MONTANA STATE PRISON
HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS E-08.0	Subject: **Nursing Assessment Protocols and Procedures**
Reference: NCCHC Standard P-E-08, 2018	Page 1 of 2 and no attachments
Effective Date: November 1, 2010	Revised: December 30, 2021
Signature / Title: /s/ Cindy Hiner / Medical Bureau Chief	
Signature /Title: /s/ Paul Rees/ Medical Director	

I. Purpose:

To define the procedure to be used by all nursing staff in completing nursing protocols.

II. Definitions: none

III. Procedure:

A. Nursing protocols must be appropriate to the level of competency and preparation of the nurses who carry them out.
   1. Protocols and procedures are developed and reviewed annually by the Clinical Services Manager responsible physician based on the level of care provided in the facility.
   2. Protocols and procedures must be available to all nursing staff.
   3. Documentation of nurses' training in the use of nursing assessment protocols and nursing procedures based on the level of car provided by the nurse to include:
      a. Evidence new nursing staff are trained and demonstrate knowledge and competency for the protocols and procedures that are applicable to their scope of practice.
      b. Evidence annual review of competency
      c. Evidence of retraining when protocols or procedures that are introduced or revised.

B. All nurses who assess patients based upon submission of a health care request are to complete a nursing protocol based on the assessment.
   1. Assessments are essential in providing continuity of care and help ensure nursing staff gather enough data to support their nursing plan.
   2. The importance of using the protocol at the visit cannot be overemphasized (a poorly documented record could indicate that the nurse did not see the patient or did not have the protocol at the visit and completed it at a later time and/or date).

C. Steps:
   1. Choose the nursing protocol based on the chief complaint, not a diagnosis. All protocols need to be completed and will include the following:
      a. Patient data: include name, ID/AO number, age, allergies, and current meds. If the patient cannot list his meds.
      b. Subjective: enter any information the patient gives you. It they say it, document it. If the patient is too unstable to give a complete history, indicate the reason why (e.g., "Subjective data limited by clinical condition-decreased LOC").
      c. Objective: enter your observations. If you see it, document it. Use blank lines to

record pertinent information to patient's care. The protocol is not intended to replace your clinical judgment. If it isn't on the protocol it doesn't mean you can't add it.

d. Assessment Decision: check the choice for referral. If subjective and objective data support referral be sure you add a Medical Provider appointment type. If you think a referral is not appropriate, yet the protocol states referral required, document a consult with the Infirmary RN or a provider, and determine why a referral is not being made.

e. Plan: protocols are standing orders. Protocols allow the nurse to follow the orders just as if written by a provider. If something is not included in the plan (certain meds, treatments, etc) do not initiate unless receiving a physician order.

f. Protocols used for nonemergent health care requests include standing orders for over-the counter medications only.

g. Protocols pertaining to emergency life-threatening conditions (e.g., chest pain, shortness of breath) may contain prescription medications and must include immediate communication with a provider.

h. Emergency administration of prescription medication requires a provider's order before or immediately after administration.

i. Nurse's Signature and date.

2. Marking the protocols.
   a. Complete all areas of the electronic protocol. Check all boxes that apply and document in all test boxes as appropriate.

3. Be prepared to jump to different areas of the protocol during the assessment. The patient may not follow the same order as the protocol does.

4. Be sure to check the "complete" box in the upper right-hand corner of the electronic nursing protocol in order to preserve it in the inmate's electronic health record.

D. Review:
   1. The nurse who completed the medical kite and protocol will place it in the "scheduled to be seen" mailing basket (the same basket medical kites are placed).
   2. A Clinical Services Manager will periodically review the HCR Sick Call cue to assess protocol completeness.
   3. If the manager finds inconsistencies, incompleteness, inappropriateness, or any other issue, he/she will talk to the nurse who completed the protocol as soon as possible to correct the problem.

IV. Closing

Questions concerning this operational procedure will be directed to the Clinical Services Manager.

V. Attachments

None