Florida Department of Health Brain and Spinal Cord Injury Acute Care Nursing Standards

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Nurse Surveyor

Standard 1.6

- Brain and spinal cord injury nursing practice is based on specialized knowledge and clinical skills necessary to care for persons with brain and/or spinal cord injury.

Standard 1.6 cont.

- A. Registered nurses providing care for the persons with brain or spinal cord injury will receive a minimum of 5 contact hours of education per year in each specific area relating to the care of persons with brain or spinal cord injury.

Standard 1.6 cont.

- B. Inservices or continuing education for all nurses caring for persons with the brain or spinal cord injury is provided annually to inform them about new knowledge, research and clinical procedures in reference to neuroscience practice, and pediatrics where appropriate

How to determine compliance

- Prior to survey, the facility to be designated sends a copy of their program to the surveyors. This will be reviewed PRIOR to site visit.
- During site visit, the surveyor can request to view the original rosters and course outline of educational material
- If trauma and BSCI survey are done in collaboration, the trauma surveyor reviews this material

Standard 1.7

- The collection of data about the health status of the individual is systematic and continuous. The data is accessible, communicated and recorded by the interdisciplinary health care team concerned with the patient

Standard 1.7

- A. Health status data includes
    1. Physical assessment and interview
    2. Clinical assessment of neurological status
    3. Assessment of developmental status
    4. Cultural needs assessment
    5. Pain assessment and management

1.7 cont.

- B. Continuous collection of data is evidence by frequent updating of Nursing Care Plans and/or Nursing Progress Notes

How to assess compliance

- Initial nursing interview and assessment
- Patient Care Record

Standard 1.8

- Nursing diagnoses/problems are derived from health status data as this is the basis for determining the nursing care needs. This data is analysed and compared to the norms when possible

Standard 1.8

- A. The individual's neurological deficits, capabilities and limitations are identified
- B. The nursing diagnoses/problems are consistent with the diagnoses of all other professionals caring for the patient.

How to determine compliance

- Initial nursing interview and assessment
- Daily patient care nursing documentation record
- Patient Care Plan or Clinical Pathway
- Interdisciplinary progress notes

Standard 1.9

- The plan of nursing care includes goals/outcomes derived from the nursing diagnoses/problems

Standard 1.9

- Goals/ Outcomes are established to maximize functional capabilities:
  1. These are congruent with other planned therapies
  2. These are stated in realistic and measurable terms
  3. These are assigned a time period for achievement
  4. The patient and/or Significant other are involved, when possible, on an ongoing basis in goal development health promotion, maintenance and restoration
  5. These are designed to prevent secondary conditions

How to determine compliance

- Review of patient care record
- Review of patient care plan and/or clinical pathway

Standard 1.10

- Brain and spinal cord injury nursing practice is characterized by recognizing each patient and family as an individual whose unique response to injury will influence care and progress. The plan of nursing care is individualized to each patient to include priorities and prescribed nursing actions that achieve the goal/outcomes derived from the nursing diagnoses and problems

Standard 1.10

- A. Consideration is given to the pre-injury biophysical status of each patient when establishing goals/outcomes.

  1. Professional goals/outcomes are individualized to each patient and family unit consistent with the patient and family goals.

  2. The right of the patient to choose limited goals is accepted, whenever possible.

1.10 cont.

- 3. Physiological measured are planned to prevent or control specific patient problems and secondary conditions such as indicated:
  - a. Skin Integrity
  - b. Nutrition, hydration
  - c. Elimination-bladder/bowel progress
  - d. Respiratory, ventilator function
  - e. Circulatory status, prevention of venous stasis
  - f. Prevention or minimization of infection, ie. repiratory, urinary and especially central nervous system
  - g. Musculoskeletal system-prevention of contractures
  - h. Secondary insults to the nervous system
  - i. Spinal Shock
  - j. Autonomic dysreflexia
  - k. Pain Assessment and management

1.10 cont.

- 4. Psychological measures are planned to prevent or control specific patient/family problems as appropriate:
  - a. Grief process
  - b. Neurological deficits
  - c. Financial concerns
  - d. Family participation in care
  - e. Privacy needs
  - f. Communication skills
  - g. Behavioral recognition/management
  - h. Altered status
  - i. Developmental issues
  - j. Community reintegration
  - k. Cultural issues and needs

How to determine compliance

- Interdisciplinary progress notes to include nursing, physician, social services, psychologist, dietician, etc.

Standard 1.11

- Brain and spinal cord injury nursing practice and actions are characterized by an ongoing teaching/learning experience for the patient and family in conjunction with all members of the health team. Nursing actions assist the patient to maximize health capabilities

1.11 cont.

- 1. Nursing actions are:
  - a. Consistent with the medical plan of care
  - b. Individualized to specific problems
  - c. Provide a save, therapeutic environment
  - d. Involve teaching/learning opportunities
  - e. Utilize appropriate learning resources to expand the patient and/or family's knowledge about the nature of the injury, therapeutic regimen and prevention of secondary complication

1.11 cont.

- B. Nursing actions are based upon an assessment of the patient’s and family biopsychosocial strengths, resources and problems as identified in the Nursing Plan of Care and daily progress notes

How to determine compliance

- Review the interdisciplinary plan of care and progress notes
- Review the daily nursing progress notes
- Review the critical pathway or care plan for problem identification
- Review the educational record for patient and family involvement

Standard 1.12

- The patients status toward goal achievement requires continuing assessment, evaluation of priorities, establishment of new goals, and the revision of the nursing plan of care. This is to assure that the plan of care is continually reviewed and updated to reflect changes in the patient/family status.

1.12 cont.

- A. The degree of goal/outcome achievement is evaluated and reassessed continually
- B. New goals/outcomes and approaches are developed by nursing staff with patient and family input in coordination with the interdisciplinary team

How to determine compliance

- Review of the daily nursing progress record
- Review of the interdisciplinary progress records
- Review the educational records by both the nursing and interdisciplinary staff to demonstrate reevaluation and new goal setting

Standard 1.13

- Nursing practice is directed toward discharge planning by the integration of care with family members and other members of the health care team for the patient's successful transfer to home, a rehabilitation facility, or other institution to determine if the patient and family are prepared for rehabilitation efforts and the transition from the acute care setting to these areas.

1.12 cont.

- A. Discharge planning efforts, when appropriate are implemented on admission to the acute care facility along with the initiation and evaluation of funding resources. Admission rehabilitation plan will be established and charted within 7 days.

- B. Nursing staff work in conjunction with patient/family and other members of the health team and community agencies to facilitate acute care, rehabilitation and discharge planning

How to determine compliance

- The discharge plan should be evident early in the hospital stay by documentation by social services and/or case management. Interdisciplinary team progress notes should reflect ongoing discharge needs and plan with discharge destination evident in planning process

Standard 1.14

- Nurse practice facilitates community awareness of persons with brain and spinal cord injury as it is important to reduce the incidence of injury and to promote prevention and proper emergency handling of these patients

1.14 cont.

- A. The nursing staff participates in community awareness, prevention of brain and spinal cord injury, lessening of disability and cost containment and first aid/handling of persons with a brain or spinal cord injury by any of the following:

1.14 cont.

- 1. Community, group lectures and in-services.
- 2. Participation in community planning boards and coalitions.
- 3. Encouraging media coverage and public service announcements
- 4. Brain and spinal cord injury prevention programs
- 5. Involvement with other community preventions groups
- 6. Involvement with public and private school systems

How to determine compliance

- The facility to be designated will have provided information related to community awareness and education in their pre-survey plan sent to the surveyors. This will be reviewed PRIOR to the site visit
- Upon site visit, the BSCI surveyor will review this plan with the facility