTOR

0.01ml/kg per dose (may be repeated every 5-15 minutes up to 3 doses)

Age	Broselow Color	Weight (lbs)	Weight (kg)	Epi Autoinjector
Infants	Pink	Under 18 lbs	Under 8 kg	N/A
	Red	18- 20 lbs	8-9 kg	N/A
	Purple	21 -25 lbs	10 - 11kg	0.15mg
Children	Yellow	26– 31 lbs	12 - 14 kg	0.15 mg
Children	White	32 – 40 lbs	15 -18 kg	0.15 mg
Children	Blue	41 - 52 lbs	19 - 23 kg	0.15 mg
Children	Orange	53 - 64 lbs	24 - 29 kg	0.3 mg
Adolescents	Green	65 - 79 lbs	30 - 36 kg	0.3 mg
Adults	NA	≥ 80 lbs	≥ 37 kg	0.3 mg

I. **Table 2. Pediatric and teen Benadryl dosage:**

DIPHENHYDRAMINE IM
(Benadryl) 50 MG/ML

Age	Broselow Color	Weight (lbs)	Weight (kg)	IM Dose	Volume
Infants	Pink	Under 18 lbs	Under 8 kg	5 mg	0.1 ml
	Red	18- 20 lbs	8 - 9 kg	10 mg	0.2 ml
	Purple	21- 25 lbs	10 -11 kg	10 mg	0.2 ml
Children	Yellow	26 – 31 lbs	12 - 14 kg	15 mg	0.3 ml
Children	White	32 – 40 lbs	15 – 18 kg	15 mg	0.3 ml
Children	Blue	41 - 52 lbs	19 - 23 kg	20 mg	0.4 ml
Children	Orange	53 - 64 lbs	24 - 29 kg	25 mg	0.5 ml
Adolescents	Green	65 - 79 lbs	30 –36 kg	35 mg	0.7 ml
Adults	NA	≥ 80 lbs	≥ 37 kg	50 mg	1.0 ml

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C. Bladder Catheterization:

A. UC Patients:

1. If patient presents with a chief complaint of urinary retention:
    i. Provide patient clean catch urine instructions, cleansing towelettes and sterile specimen container.
    ii. Place specimen collection pan (hat) in toilette.
    iii. Instruct patient to attempt to void and collect all urine in specimen cup and then pan.
    iv. Measure urine collected.
    v. Assess bladder distention post-void and perform bladder scan:
        a. If scan shows less than 500 mL urine in bladder, notify provider.
        b. If scan shows greater than or equal to 500 mL urine in bladder or if patient is unable to void, insert Foley catheter (see "performing bladder catheterization" section below). **NOTE: DO NOT** INSERT FOLEY CATHETER AND NOTIFY PROVIDER IF THE PATIENT HAS HAD ANY OF THE FOLLOWING EXCLUSION CRITERIA:
            1. Urological and/or gynecological surgery within the last 3 months.
            2. Recent trauma to the perineal area.

3. Radiation to the perineal or abdominal area within the last 6 months.
4. Recent gross hematuria.

B. Radiology Patients:

1. If an adult patient presents to the radiology department for a procedure requiring bladder catheterization (i.e. Voiding Cystogram), the UC RN may insert Foley catheter or straight catheter per radiologist's preference (see "Placement of Foley Catheter for Radiology Procedures, Policy # 37561.99). **NOTE: Pediatric catheterization shall be performed by the radiologist.**
2. Document procedure in clinical update under name of radiologist performing the procedure.

C. Performing Bladder Catheterization:

1. After determining that patient is not allergic to Betadine, maintaining sterile technique, cleanse perineal area with sterile, single-use Betadine included in the catheterization kit.
    i. If patient is allergic to Betadine, cleanse with Chlorhexidine solution with <4% alcohol (i.e. Hibiclens).
    ii. Maintain sterile technique during procedure (see SRS Bladder Catheterization Competency for complete instructions).
    iii. ADULT PATIENTS 18 YEARS AND OLDER: After confirming that patient does not have a Lidocaine sensitivity or allergy, the RN using sterile technique, may inject 5-10 mL of sterile, single-use 2% topical Lidocaine jelly via Urojet (to tolerance level) into urethra prior to catheterization. Instillation of Lidocaine via Urojet **DOES NOT** replace the need to lubricate the bladder catheter. Ensure that catheter has ample lubrication as well.
        a. May repeat above Lidocaine dosage once, in male patients, if first dose does not provide effective analgesia.
        b. PEDIATRIC PATIENTS: Consult with provider regarding use of Lidocaine 2% topical jelly for procedure.

D. If Catheter is removed before discharge:

1. Deflate balloon tip and gently remove catheter.
2. Ask the patient to void into a measurable urine collection receptacle (i.e. – urinal or toilet hat).
3. Inform provider of the patient's post void volume in mL.
4. Document in the EHR.

E. If patient is sent home with Foley catheter in place, convert Foley bag to a leg bag prior to home discharge. Provide patient with home care instructions.

D. Chest Pain:

A. Adult patients who complain of chest, substernal or epigastric pain or pressure associated with one or more of the following subjective or objective characteristics:

1. over the age of 35 years

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2. onset of pain was with exertion
3. past medical history of coronary artery disease and/or previous infarction/angina
4. diabetes
5. hypertension
6. pain radiating to back, jaw or neck
7. diaphoresis
8. pallor
9. nausea/vomiting
10. dyspnea
11. cocaine use
12. dizziness
13. palpitations

B. Immediately notify a provider.
C. Patient shall be undressed and prepared for exam (include removing pants).
D. Connect to continuous cardiac monitor and obtain pulse oximetry reading.
E. If SpO_2 is less than 93%, apply oxygen and titrate to maintain SpO_2 greater than 93%.
F. Obtain blood pressure.
G. Obtain 12 lead ECG and immediately show to assigned provider. If ordering provider unavailable, show ECG to another provider.
H. Insert a large bore saline lock (preferably in the antecubital space), draw rainbow panel and hold for provider's orders.
I. In the event of a STEMI & **no provider in department**: Call 9-1-1 & Emergency Department to advise of patient transport.
J. If ST elevation is present in leads II, III & aVF **AND no provider is present**, consider performing a RIGHT sided EKG.
K. If RIGHT sided EKG demonstrates ST elevation in V4R, II, III & aVF: DO NOT administer Morphine, diuretics or Nitro (to prevent hypotension). **If no provider in department**, RN may administer IV NS at 500 mL / hr if no contraindications.

E. Extremity and Clavicle Films:

Assessment and documentation of extremity injuries should include: when the injury occurred, the site of the injury, mechanism of injury, and any other associated subjective/objective data (i.e. appearance of wounds, muscle strength, and peripheral vascular abnormalities).

Extremity and clavicle films may be ordered on teen and adult patients meeting the below criteria. All X-ray orders shall be ordered as complete view and as **STAT.**

NOTE: Prior to X-ray, RN should conduct urine HCG testing in women of childbearing age (12 years old through menopause), if patient's last menstrual period is unknown, more than 28 days ago, or if patient is

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unsure of possible pregnancy. Provider will be consulted for any positive result or questions. HCG testing is not required in patients with history of hysterectomy.

A. An X-ray of a **digit** (finger or toe) may be ordered if the patient has had an injury **AND**:
    1. There is deformity, significant swelling or ecchymosis, or loss of function, **OR**
    2. There is a known or suspected metallic foreign body that is not obvious.
    3. **Staff to ensure rings removed prior to X-ray and removal of bulky bandages or dressings.

B. An X-ray of a **foot** may be ordered if the patient has had an injury to the foot **AND**
    1. There is an acute deformity of the foot, **OR**
    2. The Ottawa Foot Criteria are present: Inability to bear weight both at the time of the accident AND for at least 4 steps in the UC.

C. An X-ray of an **ankle** may be ordered if the patient has had an injury to the ankle **AND**:
    1. There is a deformity of the ankle, **OR**
    2. The Ottawa Ankle Criteria are present: inability to bear weight both at the time of the accident AND for at least 4 steps in UC, **OR**
    3. Bone tenderness at the tip or posterior edge of either malleolus.

D. An X-ray of a **wrist** may be ordered if the patient has had an injury to the wrist and there is significant swelling, tenderness or ecchymosis**.**
    1. ***Staff to ensure rings removed prior to X-ray and removal of bulky bandages or dressings.

E. An X-ray of the **hand** may be ordered if the patient has had an injury to hand **AND**:
    1. Complains of severe pain, **OR**
    2. Presents with deformity, significant swelling, ecchymosis or loss of function.
    3. **Staff to ensure rings removed prior to X-ray and removal of bulky bandages or dressings.

F. An X-ray of a **clavicle** may be ordered if the patient has had an injury to the area of the clavicle or a fall on their shoulder **AND:**
    1. There is obvious deformity of the clavicle, **OR**
    2. There is significant swelling and tenderness over the clavicle.

NOTE: Only the films specifically listed above may be ordered prior to provider evaluation. In cases of significant injury of the long bones of the arms or legs, elbow, knee, hip, pelvis or spine, the RN shall **immediately** consult a provider on duty prior to ordering the films.

F. Fever:

Administration of antipyretics to patients with temperature 100.4° F or greater and have not received antipyretics in the last 6 hours.

A. Pediatric:

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1. RN shall immediately notify the provider regarding any patient with the following:
    i. Patient with temperature of 100.4° F or greater
    ii. Patient with fever and history of febrile seizure
    iii. Patient less than 5 months of age with fever
    iv. Patient less than 1 month of age with subnormal rectal temperature less than 97° F
    v. Patient extremely irritable, lethargic or toxic appearance
2. Obtain antipyretic order for patients weighing less than or equal to 24 lbs.
3. Hold antipyretics for patients with abdominal pain and vomiting.
4. RN may administer either acetaminophen 15 mg/kg to max of 650 mg by mouth, **OR** ibuprofen 10 mg/kg to max of 400 mg by mouth. Do not administer ibuprofen for infants < 6 months of age.

B. Adult and teen:
1. RN may administer acetaminophen 650 mg by mouth.
    i. Prior to administration, consult provider for patients with liver dysfunction or history of heavy alcohol use.

OR

2. RN may administer ibuprofen 600 mg by mouth.
    i. Prior to administration, consult provider for patients with kidney dysfunction, anticoagulation therapy or history of GI bleeding.
    ii. Do not administer to pregnant women.
    iii. Avoid use in patients with head injuries, bleeding or if acute surgery may be needed.

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G. Hyperglycemia/hypoglycemia and/or altered level of consciousness (LOC):

For patients who have signs and symptoms of hypoglycemia (i.e. trembling, clammy, anxious, confusion or decreased LOC) **OR** for patients who have signs and symptoms of hyperglycemia (i.e. nausea, vomiting, abdominal pain, hunger, fatigue, blurred vision, headaches, frequent urination, extreme thirst, fruity-smelling breath, ketones in urine):

A. The RN shall perform and document finger stick blood glucose test and result in EHR
B. Notify assigned provider immediately of blood sugar ≤ 70 or ≥ 250.
1. For patient with blood sugar ≤ 70 who are alert and oriented x 3, able to follow simple requests and swallow, provide oral glucose.
2. For patient with altered LOC, await orders from provider.

C. If no provider in department, AND adult patient has blood sugar <70 (or <60 in obstetric patient) *WITH decreased level of consciousness,* call 9-1-1 AND:
1. **If able to secure IV:** Give 50ml D50 IV (1 amp). For Pediatric patients, refer to Broselow tape for appropriate weight base dosing of D25 IV.

2. **If unable to secure IV:** Give Glucagon 1mg IM.
3. Recheck finger stick blood sugar 15 minutes after completion of treatment.
4. Once a provider is available, inform of above and defer to provider for further orders.

D. Enter charges in EHR.

H. Influenza:

Patients who present during influenza season (October through mid-May) with abrupt onset (less than 3 days) of fever 100.4ºF or greater AND two or more of the following symptoms; nonproductive cough, sore throat, rhinitis, myalgia, headache, malaise. Among pediatrics, earache, nausea, and vomiting also are commonly reported with influenza illness.

A. Perform and document rapid influenza test and result.
B. Mask patient, if possible.
C. Pain complaints shall be addressed following the guidelines listed in Table 3.

I. Obstetric Patients:

A. The RN will check Fetal Heart Tones (FHT) in all obstetric patients with 12 weeks or more gestation.
B. FHT results will be reported to provider.
C. Abnormal FHTs (>160 bpm or <110 bpm) will be reported to provider immediately after discovery.

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J. Pain:

Patients presenting with pain should be assessed and intervention should be provided within 45 minutes of registration.

A. The RN shall notify provider of all patients who are in acute pain and distress expressed by either behavior (tearfulness, grimacing, guarding, etc.) or verbalization of pain severity or intensity, regardless of patient's reported pain scale score (0-10).
B. All interventions or refusal will be documented in medical record.

Table 3. Pain intervention suggested criteria.
** Avoid NSAIDS (Ibuprofen / Naproxen) in head injuries, bleeding or when acute surgery may be needed. Do not administer ibuprofen for infants < 6 months of age. If any uncertainty regarding indications or contraindications, consult provider.**

Pain Level	Intervention(s)
Eye pain, Any level	Examples are corneal abrasions, painful red eyes, UV exposure (but not projectile injuries or suspected globe penetration): 1-2 drops Proparacaine Hydrochloride Ophthalmic Solution. Consult provider for pediatric and teen patients.
Mild pain (1-3)	Examples are sprains, abrasions, contusions, crush injuries, lacerations: a. Immobilization, ice pack (for acute injury), and elevation b. Acetaminophen or ibuprofen in appropriate dosage (see section H. Fever for

	dosing)
Moderate pain (4-6)	Examples are fractures, back pain, finger dislocations, multiple injuries: a. Immobilization, ice packs (for acute injury), elevation, and notify provider, if indicated b. Acetaminophen or ibuprofen in appropriate dosages may be given. (see section H. Fever for dosing)
Severe pain, (7-10) Any cause	May initiate one of the above measures or request provider assessment for abdominal pain, suspected ureteral calculus or significant pain without apparent cause.

K. Respiratory Distress:

Patients who complain of shortness of breath and assessed with one of the following symptoms shall receive the interventions below.

A. Symptoms:
   1. Tachypnea (greater than 28)
   2. Stridor
   3. Cyanosis
   4. Increased work of breathing (retractions, nasal flaring, purse lipped breathing, tripod positioning)
   5. Difficulty speaking
   6. SpO_2 less than 93%
   7. Tachycardia (greater than120 beats per minute)
   8. Bradycardia (less than 50 beats per minute)
   9. Somnolent or altered mental status

B. Interventions:
   1. Immediately notify a provider.
   2. Obtain baseline SpO_2 on room air.
   3. Obtain SpO_2 if on supplemental oxygen.
   4. Connect patient to continuous cardiac monitor.
   5. Apply 4 liters oxygen via nasal cannula for SpO2 less than 93%.
   6. Consult provider for possible IV.
   7. Adult patients who complain of shortness of breath with wheezing shall also receive:
      i. Consult provider for tachyarrhythmias.
      ii. Albuterol 2.5 mg in 3 mL saline via hand-held nebulizer.
   8. Consult provider for pediatric and teen patients with any of the above symptoms.

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L. Suture removal:

For patients presenting for suture removal at instructed interval.

A. Verify, in patient record, when sutures were placed and when the patient was instructed to return for removal. For sutures placed outside of Sharp Rees Stealy Urgent Care, consult the assigned UC Provider for evaluation prior to removal.

B. Assess for evidence of normal wound healing and abnormal findings. See Table 4 below

Table 4. Wound assessment.

CHARACTERISTIC	NORMAL FINDINGS	ABNORMAL FINDINGS
Wound edges	Well approximated	Not well approximated
Inflammatory response	Good initial response: redness, warmth, induration, pain	Diminished or no response, or response persists or occurs after day 5
Drainage	None 48 hrs. after closure	Continues longer than 72 hrs. after closure
Healing ridge	Present by postoperative day 7–9	None by postoperative day 9; hypertrophic scar or keloid developing

C. Remove sutures if appropriate time frame and normal wound healing present.

D. Patients who are outside of the time frame or with abnormal wound findings shall be evaluated by assigned provider.

E. If patient record is unavailable the following Table 5 shall be used to determine appropriate time frame for suture removal.

Table 5. Suture removal.

LOCATION	DAYS SINCE SUTURES PLACED
Face and scalp	At least 5 days
Trunk and extremities	At least 7 days
Joints (i.e., knees and elbows)	At least 10 days

M. Tetanus prophylaxis:

Administer tetanus prophylaxis to a patient suffering a wound with contamination of dirt, feces or saliva, puncture, avulsion or crush injury, and, if it has been 10 years since the last dose, or, check system if last dose unknown.

A. RN may administer tetanus prophylaxis according to Table 6 below.

B. Patient shall receive VIS prior to administration of tetanus

C. Documentation shall include site of administration, manufacturer of vaccine, lot number, expiration date, VIS date and that the VIS was provided to patient.

Table 6. Tetanus prophylaxis table for age related product selection.

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Age of patient	Product Selection	Dose / Route
Less than 11 years	Obtain provider order	
11-64 years	Tdap (Adacel) *, **	**0.5 mL IM**
65 years and older	Obtain provider order	

**Contains pertussis – confirm there is not a history of adverse reaction or allergy.*

N. Throat pain:

A. For patients greater than 3 years old presenting with any complaint of sudden onset of sore throat AND has one or more of the following:
   1. Absence of cough
   2. Absence of hoarse voice
   3. Absence of seasonal allergy symptoms (nasal congestion, runny nose, sneezing, and itchy or watery eyes)
   4. Fever
   5. Swollen Tonsils
   6. Tonsillar exudate
   7. Known exposure to strep throat
   8. History of rheumatic fever
   9. History of rheumatic heart disease

B. The RN shall perform and document rapid strep A test and result.

C. If strep test is negative, strep DNA should be sent to lab.

D. Pain shall be addressed following guidelines listed in Table 3.

O. Vomiting, Diarrhea:

A. Assessment should include recent foreign travel, camping, outdoor cooking, unusual foods, recent contact with persons with similar symptoms, associated abdominal pain, fever, blood or dark stool/ vomiting, and duration/frequency of vomiting/diarrhea.

B. Patients shall be gowned for examination.

C. Ensure that Hemoccult® cards and developer, gloves in all sizes, lubricating jelly and anoscope are present in exam room.

D. RN may start an IV on adult patients with normal saline at 120 mL/hour if any of the criteria listed in Table 7 are present during postural changes.

E. If patient has no contraindications AND has a documented negative hCG during current UC visit, RN may administer Zofran (Ondansetron) 4mg PO to adult patient AND RN will inform provider of

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Zofran administration as soon as possible.

F. **Defer to assigned UC provider order if patient is pregnant**

P. Wound Care:

A. All dressings must be removed except as required for temporary hemostasis.

B. For suturing, place patient in a Procedure room (if available at the Urgent care site) and have laceration kit available.

C. For abscesses, place patient in a standard room and have an incision and drainage tray available.

D. Adequately expose the affected body part and position the patient for the procedure. If possible, have the patient lay down rather than sit.

E. Irrigate wound with normal saline. Defer to provider for soaks.

F. For all wound procedures, the following supplies should be ready in the event they are needed:

1. Betadine solution
2. Culture swabs
3. Extra 4x4 sponges
4. Chux pad

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V. DEVELOPMENT & APPROVAL

A. Method – written and approved by SRS UC Medical Director and UC Associates.

B. Review Schedule – annually.

C. Required Approval(s) - Standardized Procedures are approved initially and annually by SRS UC Medical Director, UC Site Associates, UC Site Nurse Supervisors, Nurse Manager of UC, Director of UC, SRS Policy and Procedure Steering Committee and SHC Policy and Procedure Steering Committee.

VI. REFERENCES:

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VII. ORIGINATOR:

Urgent Care

VIII. LEGAL REFERENCES:

A. Title 22

B. Board of Registered Nursing

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IX. ACCREDITATION:

A. Accreditation Association for Ambulatory Health Care, Inc. (2018). Chapter 4, A-D.

X. CROSS REFERENCES:

A. Sharp Healthcare P&P #30719, California Board of Registered Nurses Guidelines

B. Placement of Foley Catheter for Radiology Procedures P&P #37561.99

XI. APPROVALS

A. Ongoing:

1. UC Medical Director: 07/10; 03/11; 07/11, 4/12, 12/12; 03/13; 12/13; 06/14; 12/14; 11/15; 10/16; 06/17; 9/18; 2/19; 8/19; 11/19, 02/21, 02/22
2. UC Site Associates: 07/10; 03/11, 12/12; 03/13; 01/14; 11/15; 10/16; 9/18; 8/19, 11/19, 01/21, 02/22
3. UC Site Nursing Supervisors: 07/10; 03/11, 12/12; 03/13; 12/13; 02/15; 11/15; 10/16; 06/17; 9/18, 11/19, 01/21, 02/22
4. Director of Urgent Care: 07/10; 03/11, 4/12, 12/12; 03/13; 12/13; 02/15; 11/15; 10/16; 06/17; 9/18; 8/19, 01/21, 02/22
5. SRS Policy and Procedure Steering Committee: 07/10, 12/19, 03/21, 06/22
6. SRS Nursing Policy and Procedure Committee: 04/22

B. Historic:

1. SRS Pharmacy Manager: 03/13

2. Policy & Procedure Steering Committee: 10/10
3. SRS - Anti Coag Medical Director: 09/15
4. SRS Anti Coag Nurse Supervisor: 09/15
5. SHC Policy & Procedure Steering Committee: 10/10
6. Radiology Division Chief: 8/19

XII. REPLACES:

None

XIII. HISTORY:

System #30133.99; originally dtd. 10/10
Reviewed/Revised: 05/11; 07/11; 08/12; 01/13; 05/13; 02/14; 07/14; 12/14; 01/16; 10/16; 08/17; 09/18; 09/19

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A. Attachment

Attachment A to #30133.99

SHARP. Rees-Stealy Medical Centers

www.sharp.com/srs □ (858) 499-2600

SRS URGENT CARE DEPARTMENT STANDARDIZED PROCEDURES

These SRS Urgent Care Department Standardized Procedures are hereby approved and authorized for use among competent Registered Nurse staff.

_____ _____

Dr. Phil Yphantides **Date**
SRS Urgent Care Medical Director

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B. Attachment

UC Nurses that are competent to perform Standardized Procedures may order diagnostics using the following table.

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APPROVED STANDARDIZED PROCEDURES DIAGNOSIS CODES

DIAGNOSTIC TEST	COMPLAINT	ICD-10	ICD10 Description
EKG			
	CHEST PAIN	R07.9	R07.9 Chest pain, unspecified
	PALPITATIONS	R00.2	R00.2 Palpitations
	SOB	R06.02	R06.02 Shortness of breath
	DIZZINESS	R42	R42 Dizziness and giddiness
	SYNCOPE	R55	Syncope and collapse
XRAYS			
	TOE INJURY		
	On left foot	S99.922A	S99.922A Unspecified injury of left foot, initial encounter
	On right foot	S99.921A	S99.921A Unspecified injury of right foot, initial encounter
	FOOT INJURY		
	Left foot	S99.922A	S99.922A Unspecified injury of left foot, initial encounter
	Right foot	S99.921A	S99.921A Unspecified injury of right foot, initial encounter
	ANKLE INJURY		
	Left ankle	S99.912A	S99.912A Unspecified injury of left ankle, initial encounter
	Right ankle	S99.911A	S99.911A Unspecified injury of right ankle, initial encounter
	WRIST INJURY		
	Left wrist	S69.92XA	S69.92XA Unspecified injury of left wrist, hand and finger(s), initial encounter
	Right wrist	S69.91XA	S69.91XA Unspecified injury of right wrist, hand and finger(s), initial encounter
	HAND INJURY		
	Left hand	S69.92XA	S69.92XA Unspecified injury of left wrist, hand and finger(s), initial encounter
	Right hand	S69.91XA	S69.91XA Unspecified injury of right wrist, hand and finger(s), initial encounter
	FINGER INJURY		
	On left hand	S69.92XA	S69.92XA Unspecified injury of left wrist, hand and finger(s), initial encounter
	On Right hand	S69.91XA	S69.91XA Unspecified injury of right wrist, hand and finger(s), initial encounter
	ELBOW INJURY		
	Left elbow	S59.902A	S59.902A Unspecified injury of left elbow, initial encounter
	Right elbow	S59.901A	S59.901A Unspecified injury of right elbow, initial encounter
	INJURY OF CLAVICLE		
	Left clavicle	S49.92XA	S49.92XA Unspecified injury of left shoulder and upper arm, initial encounter
	Right clavicle	S49.91XA	S49.91XA Unspecified injury of right shoulder and upper arm, initial encounter

URINE MACRO			
	DYSURIA	R30.0	R30.0 Dysuria
	FREQUENCY	R35.0	R35.0 Frequency of micturition
	URGENCY OF URINATION	R39.15	R39.15 Urgency of urination
	HEMATURIA	R31.9	R31.9 Hematuria, unspecified
	BACK PAIN	M54.9	M54.9 Dorsalgia, unspecified
	NAUSEA	R11.0	R11.0 Nausea
	NAUSEA AND VOMITING	R11.2	R11.2 Nausea with vomiting, unspecified
	ABDOMINAL PAIN	R10.9	R10.9 Unspecified abdominal pain
	ACUTE PAIN IN FEMALE PELVIS	N94.9	N94.9 Unspecified condition associated with female genital organs and menstrual cycle
URINE HCG			
	ABDOMINAL PAIN	R10.9	R10.9 Unspecified abdominal pain
	ACUTE PAIN IN FEMALE PELVIS	N94.9	N94.9 Unspecified condition associated with female genital organs and menstrual cycle
	BACK PAIN	M54.9	M54.9 Dorsalgia, unspecified
	DYSURIA	R30.0	R30.0 Dysuria
	FREQUENCY	R35.0	R35.0 Frequency of micturition
	HEMATURIA	R31.9	R31.9 Hematuria, unspecified
	MISSED PERIOD	N92.6	N92.6 Irregular menstruation, unspecified
	NAUSEA	R11.0	R11.0 Nausea
	NAUSEA & VOMITING	R11.2	R11.2 Nausea with vomiting, unspecified
	UNCONFIRMED PREGNANCY	Z32.00	Z32.00 Encounter for pregnancy test, result unknown
	URGENCY OF URINATION	R39.15	R39.15 Urgency of urination
	VAGINAL BLEEDING	N93.9	N93.9 Abnormal uterine and vaginal bleeding, unspecified
RAPID STREP			
	FEVER	R50.9	R50.9 Fever, unspecified
	SORE THROAT	J02.9	J02.9 Acute pharyngitis, unspecified
FINGERSTICK GLUCOSE			
	DIABETES MELLITUS	E11.9	E11.9 Type 2 diabetes mellitus without complications
	ALTERED MENTAL STATUS	R41.82	R41.82 Altered mental status, unspecified
	POLYURIA	R35.8	R35.8 Other polyuria
	EXCESSIVE THIRST	R63.1	R63.1 Polydipsia
	FATIGUE	R53.83	R53.83 Other fatigue
	HYPERGLYCEMIA	R73.9	R73.9 Hyperglycemia, unspecified
	LIGHTHEADEDNESS	R42	R42 Dizziness and giddiness

Attachments

A: SRS Urgent Care Department Standardized Procedures

B: EHR Problem Grid

Diphenhydramine IM.pdf

Epinephrine Autoinjector.pdf

Epinephrine IM Administration.pdf

Epinephrine IM Administration.pdf

Image 05

MD Signature 6.30.22

Approval Signatures

Step Description	Approver	Date
Site Administrator	Karen Whitten: Policy & Procedure Coord	7/7/2022
Regulatory	Anais Beltran: Regulatory Comp Coord-SRS	7/1/2022
Editor	Cheri Pope: Dir Urgent Care & Occ Med-SRS	6/30/2022
	Abigail Arvizu: Mgr Urgent Care-Clinical-SRS	6/27/2022

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