EP16
Nurse autonomy is supported and promoted through the organizations governance structure for shared decision-making.

Provide one example with supporting evidence of clinical autonomy that demonstrates the authority and freedom of nurses to make nursing care decisions (within the full scope of their practice) in the clinical care of patients.

Provide one example with supporting evidence of organizational autonomy that demonstrates the authority and freedom of nurses to be involved in broader unit, service line, organization, or system decision-making process pertaining to patient care, policies and procedures or work environment.

Example #1
Clinical Autonomy: Medical Emergency Team Utilizes Standardized Procedures

Nurses are encouraged and expected to provide patient care to the full scope of their nursing practice in all patient care areas at SJO. This includes autonomous decision making guided and supported by clinical policies and procedures that are based on best practice and professional guidelines. The RN job description is the foundation that sets expectations to promote nursing autonomy.

One example of nurses’ clinical autonomy that demonstrates their authority and freedom to make nursing assessments and treatment care decisions is the immediate intervention for patients in distress.

SJO clinical nurses utilize standardized procedures (STP) to extend the RN’s scope of practice in particular situations. These STPs allow nurses to assess, make an informed decision based on the guideline within the STP and address changes in patient status immediately prior to communicating with the physician.

The Scope of Practice for RNs and physicians can overlap, requiring standardized procedures. For RNs this includes independent functions, dependent functions and interdependent functions. The Medical Emergency Team (MET) RNs, our Rapid Response Nurses, provide examples of each of these functions.

Independent functions are those activities of normal nursing practice, nursing care, hygiene, comfort and disease prevention. Assessment; monitoring reactions to treatments; and reporting, referring and initiating emergency procedures are all part of independent nursing functions and the responsibility of the RN.

Dependent functions include patient care and administration of medications and treatments that have been ordered within the scope of practice of the provider (MD, PA, NP, etc.).
Interdependent functions include implementation of appropriate standardized procedures after assessment of symptoms. These standardized procedures overlap with the practice of medicine and are written within the guidelines of the California Board of Registered Nursing.

**EP16.1.1 CA BRN Scope of RN Practice Including Standardized Procedures**

The MET team is designed to provide an additional level of safety for hospitalized patients. This is accomplished by dedicating resources and streamlining processes that allow the clinical nurse autonomy and freedom to make nursing care decisions so the highest level of care will be provided.

The MET clinical nurse functions under the STP Emergency Guidelines that allows her/him to function and make decisions to the full extent of nursing practice.

**Full scope of practice**

Emergency STPs by critical care nurses are utilized to immediately address and stabilize the clinical deterioration of a patient. Patients with critical changes in clinical status on the medical surgical floors are flagged by the MET high alert report, MET RN proactive rounding and by communication from the clinical nurse.

**STP-915 Emergency Guidelines**: The MET nurse is able to execute emergency interventions throughout the hospital for patients in cardiac and/or respiratory distress. The MET RN may initiate labs, diagnostics, emergency medications and additional monitoring depending on the patient’s emergent conditions, prior to transfer to a higher level of care. Emergency conditions covered include: respiratory distress, chest pain, hypotension, bradycardia, sustained monomorphic ventricular tachycardia and cardiac arrest.

**EP16.1.2 Standardized Procedure Emergency Guidelines**

The MET role demonstrates the autonomy and freedom of the clinical nurse to address a variety of patient situations, coordinate care, recommend treatment, and provide high levels of care to function within the full scope of their practice.

**Clinical nurses make nursing care decisions**

An example of clinical nurse autonomy and freedom to make nursing care decisions involves Ray Anne Chung, BSN, RN, CN III. On June 29, 2015 Ray Anne was assigned as the MET nurse for the day. She received a call from Summer Cortinas, AD, RN, CN II, from the Medical Telemetry unit to assess C.W., a patient who had difficulty breathing (independent function). C.W. was admitted a few days prior with a diagnosis of new onset congestive heart failure and atrial fibrillation. C.W. had a history of emphysema and chronic obstructive pulmonary disease.

The Medical Telemetry nurse was concerned because C.W. was becoming drowsy, not as arousable as she had been earlier in the shift, and her pulse oxygenation saturation
had dropped down into the 80s. Ray Anne entered the room and assessed C.W. Her breaths were shallow and her lung sounds were diminished. C.W.’s oxygen saturations again dropped to the 80s, so the bedside nurse assisted Ray Anne in placing C.W. on a simple mask at 6 liters/minute oxygen (interdependent function based on STP).

With the increased oxygen, her saturations improved. Ray Anne then initiated Emergency Guidelines again and ordered a STAT chest X-ray and arterial blood gases (ABGs).

C.W.’s vital signs were stable and she was arousable at times without respiratory distress. However, her ABGs turned out to be abnormal with a pH 7.26 and her pCO2 was 98. She was in respiratory acidosis. Ray Anne then notified the intensivist of the results and obtained orders for further treatment (dependent function). She consulted with the respiratory therapist to set up the BiPap machine, and then assisted the Medical Telemetry RN and Respiratory Therapist to transfer C.W. to the Definitive Step-Down Unit. C.W.’s condition improved on BiPap becoming more alert and responding to questions.

EP16.1.3 MET RN Documentation ABG Results
EP16.1.4 MET RN Documentation Evidence of Clinical Autonomy

This example illustrates the clinical nurses’ autonomy, authority and freedom to make nursing care decisions within the full scope of their practice, which in this case involved ordering diagnostic tests, instituting treatment and transferring the patient to a higher level of care, thus averting a respiratory arrest and the need for mechanical ventilation.

Example #2
Organizational Autonomy: Clinical Nurses Develop Code White Policy and Carts

Nurses’ autonomy occurs through membership and participation in the nursing Shared Governance structure. Within the Nursing Professional Practice Model, nurses are empowered to join and participate in a council or workgroup in which they have interest and/or expertise. Nurses participate in organizational-wide changes through this structure making decisions and changes that impact patient care.

The Code Blue workgroup is a multidisciplinary team of nurses, physicians, respiratory therapists, pharmacists, quality management, and support personnel such as purchasing. The team meets bimonthly and is chaired by Soudi Bogert, BSN, RN, CCRN, and Elizabeth Winokur, PhD, RN, CEN. Additional nursing membership includes clinical nurses from the Emergency Care Center (ECC), Critical Care (CC) and clinical nurse educators. The goal for this workgroup is to provide a mechanism that ensures resuscitation processes meet quality and regulatory standards with a focus on patient safety. The scope of work involves patients, families, all healthcare team members and hospital staff involved in emergency response teams, processes and events.
One of the group’s major functions is to optimize response to resuscitation and other emergency situations by ensuring consistency in practice. In the workgroup’s meetings factors related to all emergency response teams are routinely discussed, reviewed and analyzed for compliance. Outcomes are evaluated and processes are developed to address identified opportunities to improve care.

**Clinical nurses involved in organizational decision making process**

In 2013 SJO separated services from CHOC Children’s (Children’s Hospital of Orange County), a pediatric facility. The two facilities shared many services including emergency services, surgical services and cardiac catheterization laboratory. With the separation came many challenges including restructuring the shared emergency response between the two facilities. SJO ECC clinical nurses, physicians, and a pharmacist provided the code blue (adult cardiopulmonary arrest) and adult rapid response teams for CHOC.

CHOC augmented SJO ECC response to code white (pediatric/neonatal resuscitation) by providing physician, nursing and respiratory therapy response. Code blue carts in both facilities were owned and maintained by SJO, while Code white carts located in both facilities were owned and maintained by CHOC. Chairpersons from each facility attended the other facility’s Code Committee workgroup meetings. With this separation, a plan needed to be developed and implemented to respond to resuscitation and other rapid response emergencies for pediatric patients occurring within SJO without equipment and personnel from CHOC.

Beginning in July 2012 the Code Blue Workgroup developed an outline of the processes and equipment affected by the separation of the facilities. Workgroup clinical nurses, Elizabeth Winokur; Soudi Bogert; Cyndi Morton, MSN, RNC-OB; Kathy Dureault, MSN, RN, CPAN; Vivian Norman, MSN, RN, CCRN; Sharon Kleinheinz MSN, RN, CNOR; Leon Vong, BSN, RN, CEN, CN III; and Amy Waunch, MSN, RN, CEN, worked together to identify gaps and to develop strategies to manage each. Identified areas included policy and procedures, equipment, Code White team membership, and training needs.

**EP16.2.1 Code Blue Meeting Minutes – July 2012**

Clinical policies guide clinical nurses’ autonomous decision making in patient care. One example of nurses’ clinical autonomy that demonstrates their authority and freedom to make decisions pertaining to patient care is in the development of SJO responses to a Code White. A subcommittee of the workgroup, Cyndi, Sharon, Kathy, and Elizabeth met on several occasions to separate the combined code blue and code white policies. Drafts of the new policies were presented to the Code Blue Workgroup for approval as the first step in the normal hospital approval process. Policy was approved in April 2013.

**EP16.2.2 PC-332 Code White Response-Pediatric**
Another example of clinical nurses’ autonomous decision making pertaining to patient care is the development of a new code white cart. Code Blue Workgroup chairs Soudi and Elizabeth, in conjunction with Scott Seto from Pharmacy and Anthony Sanchez from Central Supply worked to acquire, determine appropriate contents for, and stock new code white carts. The workgroup decided on locations where the carts would be stored throughout the facility. Soudi partnered with CHOC nurses from CHOC’s Code White committee to review and evaluate their code white cart contents and input was sought regarding the needs of the pediatric populations that would continue to receive care at SJO. While most items in the CHOC code white carts were necessary for an effective pediatric resuscitation, the SJO nurses discovered that some items catered to specialty populations that only CHOC would encounter; these items were removed. The review highlighted some previously unidentified gaps, including the need for a drug dosage guideline for cart inclusion. This item was brought by Elizabeth to Scott Seto, the pharmacist member of the workgroup for development and implementation. Cart final contents were reviewed by team nurses and presented to the entire workgroup.

**EP16.2.3 Code Blue Meeting Minutes - November 2012**

Training needs were identified by the workgroup. An additional code white cart was acquired for training purposes. The cart was used by the clinical educators who had staff who provided care to pediatric patients and/or responded to a code white. Review of the new code white cart was also accomplished during 2013 skill days pediatric scenarios. Policy updates and review were included in the bimonthly clinical education newsletter as well as in the annual education manual.

Recognizing an organizational need the Code Blue Workgroup nurses’ proactively and autonomously assessed the issues, developed an organizational-wide plan, and implemented a process to provide emergency care to pediatric patients that was safe, consistent and compliant with all pediatric care standards.