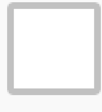
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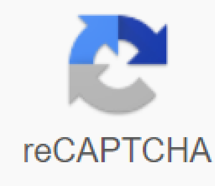

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Emergency department policy and procedure manual

1 Emergency Medicine Policy and Procedures Guide UPDATE: July 27, 2009 All recent entries in this guide with New zealand in bookmarking. The policy guide may have been updated, revised or supplemented. They will be marked new for up to 6 months after adding 2 Table Content I. PREFACE ... 5 II. Mission... 6 III. 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ADDITIONAL REFERENCE GUIDES PREFACE 1. Guide to the Department of Emergency Management's Care Protocol 2. Safety Guide 3. UNC Guidelines on Policies and Procedures in Hospitals 4. UNC Hospitals Nursing Department Nursing Standards Guide 5. UNC Hospital Care Procedure Guide 6. Disaster Plans Guide 7. Charters, rules and regulations of medical personnel 8. Infection Control Guide 9. Poisindex 10. Injury Protocols Guide 11. Carolina Air Care Guide 12. The Hospital and University Staff Guidance This guide is designed as a guide for the medical, nursing and administrative staff of the emergency department of the University of North Carolina Hospitals. The information contained in this guide was collected by the Office of Emergency Medicine and Medical Management and approved by the Chairman of the Department of Emergency Medicine. Full guide review: October 1978 October 1985 February, 1995 June, 2001 November, 1979 November, 1986 February, 1996 September, 2003 November, 1980 March, 1992 January, 1997 November, 1982, January 1993, January 1993, January 1993 1998, 1998, October, 1983 January, 1994 January, 1999 Judith E. Tintinalli, MD, MS Chair Brian Goldstein, MD Chief of Staff Sandy Pathers, RN, CNS II Department Of Nurse Manager Ed Jackham, MBA Department Administrator James L. Larson, MD Associate Professor Clinical Director Jeff Strickler, RN, MA Administrative Director of the Department of Emergency Situations and Carolina Air Care 5 Updated September 27, 2006 II. MISSION STATEMENT Emergency is a private practice site for emergencies That is why we depend on good relationships with the University, UNC health systems, community doctors and citizens in our communities for successful practices. To function as an integral and responsible member of the University of North Carolina, The Division of Health, Medical School and Hospitals of the University of North Carolina. Provide patient care, care for doctors, community, region and state. Teach the principles and practices of medicine and emergency medicine to medical professionals, students and home officers of all specialties, including residents of emergency medicine. Provide referrals to the Orange county and state emergency services. To become an influence in local, state and national emergency medicine academic and political activities. To carry out research in clinical care, basic sciences and health systems, both in emergency medicine and in interdisciplinary fields. Produce national academic leaders in the field of emergency medicine. Judith E. Tintinally, MD, MS Chairman Dexter Morris, Ph.D., MD Vice Chairman Sandy Pabers, RN, CNS Revised: 7 / Updated September 27, 2006 7 III. KEY POLICIES 7 Updated September 27, 2006 8 ACTIVATION TRAUMATOLOGY UNIVERSITY NORTHERN CAROLINA HOSPITAL LEVEL 1 TRAUMA CENTER Date 08/21/03 Review 09/01/99 08/01/97 05/0 5/2 28/96 Date 08/21/03 Review 09/01/99 08/01/97 05/28/96 Origin Date: January 1, 1991 Policy Section No, Section II Page 1 of 3 Description: Purpose: Procedure: Activation Of Traumatology System Should Be started prior to the arrival of the injured patient in the emergency room (ED) by ED staff. The Pediatric Trauma Group will be called for patients under the age of 16 and an adult trauma team for patients 16 years of age and others. Notify and mobilize the trauma team based on the physiological and anatomical criteria of the injured patient, as reported by pre-hospital or emergency personnel. Injury activation should be initiated on the basis of the criteria of the trauma-level system listed below: I. CRITERIA FOR SYSTEM INJURY SYSTEM ACTIVATION SYSTEM TO ensure that affected patients receive appropriate care, the following criteria should direct health care professionals in the provision of traumatology. Criteria for Injury Red Alert Activation Respiratory Pathway Compromise /Respiratory Distress / Intubated Trauma Patients Unconscious/Decreased Consciousness (Indicator May Include GCS 8) Shock (indicators may include clinical signs of hemodynamic instability, RTS No. 8) Spinal Cord Injury Crush Chest Injury, Abdomen and/or Pelvic Amputation or Degloving Proxy Note: Red Anxiety injury should be activated based on physiological instability. If the patient's condition is uncertain; The Charge Nurse or ED Visit should initiate the trauma of Red Alert. Special precautions: pediatric and geriatric geriatric Initiate Injury Read Alerts if unsure of the patient's condition at any time. Injury Red Alert for Inter-Hospital Patient Transfer Criteria: Multi-system injured patients who need surgery upon arrival at the Trauma Center Gemodynamically Unstable Patients Change in Neuro Status Criteria for Injury Yellow Alert Activation RTS Updated September 27, 2006 9 GCS 9-14 Pedestrian struck with RTS No 9. MVC with ejection, rollover, death of another person at the scene with RTS No. 9. Injuries with deformities are marked up to two or more long bone fractures. Grinding, amputation or de-icing of dystal injuries to the elbow or knee. Special note: Yellow injury should be started based on the mechanism of injury and RTS/GCS in the physiological stable patient. Criteria for Injury Green (NO ALERT ACTIVIATION COMPUTER VIA COMPUTER IS NECESSARY) Hemodynamically Stable GCS 15 RTS 12 Falls More, Than 20 feet with GCS 15 or RTS 12 Patient travels at speeds of more than 40 mph with GCS 15 or RTS 12 No obvious deformities classified as green ems tag or transfer agent II. RESPONSIBILITY FOR ACTIVIATION OF A TRAUMA ALERT Prior to the arrival of a patient in ED Nurse charge activates the injury flushing system with a goal 15 minutes prior to the arrival of the patient. If significant (more than 15 minutes) the nurse-charger notifies ED Attending about the number of patients, the type of injury and the calculation of arrival time. ED Visitation must notify the home surgery residents. Activate while the patient in ED If the patient's status changes, the nurse charge activates the paging injury system and document updating or downgrading status on injury streams. III. SYSTEM TRAUMA ACTIVATION NOTIFIES THE FOLLOWING TRAUMA TEAM MEMBERS: TRAUMA RED ALERT TEAM MEMBERS Red members of the Red Special Trauma Team attending pediatric surgery, Visiting Anesthesiologist on call pediatric surgery Chief Resident on Call Trauma Surgery Chief Resident on Call Pediatric Surgery Resident Trauma Resident Surgery Visit Radilogy, CT Scan OB Chief Resident critical care Bed Commander PICU Charge Nurse Respiratory Therapy Critical Care Supervisor/Home Reception Services Trauma Program Clinical Director Of Trauma Chaplain 9 Updated September 27, 2006 10 Doctor Response Trauma Resident (PGY4 or above) will be present at ED until the patient arrives or within 20 minutes of notification. ED Visitation will be in charge before a trauma resident (PGY4 or above) arrives. Injury Participation will respond in 20 minutes after activation. Doctors are expected to sign the Injury List to be prosecuted. The primary nurse will record all other team teams TRAUMA YELLOW ALERT TEAM MEMBERS Yellow Team Members of the Yellow Specialty Team members attending pediatric surgery attending emergency medicine resident pediatric surgery resident Respiratory Surgery Burn Surgery Attend Radiology, CT Scan OB Chief Resident Critical Care Program Manager of the Clinical Program Program Yellow Specialty Team members will be activated by the Emergency Medicine Department of Nurses when the injury includes their specialty. Special note: The Trauma Service should consult for all patients with yellow alert injuries who are hospitalized before going to the operating room. The trauma team will receive an alert page, but will not respond to a yellow alert until ED Attending is called. TRAUMA GREEN TEAM MEMBERS Green Team Members Green Team Specialty Members of Emergency Medicine Attend Emergency Medicine Resident Traumatology Resident Traumatology Resident Department of Emergency Medical Surgery Staff Pediatric Surgery Attend Pediatric Surgery Resident Burn Surgery Visit OB Chief Resident's Green Team Specialty Members will be consulted as needed em Visit. 10 Updated September 27, 2006 11 CRITICAL ED STATUS 11 Updated Sept. 27, 2006 12 12 Updated September 27, 2006 13 CRITICAL STATUS BED PROCEDURE UNC HOSPITALS POLICY This is a policy by the University of North Carolina Hospital to provide a systematic method for identifying critical bed status to ensure that beds are properly used during critical bed status, and to minimize denial of transfer from facilities during periods of critical bed status. Procedure House Nursing Supervision reports the condition of the beds for emergency room doctors every day at the beginning of the afternoon shift. When critical bed status is achieved, potentially affecting transfers, the hospital administrator on call will also be notified by the head of the nursing home and critical units identified. II. Ill. IV. The head of the nursing home will call the attending physician on call to the ward and ask the attending physician to review the beds in his/her unit. Periodic reassessment will continue approximately every four hours during the critical condition of the bed. During a critical bed condition, requests for emergency transfers will be determined on a case-by-case basis, in accordance with federal law (Emergency Medical Treatment and Active Labor Act-EMTALA). The attending ambulance will discuss potential transfers with both the nursing home manager and the responsible call teacher before refusing the transfer. beds and the inability to provide in any way for its placement must be fully documented. Individual services will notify the Nursing Home when their units reach critical bed status or critical bed status is unavoidable. HEALTH Executive Committee OF RESPONSIBLE UNIT UNIT and revised as needed: 4/99 9/00 12/01 13 Updated September 27, 2006 14 ED ACCESS AND GOOD FROM OTHER HOSPITALS Emergency Department at UNC Hospitals supports access to patients in our EMS catchment area and Carolina Air Care scene calls. The following policy requirements must be complied with in accordance with the federal law on accepting transfers. Transfers of injuries from other emergency departments can only be redirected with injury approval, attending the call, and the chief of staff. Admission or refusal to transfer other types of patients from other emergency departments is determined by the attending physician. Such decisions are based on the best information available from a variety of sources, including the patient's medical needs; OR, ICU, and floor bed capabilities and care resources; and beds and care resources in ED. Transfers from inpatient beds in other hospitals to UNC inpatient beds may be accepted or denied only to the visit responsible for the service. Judith E. Tintinally, M.D., M.S. Professor and Head of the Department of Emergency Medicine, 2001, on 2 July 2001, approved by the UNC Medical Hospital Executive Committee, replaces the Department of Emergency Medicine Policy, originally written in October 1989; Revised December 1990; December 1991; November 2000 Review and Revised as needed: Dec Updated September 27, 2006 15 15 Updated September 27, 2006 16 CHART DOCUMENTATION AND SUPERVISION STANDARDS, DEPARTMENT EMERGENCY Oversight Standards All patients must be submitted to the emergency department. Medical students are present directly at the visit. Any cases controlled by a resident must be reviewed by the Resident prior to the approval of the work. ED Documentation Standards for all patients with moderate or high difficulty problems are as follows: 1. Exam time 2. ROS as needed 3. History and Physical Examination 4. Results of laboratory values requiring medical action. The rot of transcription of laboratories in WebCIS is not recommended. The webcis phrase is considered preferable to transcription of laboratory values. This should reduce unnecessary work and mistakes. 5. Results of radiological studies and ECG. Procedural Notes 7. Re-evaluation notes when necessary. Notes indicating the time of consultations. 9. State of discharge. Notes on the justification of the activity. 11. Follow the instructions. A sacrament note, a document of the relevant level of participation in this case. James L. Larson MD Medical Director of UNC Hospital Emergency Department May 10, Updated September 27, 2006 17 PATIENT FLOW IN EMERGENCY DEPARTMENT EFFECTIVE: IMMEDIATELY POLICY This is the goal of the University of North Carolina Hospital to ensure effective care for all patients. PROCEDURE 1. Disputes about admission between services should be resolved within 2 hours. Hours. The emergency room will be delegated to an emergency medical doctor if a decision is not made within 2 hours of notification of possible admission services. 2. Admissions is responsible for setting up a hospital bed before transferring the inpatient from another facility. Patients taken by ambulance will be assessed by an emergency room nurse and an ambulance nurse. The doctor will check the patient's stability, allow transportation to the hospital bed and notify the appropriate foster resident. Patients will be registered in the emergency department if they are unstable or if the bed is arranged not suitable for the patient's condition. ORIGINATING UNIT Department of Emergency Medicine Administrative Approval: Todd Peterson 10/05/95 Director of Medical Personnel Operations Allegation: Stanley Mandel 10/02/95 Chief of Staff Review: 6/28/01 Dr Tintlliina Revised: 9/08/03 Dr Tintinalli 17 Updated September 27, 2006 18 REFERRALS to EMERGENCY DEPARTMENT PURPOSE: Insure visits to communications regarding emergency referrals and requests, as well as to provide adequate hospital resources for future hospitalizations. PROCEDURE: Prospective referrals over the phone from external doctors, hospitals or institutions should be directed to the nurse charge or emergency medical care physician. Complex calls should be directed to the ambulance doctor. Calls from outside institutions or doctors should be sent to an emergency room doctor at UNC hospitals. The bed status is maintained by the head of the nursing home, who will notify ED Visiting several times a day about the availability of the bed. The collection nurse enters the information about the sms transmission. ED Directions from Orange County, Injury Directions, Referrals from other emergency departments All requests to assess emergency room patients from doctors or facilities in Orange County, or for scene trauma calls or acute injury transfers, or from other emergency departments in the state, are taken directly by a sorting nurse or emergency room doctor. Referrals from inpatient units to UNC requests for transfer to the hospital should be sent to the emergency department, which will then find call-ups for appropriate inpatient care. Only inpatient treatment can take inpatients. Refusals to transfer only visits may refuse to transfer. The Head of Traumatology is the only person who can authorize adult or pediatric injury transfer failures. The log bounce in transmission due to insufficient resources of the hospital ED will be supported by ED Visitation and monthly submitted to the hospital administration. A patient's transport to UNC-ED Visitation can arrange an air or transportation via Carolina Air Care. Judith E. Tintinally, MD, MS Chair Chair 1/25/99 Revised 6/27/01 18 Updated September 27, 2006 19 TRANSFER DIVERSION LOG : EMERGENCY DEPARTMENT Policy: The transfer of the leaked log will be maintained by the Emergency Department to document the time and dates of the leak status. Procedure: Maintain a log of transmission leakage. The transfer of the leaked log will be supported in the looseleaf folder on the side of the visiting table. Each teacher must specify the leak status as OPEN or CLOSED at the beginning of each shift, i.e. at 7 a.m., 4:30 p.m. and 1:30 a.m. Date and time should be entered. When THE status of DIVERSION, the date and time of the leak and the person in charge (home nursing supervisor, injury visit) should be logged. The Chief of Staff must be notified, and this must also be logged. DIVERSION usually lasts throughout the shift. The status must be double-checked at the beginning of each shift, as above. Requests from individual faculty at other departments other than trauma to divert attention. When teachers from other departments request leaks for cases in their specialty, which must be documented in a leaked journal, the name of the specialty involved is also documented. The Chief of Staff must also be notified of such requests for recusal. Documenting any denials of translations. In order to be in compliance with EMTALA rules when ED is on DIVERSION or CLOSED status, if any cases are actually denied transfer, document the patient's name and clinical data, according to the form of MIM #505, located in the first section of the transfer leak log. Message OPEN or CLOSED status to the emergency department. The side faculty must also write OPEN or CLOSED for each shift on a large waxboard in the emergency department. Communication with the hospital administration. Administrator ED re-want a copy of the leaked magazine Sandra Evans, RN, MBA, on the first of each month. Judith Tintinally, MD, MS, Chair James Manning, MD, Vice Chairman 19 Updated September 27, 2006 20 Excludes Rex Health Name Policy Number Date This version of Policy Effective Department, RESPONSIBLE for reviewING MANAGEMENT PATIENTS that FAIL TO RESPOND TO CALLBACKS September 27, 2005 Emergency Department POLITICO: It is THE policy of UNC HOSPITAL to provide a reasonable and appropriate period of time for patients to answer calls from procedure: If the patient does not respond to a sorting call or to the department, then emergency department staff will not document the response and time on the computerized documentation system (T-system). Attempts will be made to call the patient back three times, about ten minutes apart, with each attempt documented as above. After three attempts, the patient will be documented as being left without being seen and discharged in the computer system choosing the left one without receiving medical advice. 20 Updated September 27, 2006 21 ENTER PRE-ARRIVAL INFORMATION INTO THE COMPUTER November, 2000 POLICY: Physician-to-doctor information will be entered by a senior emergency physician into the sorting system. A private doctor or other UNC

system is required to communicate with an ambulance doctor or nurse in charge of ED with information required for pre-arrival. PROCEDURE: Pre-arrival information can be entered into the SMS system by a nurse, a sorting nurse or a senior emergency physician. Calls to the doctor will be entered directly by the senior emergency physician in the system of sorting SMS. UNC IND HOSPITAL is responsible for the maintenance of all SMS sites. There is no method of pre-registration of information before arrival, as all this is in temporary files. A sorting nurse or a collection nurse should actively request a sorting direction screen to determine whether information has been entered prior to the patient's arrival. Systemic errors that may result in loss or inability to capture information prior to arrival include: 1) the patient arrives at ED before a private doctor or UNC service calls ED; 2) The nurse or attending physician is busy with the patient's critical tasks and enters the information after the patient arrives; 3) A private doctor or UNC service does not communicate with ED on information prior to arrival; 4) Sorting or charging the nurse may not request a pre-arrival screen. Judith E. Tintinalli, MD, MS Professor and Chair James L. Larson, MD Professor and Clinical Director 21 Updated September 27, 2006 22 MENTAL HEALTH EVALUATION IN DEPARTMENT NOVEMBER 3, 2000 POLITICO: Priorities and effective patient management by submitting to the emergency department with mental health problems, and to ensure the provision of appropriate medical evaluation for all patients with mental health problems. For the purposes of this policy, patients with mental health problems are patients with a major psychiatric complaint and without acute medical problems identified during sorting. These patients are sorted directly into the Psychiatry Crisis Service in ED. PROCEDURE: 1. American ntS (National Sorting Scale), The Australian College of Emergency Medicine) will be modified to sort mental health patients as follows: Level 1 does not apply Level 2 Actual or potential violence or aggression, suicidal or murderous ideas, suspected of being dangerous to themselves or for others Level 3 Of Unmaxial Anxiety or Arousal or Intoxication, Non-Suicidal or Murderous Ideas Level 4/5 Stable, Non-Implicit Anxiety or Excitement, Non-Suicidal Or Suicide Assessment Of Level 2 and 3 should start within 30 minutes after the was notifed by their presence. They will be sorted into rooms 16 and 17 in ED or other appropriate emergency bed in a direct visual range of nurses. Level 4/5 patients will be triaged to a minor injury, or pediatrics, if No.16, when these areas are staffed, and the psychiatry assessment should begin within 60 minutes after the psychiatric service has been notified. 2. All patients aged 60 and over with a psychiatric main complaint, or any psychiatric patient with an acute medical problem suspected of sorting, will be gowned and placed in a room for a medical examination. 3. The Psychiatry Service will be consulted to assess mental health problems when a patient is placed in a room for examination, regardless of whether a medical evaluation has been carried out. A primary care nurse will page a psychiatric counselor when the patient is in the examination room. Emergency medical examination is necessary for all patients with mental disorders. A psychiatric counselor is required to inform emergency medicine or paediatric care that a medical examination is necessary before the patient is admitted. In the event of a patient being transferred to an external psychiatric institution, the psychiatric service is obliged to ensure that all documentation on the diagrams, including the forms of transmission and documentation of the medical examination, is completed before the transfer is completed. 5. For psychiatric patients, where more than 60 minutes of delay in psychiatric examination is expected, the psychiatric resident is responsible for receiving additional care. For unusual delays or situations, or when ED medical staff determines a critical psychiatric overload patient, emergency medicine attends should notify a psychiatric visit on call. 6. Patients suspected of suicidal or murderous idea, or persons with potentially aggressive or aggressive behavior, will look for weapons in UNC hospital police. This should occur during sorting or when the patient is placed in the treatment room. Judith Tintinally, MD, MS Chair Sandy P makers, RN, CNS II Nurse Manager R. Golden, MD Clay Bordley, MD, MPH L. Nicholas, MD 22 Updated September 27, 2006 23 Excludes Rex Health Policy Name Number Date This Version of Policy Effective Department responsible for review of HEALTH SCREENING Examination Legal and Risk Management POLICY: This is THE UNC Policy of the Hospital to Offer a Medical Examination for Each Patient. The purpose of the medical screening is to determine whether there is an emergency disease and to provide appropriate stabilizing treatment. PROCEDURE: Patients will be provided with information about the need to assess their condition Patients will be advised sort nurse if their condition changes or if they plan to leave without being noticed. If the patient wishes to leave, he will be informed of the risks of refusing a medical examination and will be asked to sign a withdrawal form for a medical examination. If the patient refuses to sign, the sorting nurse will document the patient's waiver, sign and date of the form. The form will be retained as a permanent piece of medical documentation. University of North Carolina Hospital 23 Updated September 27, 2006 24 OBLIGATION TO PERFORM MEDICAL SCREENING EXAMINATION UNC Hospitals obligation under federal law is to provide patients with medical examination and indicated stabilizing treatment. The purpose of the medical examination is to determine whether there is an emergency disease and to provide appropriate stabilizing treatment. You will be evaluated and triaged as soon as possible depending on the severity of your condition. If you choose to leave the emergency department of UNC hospitals or other places in UNC hospitals where emergency care is provided before you receive a medical examination from your doctor, you are asked to notify the nurse before leaving. Care before receiving further medical examination will be against medical advice and may worsen your condition and may pose a threat to your life, health and medical safety. 24 Updated September 27, 2006 25 PEDIATRIC RED (LEVEL ONE) TRAUMA RESPONSE COVERAGE September 13, 2005 Children's Surgery Service can not reliably ensure participation in covering children's red injury alert within the required 20 minutes of time in it, given the geographical limitations of WakeMed's coverage in Raleigh. The following changes to pediatric red injury coverage have been designed to ensure the injury visiting presence within 20 minutes. In addition, the red injury criteria will be revised to reduce unnecessary pediatric warnings. The purpose of this mechanism is to provide initial resuscitation advice to maintain compliance rather than stubborn participation or assumptions about the responsibility of pediatric surgery. Coverage of children's red injuries 1. Pediatric surgery will be the primary responder for all pediatric red alert injuries between 7:00 a.m. and 5:00 p.m. on weekdays. The Adult Injury/Critical Care team can provide backup if not attending a pediatric surgeon is available during the day, although it is expected that this will happen rarely, if ever. If necessary, the pediatric surgery involved will personally call an adult injury visit to report the need. The festive coverage will be based on each case. 2. Although all paediatric trauma patients (before years) will be hospitalized in the pediatric surgery service (with simultaneous care PICU when necessary), adult trauma/critical care care will be the primary responder for pediatric red injuries on weekends (7am Sat 7am Mon, and between 5:00 p.m. and 7:00 a.m. on weekdays.) 3. Pediatric surgery goes will continue to receive red alert pages and will respond as soon as available. If this response is expected to be more than 40 minutes from alert time, the pediatric surgery involved will alert pediatric surgery to a backup visit so they can respond. Pediatric surgery residents and picu guy will respond to all pediatric red alert pages as part of the initial resuscitation phase. 4. Pediatric surgery visiting will be available for telephone consultations immediately and either an initial visit or backup visit will be physically present within 40 minutes for patients in need of surgery or those who require constant evaluation or surgical care. 5. Children's surgery will take over the management of the patient no later than the time in which the patient leaves the trauma compartment or within 40 minutes, depending on what happens in the first place. 6. The Pedi Surgery Service is responsible for writing orders for admission 7. The ped-surgery service is responsible for f/u at all consultations/laboratories/scanning/radiography performed in ED 8. The Ped Surgery Service is responsible for interaction with PICU, including beds. 25 Updated September 27, 2006 26 REQUESTS FOR BLOOD ALCOHOL LEVELS PURPOSE: The North Carolina Statute requires that the opportunity be granted to individuals who have taken an ethanol breath analyzer test to obtain ethanol levels in their blood. As a public institution, we are obliged to provide such an opportunity on a 24-hour basis. Procedure 1. Individuals who are accused of DWIs and get a breath test in Orange and Chatham counties will be advised that they can come to the emergency room at UNC hospitals to have blood ethanol levels drawn, and that they will receive standard emergency departments and laboratory fees for procedure 2. The individual reports to the sorting department with a form signed by the responsible police jurisdiction. Individuals who do not show this form are not eligible to have blood ethanol drawn and fall under the ED policy of requests for diagnostic tests without medical indications. 3. The sorting nurse will complete the sorting form and send the patient to ED registration. 4. The full ED chart will be created when you register. 5. The patient will return to the sorting department with the completed chart and will have the level of ethanol in the blood drawn (no alcohol tampons used) by the sorting nurse. 6. The doctor must document that the patient has a medical certificate to discharge from ED. Judith Tintinally, MD, MS, Chairman Sandy Pabers, RN, CNS II, Nurse Manager Emerged 9/14/94 Revised 1/28/99 26 Updated September 27, 2006 27 FOR DIAGNOSTIC RESEARCH WITHOUT MEDICAL INDICATION PURPOSE: To ensure that diagnostic or interventional studies are conducted for medical evidence. PROCEDURE: Requests for diagnostic or interventional examinations without urgent medical indications are not performed in the Emergency Department. Examples of such requests include, but are not limited to, lawyers' requests for blood ethanol levels for clients, requests by parents for routine toxicology tests on the child and requests for regular HIV testing. Judith E. Tintinalli, MD, MS Chair Sandy Pmakers, RN, CNS II Nurse Manager 27 Updated September 27, 2006 28 SEXUAL ASSAULT EVALUATION Department of Emergency Medicine Policy: Sexual Assault Assessment performed by the SANE team. Doctors assist in the medical aspect of assisting in sexual violence. Procedure: SANE Role Collecting Forensic Evidence General Patient Evaluation General Assessment To Provide Preventive Treatment for STDs, HIV, Hepatitis B, and Pregnancy Prevention Referral to Infectious Diseases, Psychiatry and Social Services, as stated by ED Physician Role Review Case Presentation sane Specialist Document on ED Record that the case has been discussed to intervene or assist in the examination if necessary / specified prescriptions mark for preventive drugs 31 October 2002 Judith T. Tintinally, MD, MS Professor and Chair Sandy Pmakers, RN, CNS II Nurse Manager 28 Updated September 27, 2006 29 ER NURSES ROLEVIC AND SEXUAL ASSAULT EXAMINATIONS PURPOSE (1) Develop guidelines for helping emergency room nurses provide quality care to patients requiring pelvic and sexual research. (2) Clarify the role of an emergency department nurse (male and/or female) in assisting in pelvic or sexual assault surveys and gathering forensic evidence. GENERAL STATEMENTS (1) The North Carolina Care Board does not differentiate the role of a nurse because it relates to gender. (2) The North Carolina Nurse Practices Act does not differentiate the role of a nurse because it refers to gender in providing nursing. (3) University of North Carolina Hospitals does not differentiate or limit the role of nurses as it relates to gender in providing nursing. (4) The University of North Carolina Hospital Legal Department is unaware of the existing policy addressing gender in pelvic or sexual assault examinations and forensics. (5) The provision of medical care should be based on patients and, if possible, reflect the needs and desires of the patient. GUIDELINES (1) Prior to pelvic and/or sexual assault research and forensic evidence collection, an explanation of the exam should be given to the patient and any questions answered. An explanation should be given in terms the patient understands. (2) All patients should be informed of the staff who will be during surveys, as well as their role. (3) In cases of sexual violence, the patient should be informed of the presence of a rape counsellor. Patient patient request, a rape counselor may be present throughout the exam. (4) This department of emergency department policy and procedure will be reviewed and updated periodically as needed, taking into account current nursing practices. Revised: February, Updated September 27, 2006 30 EMERGENCY DEPARTMENT STANDING ORDERS Clinical Operations Group of the Department of Emergency Medicine has developed permanent orders for the exercise of nurses before the patient is evaluated by an ambulance doctor. These are guidelines for actions to be taken by nurses based on the main patient complaint. They do not replace clinical judgments and should be used in conjunction with the patient's clinical presentation. Vital Sign Guidelines: Vitals signs can vary for each patient. Below are some general guidelines for each vital sign (for adult patients). If the patient falls outside these, the patient should be placed on a monitor and the doctor contacted immediately. Temperature 38 C Pulse beats per minute of respiratory breath rate per minute of systolic blood pressure mm Hg Diastolic blood pressure mm Hg Pulse Oximetry 96% Exercise procedure: After the care of the patient's assessment, the bedside nurse can activate the constant orders most consistent with the patient's complaints and physical evaluation. Again, any patient out of the norm for life signs should have a doctor at bed as soon as possible. The nurse will document on the order sheet the protocol of the permanent order is carried out, notify the attending physician, and document the doctor's name on the order sheet. For example: Abdominal pain Standing orders for Dr. Tintinalli. HuC then order the appropriate labs and research according to the protocol. The order sheet will be part of the medical documentation. I repeat: these are guidelines based on the patient's main complaint and designed to speed up care. The primary nurse is asked not to make a diagnosis, but rather to evaluate the patient's complaints. They do not replace nurses or a doctor of clinical judgment. Judy Tintinally, MD, MS Chair Abhi Mehrotra, MD Assistant Medical Director Jim Larson, MD Medical Director Sandy Pathers, RN Nurse Manager Jeff Strickler, RN, MA Clinical Director 30 Updated September 27, 2006 31 TREATMENT PATIENTS WITH EMERGENCY MEDICAL CONDITIONS POLICY This is a policy by the University of North Carolina Hospital that all patients present for examination or treatment, including women in the work, should be provided by a medical officer to determine if an emergency medical condition exists. If the doctor determines that there is an urgent medical problem or that the woman is in a state of labor having contractions, the patient should be treated; The patient may be or discharged only in accordance with the procedures described below. Whenever a man is a man Located within 250 yards of buildings hospitals need medical care, but is not inside the hospital building, 911 must be called promptly to provide a person with an appropriate level of life support and transport the person to the emergency department of the hospital. If a person comes to a hospital-based clinic from the hospital's main campus, medical professionals at that clinic must perform a medical screening to determine if there is an emergency medical condition. If this is the case, they should provide care within their means in an attempt to stabilize the patient, and call 911 if it turns out that the patient cannot be stabilized. If the ambulance/rescue team is going to take the patient to the emergency department of UNC hospital, no official transfer documents should be filled out, but the Emergency Department must be notified of the situation, if, however, the patient is taken to any other emergency department of the hospital, the EMTALA transfer documents must be filled out, including the call of the emergency department to the patient. For the purposes of this policy, an emergency medical condition is a disease of severe enough acute symptoms, such that it might reasonably be expected that abstinence from immediate medical care would result in: to seriously endanger the health of the patient (or, in the case of the pregnant woman, the health of the woman or her unborn child); Serious violation of any bodily functions; or, serious dysfunction of any body organ or part. With a respedt to a pregnant woman who has contractions, it means: that there is not enough time to deliver a safe transfer to another hospital before delivery; or that transmission may pose a threat to the health or safety of the woman or the unborn child. The terms are stable or stable defined in paragraph 7 below. PRESES MEDICAL Survey 31 Updated September 27, 2006 32 1. All patients applying to University of North Carolina hospitals for examination or treatment, including minors without parents and women in childbirth, should be provided with appropriate medical examinations by a doctor to determine if an emergency medical condition exists. Medical examinations may include laboratory tests, radiological studies or consultations as needed. 2. Medical examination is carried out without taking into account the patient's ability to pay, and without taking into account the diagnosis, financial situation, race, colour, national origin, disability, gender or age. Medical examination and/or stabilizing treatment should not be delayed in order to find out about the way the patient is paid, insurance status or permission to pay from a managed plan 3. If the attending physician or other staff determines that a doctor of a particular specialty, specialty, needs a consultation from a doctor of a particular specialty, Doctor on call for this specialty service should be called. Call doctors should call or come to the emergency room or elsewhere as to find out in the Department of Emergency Situations Policy Advice. 4. If the doctor determines that there is an urgent medical problem, appropriate treatment is offered to stabilize the patient's condition. 5. If a doctor determines within a reasonable medical probability that there is no emergency medical care, this conclusion should be explicitly stated in the patient's medical records, along with notes to that examination and a conclusion as to why there is no emergency medical examination. 6. A patient (or person acting on behalf of a patient) who has an urgent medical condition may, in the name of medical advice, refuse consent for treatment or transfer after he/she has been informed of the risks and benefits of denial of treatment or transfer. A report to the relevant county Department of Social Services should be considered if care is denied on behalf of a patient who is unable to make his own informed decisions. Extract or transfer 7. If the doctor determines that the emergency medical condition does exist, the patient may be discharged or transferred from UNC hospitals while the patient's condition is stabilized. A final emergency medical decision is not required before the patient can be discharged or transferred, however, the patient should be provided with a plan for proper follow-up care with the statement instructions. a. Stabilization for discharge means, within a reasonable medical probability, that no significant deterioration of the condition is likely as a result or after discharge, and that the patient has reached the point where continued care, including diagnostic work and/or treatment, can be reasonably performed as an outpatient or later in the hospital. In the case of a pregnant woman who had contractions, stabilization meant that the woman had given birth to a child, including the placenta. A psychiatric patient is stable to be discharged when he/she is no longer considered a threat to 32 Updated September 27, 2006 33 self or other. B. Stabilized for transmission means, within a reasonable medical probability, that no significant deterioration of the condition is likely as a result or during the transfer of the patient to another institution, and that the receiving institution has the ability to manage the patient's condition and any reasonably predictable complications of the condition. In the case of a pregnant woman who had contractions, the stabilization for transmission meant that the woman had given birth to a child, including the placenta. The psychiatric patient is stabilized for transmission when he/she is protected and cannot injure himself or others. 8. If the doctor determines that medical condition does exist and the patient does not stabilized, the patient may be transferred to another medical facility when either: a. Patient (or legally responsible person acting in favor of the patient when the patient is unable to make an informed choice): i. Refusal of treatment after examination, further examination and/or treatment (and all this is documented in medical records); and ii. Requests in writing, including reasons for transfer to another medical facility (a) after they have been informed of the obligation of UNC hospital to provide assistance without Fegard on the possibility of payment and the obligation to stabilize the patient prior to transfer, and b) after they have also been informed of the risks and benefits of translation, or - b. The doctor has signed a written statement, including on the risks, benefits and reasons for transfer, that the medical benefits reasonably expected from the provision of appropriate medical care in another medical institution outweigh the increased risks to the person and, in the case of childbirth, to the unborn child from the transfer. A patient with no mental health obligations who has not stabilized may be transferred to another facility if the doctor has documented in the medical records the risks and benefits of translation. Patients, with the exception of those who are under involuntary obligation, must consent to the transfer. 9. Transfer should be carried out at the expense of qualified personnel and transport equipment as required, including the use of necessary and medically appropriate life support measures during transfer. In order to translate the medical benefits initiated by the doctor, the patient's re-evaluation must be carried out shortly before the actual transfer, as well as the results documented in the medical records. If the patient's condition has stabilized or has not changed, continue the translation. If the patient's condition has deteriorated, the risks and benefits of the transfer should be overestimated and re-documented. 10. In order to transfer a UNC hospital patient who is in a state of stabilization, doctors must provide medical care within their means in order to minimize the risks to the patient's health or to the health of the unborn child. The receiving medical facility should have sufficient space and qualified staff to treat the patient, and must have agreed to accept the transfer of the patient prior to transfer and agreed to provide appropriate medical treatment. The consent of the host medical institution to accept the transfer is documented, including the date and time of the acceptance agreement and the name of the person accepting the translation. 33 Updated September 27, 2006 2006 emergency department policy and procedure manual pdf

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