

Erlanger Health System Policy and Procedure

| | | |
|-------------------------|----------------------------|-----------------|
| Origination Date: _____ | | |
| Approval: _____ | | |
| Reviewed Date: _____ | Revised Date: <u>02/09</u> | Approval: _____ |
| <u>06/12</u> | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Index Title: Standards of Care

Originating Department: Children's Emergency Department (CHED)

Number: 6231.004

Description for EHS Intranet:

Policy statement: To provide consistent, quality nursing care to pediatric patients arriving to the ED. Every patient will have an initial and continued assessment of their physical and psychosocial problems by a Registered Nurse.

Scope: All CHED personnel, CHED physicians and mid-level providers, and house staff.

Procedure:

I. Triage:

The purpose of triage is to prioritize incoming patients and identify those patients who cannot wait to be seen. The remaining patients who do not require immediate life-saving treatment are sorted based on presenting complaint and/or severity of illness/injury can wait for a physician evaluation.

- a. All patients presenting to CHED are triaged and evaluated without regard to insurance or financial status.
- b. The Emergency Severity Index (ESI) is used to determine which patient should be seen first and determine what resources are necessary in order to determine an ED disposition.
- c. A Registered Nurse (RN) assesses every patient in a timely manner. A triage assessment is completed according to the acuity of the presenting complaint. The priorities of care are determined for each patient in accordance with their physical and psychosocial needs.
- d. The RN obtains an immediate, brief evaluation of the patient and determines the general nature of the problem, medical history, and associated symptoms. The ED technician may assist the RN.
- e. The RN assesses the patient's vital signs. An ESI acuity level is assigned based on severity of illness/injury or needed resources.
- f. Correct identification (ID) bands are verified and/or placed on all patients presenting to the ED.
- g. Routine labs and tests may be initiated by RN according to Nurse Initiated Guidelines (6231.081).
- H. Any Special Needs identified according to assessment, are assisted by addressing language, hearing, learning, or spiritual needs. These needs will be met via House Supervisor, Language line or hospital interpreter.

II. Priorities of Care and Emergency Severity Index level (ESI)

ESI Level I Pulseless/Apneic/Unresponsive or immediate danger. A patient who requires immediate room placement, resuscitation treatment, and an emergency physician at the bedside immediately. The patient is taken straight back to a treatment room, and the primary nurse completes initial assessment.

ESI Level II A patient who presents with a high-risk situation, confused/lethargic,

disoriented, severe pain/distress, abnormal vital signs. Immediate room placement should occur if nurse feels the patient requires immediate care after primary survey. This patient requires monitoring and frequent reassessment until room placement and interventions initiated.

ESI Level III

A patient who presents with a stable condition that requires therapeutic observation or treatment and requires two or more resources. Patients in this category should be reassessed as condition warrants. These patients should be seen within a reasonable time frame. The nurse determines patient's heart rate, respiratory rate, oxygen saturation (if pertinent), and temperature to decide if up-triage is necessary. These patients will be placed in a treatment room as soon as one is made available, and reassessed as appropriate.

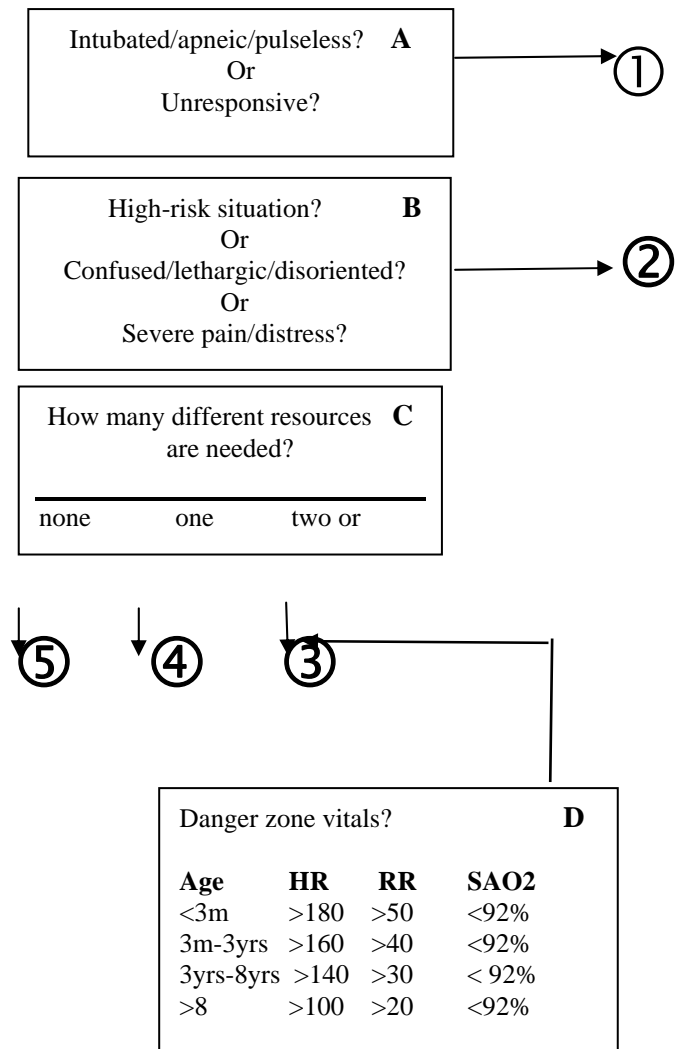
ESI Level IV & V

Stable, requires one or no resources. These patients will be placed in treatment room as soon as one is made available, and reassessed as appropriate.

The ED Physician or mid-level provider must perform a medical screening exam to determine the nature and seriousness of presenting complaint. Reassessment should occur as condition warrants.

Five-Level Triage System

- A. Unresponsiveness** is defined as a patient that is either:
 - (1) nonverbal and not following commands (acutely): or
 - (2) requires noxious stimulus (PU on AVPU) scale
- B. High-risk Situation** is a patient you would put in your last open bed. **Severe pain/distress** is determined by clinical observation and/or patient rating of 7 or greater on 0-10 pain scale.
- C. Count number of resources**, not individual tests needed, to determine what acuity level to assign (e.g. lab, radiology, EKG) 3 resources



Level 1 Examples are:

- Cardiopulmonary arrest
- Severe respiratory distress requiring life-saving measures
- Any unresponsive patient
- Bradycardia or tachycardia with signs of shock
- Major traumas
- Flaccid infant
- SVT requiring emergent cardioversion
- Hypotension with signs of shock

Level 2 Examples are:

- | | |
|---|---|
| <ul style="list-style-type: none"> Kidney stones Oncology patients Acute Sexual Assault Burns not requiring life-saving measures Severe flank pain Orthopedic fracture with severe pain Severe dehydration Peritonsillar abscess Inhalation injuries Facial trauma Respiratory distress not requiring life-saving measures | <ul style="list-style-type: none"> DKA Testicular or ovarian torsion Psychiatric emergencies: suicidal homicidal, psychotic, violent Severed headache, acute mental changes, shunt patients Acute head injuries Acute eye injuries Compartment syndrome Transplant patients Overdoses-ingestions |
|---|---|

Immediate Life-saving Interventions

| <i>Intervention</i> | <i>Life Saving</i> | <i>Not Life-Saving</i> |
|---------------------|--|--|
| Airway/breathing | BVM ventilation Intubation Surgical airway Emergent cpap Emergent bipap | Oxygen administration <ul style="list-style-type: none"> • Nasal cannula • Non-rebreather |
| Electrical therapy | Defibrillation Emergent cardioversion External pacing | Cardiac Monitoring |
| Hemodynamics | Significant IV fluid resuscitation Blood administration Control major bleeding | IV access Saline lock for medications |
| Procedures | Chest needle decompression Pericardiocentesis Open thoracotomy Intraosseous line (IO) | Diagnostic tests <ul style="list-style-type: none"> • ECG • Labs • Ultrasound • FAST (Focused abdominal scan for trauma) |
| Medications | Naloxone, Epinephrine D50W/D25W/D10W Dopamine Atropine | Antibiotics Heparin Analgesics, Respiratory Treatments |

| | | |
|--|-----------|--|
| | Adenocard | |
|--|-----------|--|

III. Initial Vital Signs (VS) include:

- * Blood Pressure (BP)
- * Temperature
- * Heart Rate
- * Weight (in kilograms)
- *Respirations
- *Oxygen saturation (if indicated)
- *Pain scale (age/developmental appropriate)

IV. Initial Triage:

* Initial triage should occur within 15 minutes of presentation to ED. Once triaged, the patient will be assigned a room based on availability. If a room assignment has not been made within an hour, a reassessment should be performed by the triage nurse or designee to determine if patient's condition has changed from the initial assessment.

V. Triage is not delayed due to inability to complete VS. If unable to obtain BP after 2 attempts, staff will document reason for inability to obtain BP, and a nurse will attempt again. The primary nurse will reassess any abnormal VS according to established ranges indicated in electronic record, and notify attending or mid-level provider of VS abnormality by documenting it in the electronic medical record (EMR) and/or verbal communication.

VI. All changes in the initial Triage decision is reflected in the nursing documentation and includes the following:

- * Change in condition that substantiates reprioritization
- * Consultation with physician
- * Reassessment and VS taken according to new priority
- * Triage level can be changed to a higher acuity level in the patient data template, but not down graded.

VII. Patient's initial Triage acuity level can be changed under the following circumstances:

- * Reassessment of patient waiting to be brought into treatment area determines a change in patient's condition
- * Reassessment of patient after treatment initiated determines the appropriateness of changing the acuity.

VIII. The triage nurse assigns the patient to the appropriate treatment area based on the initial or subsequent assessment.

IX. Other assessments which are documented are:

- * Childhood immunizations including tetanus.
- * Allergies
- * Current Medications (including OTC, Rx, herbals)
- * Special needs (language, vision, hearing, learning, spiritual)
- * Evidence of Abuse
- * Seasonal Influenza Screening

X. Clinical Alarms:

- a. Patients are placed on a pulse oximeter or cardiac monitor as condition warrants or presenting complaint.
- b. Alarms are to be "ON" at all times when the patient is not being directly attended by the nurse.
- c. The alarm limits are set as follows unless otherwise indicated. Limits depend on monitor model.

| | | | | |
|---------------|-----|--------|-------------------|--------------|
| * Pediatrics: | HR | 60-200 | * Pulse oximeter: | 90-100% |
| | RR | 12-60 | | |
| | SBP | 85-140 | * Apnea: | > 15 seconds |
| * Neonate: | HR | 90-220 | | |
| | RR | 10-75 | | |
| | SBP | 50-100 | | |
| * Adult: | HR | 50-160 | | |
| | SBP | 75-220 | | |
| | RR | 8-30 | | |

- d. Alarm status is checked each time a new patient is placed on a monitor.
- e. Stable patients may be removed from the monitor for brief periods of time for procedures, with ED Physician/MLP approval.
- f. **Alert:** During initial use of a monitor, pump or other piece of equipment, ensure that PM is not due on the equipment. Make sure that the equipment beeps when turned on. That beep is an indication that the speaker portion of the alarm function is working within the device. The **lack** of an audible alarm when a piece of equipment is initially turned on indicates the need to pull that equipment from service, obtain another piece of the same type of equipment for the patient and notify BioMed of problem with equipment, and have them to inspect the equipment.

XI. Routine Nursing Care and Documentation:

- A. Vital Signs are repeated on every patient as follows:
 - * ESI Level 1: 15 minutes or sooner if condition warrants
 - * ESI Level 2: 1 hour or sooner if condition warrants
 - * ESI Level 3: 2 hours or sooner if condition warrants
 - * ESI Level 4 & 5: 4 hours or sooner if condition warrants
 - * Reassess vital signs within 30 minutes of discharge, admission, or transfer to another hospital.
 - * Any abnormal vital sign out of established range.
- B. Temperatures are done rectally if patient cannot hold thermometer in the mouth (exceptions include oncology patients rectal trauma/surgery, parent requests). For these patients, an axillary or oral temperature is done.
- C. Chart documentation reflects the names and titles of all care givers.
- D. All treatments, medications, procedures are documented in electronic record with appropriate corresponding physician signature orders. Patient's response to treatment, medications, and procedures are also documented appropriately.
- E. All charting documented in a timely manner as well as signing chart.
- F. All physician orders are signed in timely manner.
- G. Medication documentation includes:
 - * Time
 - * Name of medication
 - * Dose
 - * Route
 - * Any IVPB medications require documentation of time of completion or length of infusion while in the department
 - * Site of injection
 - * Patient's name
 - * Response to PRN medications and affects
 - * Physician signature verifying order

- H. Any response to a medication and/or treatment is documented, i.e. nausea, pain relieved, patient's response to any treatment
- I. Documentation of intravenous fluids includes:
 - * Type and amount of fluids
 - * Type and size catheter utilized to initiate fluids
 - * Site of IV initially and repeated hourly
 - * Rate of infusion
- J. Lab draws of more than 5 ml of blood at one time in a child under the age of 1 year will require an order from an Attending Physician.
- K. Intake/Output is documented on all patients receiving IV Fluids and all admissions/transfers.
- L. Output includes urine, stool, emesis, or any other type of drainage.
- M. Intake includes Intravenous fluids and/or fluids taken by mouth, NG tube, feeding tube, gastric button, etc.
- N. Discharge instructions include parent/caregiver/legal guardian receiving a copy of their discharge instructions, signage electronically, discharge teaching done by licensed personnel.
- O. All patients, family and/or significant others receive follow-up instructions.
- P. Staff are expected to be ready to give report in a timely manner.
- Q. The RN gives report to another RN using the Situation Background Assessment and Recommendations (SBAR) when going to lunch, leaving department, or with another patient for extended period of time.
- R. Staff must communicate verbally and directly to the charge nurse, ANM, and/or physician/MLP of any changes in patient's condition. This is reflected in patient's EMR.
- S. All specimens are labeled at the patient's bedside when collected and sent to the laboratory as soon as obtained. The correct specimen label and requisition should be attached to the specimen and correct patient will be identified using the two patient identifiers (Name of patient/ID bracelet and date of birth).

XII. Medications:

- 2 A. A complete count of controlled substances will be performed every Monday and Friday preferably 7:00 – 7:30 AM. The count will be done with a nurse from the oncoming shift counting and an off-going shift nurse to witness (preferably charge nurse/ANM). The count should never be done with 2 temporary nurses (temp nurse may witness only). See policy # PC 097 Pyxis Medstation.
- B. Two nurses' signatures are required prior to giving insulin, heparin, digoxin, sedation meds, vasopressors, or any IV drips. Signatures will be documented electronically.
- C. Any medications that are mixed by pharmacy are based on standard concentrations according to the Med-Net drug library (Hospira) or Smart Pump. Medication that is in a syringe will be placed on the Smart Pump, and those in an IV bag will be placed on the Med-Net drug library (Hospira).
- D. Multi-dose vials, including insulin are discarded every 28 days after opening or according to the Manufacturer's Expiration date or any time contamination is suspected. Once vial is opened, the date the vial is to expire should be written on the opened vial.
- E. All adverse drug reactions should be reported. Call 2379/ ADRX Hotline. Fill out a Risk Pro report via the Intranet. Update allergies in medical chart.

XIII. IV Therapy Administration

- A. All pediatric patients with IV Fluids are placed on an infusion pump with the exception of those patients requiring rapid fluid replacement.
- B. Site checks are done at least hourly or sooner if condition warrants.
- C. IV bags and tubing are labeled with proper identification.

XIV. Nutrition

- A. Patients that present to triage will be made NPO until seen by a physician/MLP. A "Do Not Feed Me" sticker will be placed on child, and an explanation provided to parent/caregiver of patient's NPO status. Nursing staff may approach physician/MLP if child has not yet been seen and child/caregiver wants to be able to drink/eat.
- B. Popsicles, Gatorade, sprite, pedialyte, and/or formula are stocked in nutrition room for patients only.

XV. Oncology Patients

Any oncology patient that presents to the ED are sent back to a treatment room immediately. These patients are not placed in rooms 10 or 12. See Hematology/Oncology Standards of Care. 6012.071

XVI. Drugs

- A. Documentation of any drug the patient is on including over the counter medications and herbal remedies.
- B. Documentation of any food or drug allergies.

XVII. Food

- A. Documentation is done for any food the patient is on including type of formula or breast fed.
- B. Special diet instructions are given to the patient/caregiver and verbally explained.

XVIII. Activity

- A. Activity level are explained to patient/caregiver. Teaching and instructions explained if the use of slings, splints, crutches, etc. are necessary.

XIX. Follow-up instructions/Discharge Planning

- A. No patient will be discharged home until determined by the physician/MLP to be ready to do so.
- B. No patient will be allowed to leave the ED until the physician/MLP has dispositioned them home in the electronic medical record.
- C. Patients presenting to the ED for care are evaluated by both the physician/MLP and nursing staff for educational needs throughout their visit.
- D. The staff identifies the learning needs of patients and caregivers and documenting it in the discharge plan of care.
- E. Patients and their caregivers receive pertinent information regarding diagnosis, follow-up care, and any specific learning needs prior to discharge. Discharge instructions are verbal, written, and when necessary utilizing return demonstration.
- F. The patient/caregiver are told to return to the facility if condition necessitates. The patient or care giver are told to follow-up with their Primary Care Physician/Specialists as warranted, with a physician name, phone number, or specific clinic phone number for scheduling a follow-up appointment.
- G. If there are no restrictions, no documentation necessary.
- H. Each patient receives instructions to include a description of the problem and its natural course and identifies the most important warning signs indicating the need for prompt medical follow-up.
- I. Medication instructions are given to include Medication Reconciliation that are completed by the physician/MLP.
- J. The physician/MLP is responsible for selecting the type of discharge instructions for each patient's condition.
- K. The nurse discharges the patient by explaining discharge instructions to the patient/caregiver and having caregiver sign that they have received the instructions. The nurse is responsible for ensuring that the patient/caregiver receives the right paperwork upon discharge using the two patient identifiers.
- L. Any discharge teaching is documented in the chart and understanding of patient/caregiver.

M. Follow-up is routinely done for:

- * Positive culture results
- * Abnormal lab results reported after discharge
- * X-ray discrepancies
- * The appropriateness of care is questioned by the physician completing the Quality Assurance review of the ED record.

N. Any patient requiring immediate or routine follow-up is contacted by the charge nurse or physician, and documentation is completed in the electronic chart.

XX. Transfers to other areas within hospital

A. Before transfer to the floor:

- * Complete vital signs within 30 minutes of transfer
- * Intake and output documented
- * Completed Bedside Hand-Over Communication Sheet
- * PEWS Score in chart
- * Report given to the receiving nurse using SBAR format and documented using SBAR
- * Brief assessment of patient's condition at the time of transfer
- * Mode of transport
- * Documentation of IV site if appropriate
- * Nurse notifies physician/MLP that patient is about to leave the ED PRIOR to transporting patient to floor.

B. Transfer to ICU/Surgery/Monitored Bed

- * Complete set of vital signs within 30 minutes of transfer
- * Intake and output documented
- * Report given to receiving nurse/unit using SBAR format
- * Brief assessment of patient's condition at the time of transfer
- * Mode of transport including name of RN/Paramedic transporting patient and any ancillary equipment
- * Pre-op SBAR form is completed on all surgical patients and sent to surgery with chart
- * If patient is going to surgery from the ED, and an Op-permit is signed using the in-house Informed Consent for Treatment/Procedures
- * Surgical patients are provided with a hospital gown and asked to empty bladder prior to transfer to surgery
- * Nurse notifies physician/MLP that patient is about to leave the ED PRIOR to transporting patient to PICU/operating room/GI lab, etc.

XXI. Transfer to another facility: Prior to Transfers

A. Complete assessment of patient with repeat vital signs within 30 minutes of transfer.

- * Intake and output documented
- * Report given to the receiving nurse using SBAR format
- * Completion of transfer form
- * Notify House Supervisor of transfer
- * A physician's note on mode of transport and level of care required during transport is documented

XXII. Family Centered Care

- A. Patient Rights – Infants and Children have the right to considerate and respectful care in a family centered environment. (Policy 8316.965)
- B. The nursing philosophy is to focus on Family Centered Care. In providing this care, staff must recognize the needs of the family, as well as, those of the patient.
- C. Guardians are encouraged to stay with their child and participate in care when possible.
- D. Child life is available and assists with distraction techniques when appropriate.

XXIII. Infection Prevention

A. All patients are protected from cross contamination by maintaining

Body Substance Isolation (BSI)

- B. Decisions regarding patient room assignment and the need for isolation Are made according to EHS Infection Control Policy (Isolation Precautions 8304.075)
- C. Rooms and equipment are cleansed according to hospital Infection Control Policy (Disinfection and Sterilization 8304.040)
- D. Any patient presenting to the ED by triage or EMS with suspected cases of airborne diseases such as tuberculosis, varicella, measles, smallpox are placed in Exam room 10 or 12 negative pressure room Refer to Isolation Precautions Policy # 8304.075.
- E. In the event of suspected smallpox or other potential biological weapons, House Supervisor to contact Infection Control staff.

XXIV. Safety: General Care

- A. Infants are kept on their back in a flat position. All infants are transported on a stretcher unless carried by guardian/caregiver or employee for a procedure and escorted by an ED staff member with a green Erlanger employee badge.
- B. Side rails are up at all times.
- C. Toddlers are not allowed to play with toys with sharp edges or points. No rubber balloons or gloves are allowed.
- E. In the event of "Code Pink", the actions listed in the Infant Security Guideline are followed, as well as, the following specific guidelines:
 - * The ANM or charge nurse assigns staff to observe all exits for attempted abductions (entrances, exits, hallways, doorways, ambulance entrance, elevators G, K; stairwells, door exiting front lobby).

XXV. Care of Population-specific Patients

A. Consent for Treatment of Minor

- * A licensed physician in accordance with Tennessee State law may treat a minor not accompanied by parent or guardian, as well as unaccompanied, unconscious patient. In an emergent situation the licensed physician may perform emergency medical or surgical treatment without parental consent or court order when based on his/her professional judgment the physician determines that delay in rendering emergency care would result in serious threat to life, limb, or sight of the patient.
- * If no emergent condition exists after a medical screen, an attempt is made to contact the parents/guardian by telephone. The telephone conversation is witnessed by two licensed staff members with documentation to include name of person granting permission to treat, telephone number dialed, and name of two licensed staff members witnessing conversation.
- * An Emancipated Minor is defined as any "minor who is or has married or has by court order otherwise been freed from the care, custody, and control of the minor's parents: "minor means under eighteen years of age." (TNST Code 37-10-302).

B. Management of Emotionally Disturbed Patients

- * Any patient that arrives in ED with a psychiatric/psychological disorder or under influence of alcohol or drugs has a Medical Screen first, and kept in ED until proper disposition or referral can be made.
- * A psychological consult and evaluation may be completed to help determine if a psychiatric admission is necessary.

- * If any admitted patient that is in need of constant supervision, the House Supervisor is contacted to arrange for one-on-one sitter services.
- * If a patient requires involuntary psychiatric hospitalization, a Certificate of Need is completed, and the Hamilton County Sheriff will accompany patient to psychiatric facility.

D. Radiation Contamination Patients

- * Any patient presenting to ED that has been exposed to radiation that is classified as a radiological emergency and no other injuries, is sent to the decontamination area for appropriate decontamination. After decontamination and evaluation is complete, the patient may be treated.

| Committee | Approval/Date |
|-----------|---------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| Medical Director | Approval/Date |
|------------------|---------------|
| _____ | _____ |
| _____ | _____ |

References:

Gilboy N, Tanabe P, Travers DA, Rosenau AM, Eitel DR. *Emergency Severity Index, Version 4. Implementation Handbook*. AHRQ Publication No. 05-0046-2, May 2005. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/esi/>