MONTANA STATE PRISON
OPERATIONAL PROCEDURE

Procedure:	**MSP HS E-08.0 NURSING ASSESSMENT PROTOCOLS**
Effective Date:	11/01/2010 Page 1 of 2
Revision Date(s):	12/30/2021; 06/30/2026
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I. PURPOSE

Define the processes to be used by all nursing staff in completing nursing protocols.

II. DEFINITIONS (see Glossary)

III. GENERAL REQUIREMENTS

A. Nursing Protocols

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

B. Health Care Requests

1. All nurses who assess patients based upon submission of a health care request (HCR) are to complete a nursing protocol based on the assessment.
2. Assessments are essential in:
   a. providing continuity of care; and
   b. helping ensure nursing staff gather enough data to support their nursing plan.
3. The importance of using the protocol at the visit cannot be overemphasized
   a. 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. The nursing protocol must be chosen based on the chief complaint, not a diagnosis. All protocols need to be completed and will include the following requirements for nurses:
   a. Patient data: Include name, DOC ID number, age, allergies, and current meds, if the patient cannot list the patient's meds.
   b. Subjective: Enter any information the patient provides. If the patient says it, document it. If the patient is too unstable to give a complete history, indicate the reason why (for example, "Subjective data limited by clinical condition-decreased LOC").
   c. Objective: Enter observations. If you see it, document it. Use blank lines to record pertinent information about patient's care. The protocol is not intended to replace clinical judgment. Even if it is not on the protocol, it does not mean it cannot be added.
   d. Assessment Decision: Check the choice for referral. If subjective and objective data support referral, add a Medical Provider appointment type. If nurse thinks a referral is not appropriate, yet the protocol states referral required, nurse documents a consult with the Infirmary RN or a provider, and determines 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.), the nurse does not initiate unless the nurse receives a physician's order.
   f. Protocols used for nonemergent health care requests include standing orders for over-the-counter medications only.
   g. Protocol medications will be automatically placed on the Electronic Medication Administration Record (EMAR) and the nurse must go to EMAR and document administration of the medications. If the stock medication is to be administered Keep On Person (KOP), nurse must click "administer KOP" and then put the number of pills or items issued in the comment box.
   h. Protocols pertaining to emergency life-threatening conditions (for example, chest pain, shortness of breath) may contain prescription medications and must include immediate communication with a provider.
   i. Emergency administration of prescription medication requires a provider's order before or immediately after administration.
   j. If the inmate is seen urgent or emergent, nurse must check box at the top of the protocol.

2. Marking the protocols:
   a. Nurse must complete all areas of the electronic protocol, check all boxes that apply, and document in all test boxes as appropriate.
   b. Nurse must be prepared to shift to different areas of the protocol during the assessment. The patient may not follow the same order as the protocol does.
   c. Nurse must 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 (EHR).

D. Review

1. The nurse who completed the medical kite and protocol will schedule any follow up appointment while completing the protocol. If the inmate needs to be seen ASAP, the nurse should schedule an HCR Sick Call priority appointment for the next clinic day.

2. The MSP Health Services Manager will periodically review the HCR Sick Call Queue to assess protocol completeness.
   a. If inconsistencies, incompleteness, inappropriateness, or any other issue is found, the Health Services Manager will talk to the nurse who completed the protocol as soon as possible to correct the problem.

IV. CLOSING

Questions about this procedure should be directed to the Medical Health Services Manager.