I. DESCRIPTION AND MISSION

A. DESCRIPTION

1. Type of unit

The ED is located on the main floor of the hospital building, adjacent to the main entrance, Cancer Clinic area on one side and x-ray, patient elevator area on the other. The department is equipped with automatic sliding glass doors for easy access by ambulances and wheelchairs. This area is reached via the driveway from the main road around the hospital. There are not any off site locations that are considered part of the ED.

The ED is a primary care unit, designed for the care of all patient problems from urgent to non-urgent. All patients are properly assessed by qualified individuals. Diagnosis, treatment, admission, and appropriate referral and follow-up services are initiated here. Intensive care for acute medical and surgical emergencies and emotional problems are provided on a short term basis until the patient is transferred to the appropriate in-patient area. The most critically ill patients receive the top priority care, determined by triage guidelines.

2. Size

a. Patient Rooms

There are 18 patient care areas in the main ED with various functions, an intensive care area and a triage area. All rooms are arranged as similarly as possible, with specific rooms for ENT, orthopedic and obstetrical-gynecological procedures. All rooms are equipped with oxygen, suction, air and grounded electrical outlets. Rooms 5, 6 and 18 are negative pressure. The isolation room (18) is to be used to treat patients that require negative air flow and isolation precautions or need decontamination.

There is a Decontamination Unit outside the ambulance entrance of the ED that is opened to provide decontamination of patients brought to the ED.

Central monitoring equipment is available.

The condition of the unit is the responsibility of all staff; however, specific duties may fall to each shift. Each off-going shift is responsible for leaving the unit neat, clean and in good working order. The oncoming shift accepts responsibility for the condition of the unit at shift change.

It is the responsibility of the charge nurse to check the emergency equipment and sign off on the Emergency Equipment Checklist. Room check lists are checked by the nurse assigned to the area each shift. Documentation must be noted on appropriate checklists (Appendix I). Routine maintenance of equipment is the responsibility of the Biomedical Engineering Department (BME). Broken equipment should be reported to the Day Charge Nurse and recorded in the BME Repair book.

b. Central Module

(1) Kitchen facilities are maintained by Dietary and Housekeeping personnel.

(a) There is a thermometer in the refrigerator to monitor temperature range. A sign reading: "Food Only" is placed on the door. The temperature is checked daily by dietary.

(b) The freezer is emptied and cleaned upon request by Housekeeping staff. The temperature is checked daily by dietary.

(c) The ice machine is maintained by the Maintenance Department.

(d) The refrigerator in the Pyxis has a sign on the door, reading: "No Food". A separate refrigerator is for biologicals. The monitoring of the temperature for these refrigerators is done by the day charge nurse.

(2) Electrical equipment must by checked by Clinical Engineering.

(3) Computerized EKG machines are located in Room 1 and across from the nurse’s station.

(4) Utility Rooms

(e) Cleanliness is the responsibility of the Housekeeping Department.

(f) Central Sterile Supply technicians are responsible for removing soiled equipment, which has been properly placed in receptacle for re-sterilization.

(5) Offices

The Nursing Manager and Medical Director’s offices are located in the ED.

c. Scope of Nursing Services

(1) Clinical

Nursing care is provided to all patients. Standards of care are consistent for all services unless otherwise specified. Practice concerns may be addressed through unit representation to the Nursing Manager or Assistant Nursing Manager.

The ED of the John Dempsey Hospital offers 24 hours/day care. Qualified MDs and RNs and LPNs are on duty 24 hours/day. Specialty consultation with appropriate support services is available 24 hours/day.

Scope of Practice include:

(a) Initiate life saving treatment.

(b) Administer physical and psychological comfort for patient and family.

(c) Provide discharge and follow-up care instructions appropriate to specific needs.

(d) Instruct patient on recommended treatments, examinations, and medications.

(e) Assess, administer and supervise tests, treatments and medications ordered by the physician after examination.

(f) Guide and supervise auxiliary personnel and patient care.

(g) Adhere to approved nursing job description, unit protocols and procedures.

(h) Triage all incoming patients. (UPM Triage Protocols)

(2) Professional:

There is a comprehensive focus on the professional needs of ED staff including unit and hospital inservices, unit standards including practice and guidance for advancement through the Clinical Advancement System. Professional concerns may be addressed to the Nursing Manager, Assistant Nursing Manager.

(3) Administration:

The structure and organization of the ED is written in these standards for the purpose of planning, organizing, implementing, controlling and evaluating the conduct of the ED. The Nursing Manager is responsible for administrative concerns. The Medical Director is responsible for medical staff.

(a) The ED is under the direction of a Medical Director.

(b) Nursing policies and procedures are formulated by the staff members with the approval of the Nursing Manager and Medical Director.

(c) Medical Policy emanates from the Medical Board and the ED staff, through the Medical Director of the ED to the medical staff.

(d) Issues regarding EMTALA quality assurance and or violations are reported through the hospital compliance reporting telephone line.

B. MISSION

The mission statement of the ED is consistent with that of the Department of Nursing and that of John Dempsey Hospital. Refer to Department of Nursing Structure Standards.

II. PHILOSOPHY AND WORK PLAN

A. PHILOSOPHY

The philosophy of the ED is consistent with that of the Department of Nursing and that of John Dempsey Hospital. Refer to the Department of Nursing Structure Standards (Appendix 3).

B. WORK PLAN

Appendix 3 - UPM Structure Standards

III. ADMINISTRATIVE POLICIES

A. ORGANIZATION

1. Relationships

a. Administrative

Emergency Services are organized as a unit within the Department of Nursing). The Medical Staff is organized under the Department of Traumatology and Emergency Medicine. See the Emergency Services Organizational Chart, Appendix 2.

b. Interdepartmental

Emergency Services are an integral part of the Nursing Department under the direction of the Nursing Manager who reports to the Vice President of Operations/Director of Nursing (VPO/DON).

c. Intra-unit

The overall nursing direction of the unit is the responsibility of the Nursing Manager with supervision, direction and support from the VPO/DON. The medical direction is the responsibility of the Medical Director. Collaboration with nurses, physicians, nurse practitioners, physicians' assistants and appropriate department heads takes place through staff meetings. The organization of the services are consistent with the scope, variety and complexity of patient care services provided. Emergency Services Organizational Chart is in Appendix 2. Performance descriptions exist for each position on the organizational chart and can be found in the Performance Description Book in Human Resources.

2. Communication Mechanisms

a. Administrative

Verbal, written and electronic information to and from Emergency Services, Hospital and Health Center Administration is delivered, received and transmitted through the Nursing Manager and/or Medical Director.

b. Interdepartmental

Communication channels to and from Emergency Services and the Department of Nursing are based on the Departmental Organizational Chart (Department of Nursing Structure Standards).

c. Intra-unit

Communication channels are based on the Emergency Services Organizational Chart (Appendix 2).

d. Mechanisms

A variety of communication mechanisms are available, such as TTY/e-mail/shift/transfer report, telephone/paging system throughout the Hospital, bulletin boards/mailboxes on the unit, unit staff meetings, meeting minutes and memos, Emergency Service committees,

and the availability of foreign language/deaf and hard of hearing interpreters.

3. Unit/Extent of Command

   a. The authority, final responsibility for, and control of all actions directed toward the nursing goals of the Emergency Services are vested in the Nursing Manager. The Nursing Manager is also responsible for the nursing staff, medical assistants, volunteers and patient representatives. In the absence of the Nursing Manager, coverage is provided by the Assistant Nursing Manager or designee. The Nursing Supervisors are qualified to act in the absence of the Nursing Manager on the off-shifts, weekends and holidays. The VPO/DON appoints an Interim Nursing Manager when necessary.

   b. The authority, final responsibility for, and control of all actions directed toward the medical goals of the Emergency Services are vested in the Medical Director. The Medical Director is also responsible for the residents and senior resident, medical students and mid-level providers. The Medical Director appoints a qualified alternate in his absence.

   c. Nursing management of the Emergency Services is provided by a registered nurse who supervises the care provided by all nursing services.

   d. Medical Staffing:

      (1) Responsibilities of the Medical Director:

      The Medical Director assumes responsibility for the medical administrative control of the ED and, with advice from Clinical Department Heads, sets medical standards of care. The Director assures that the quality, safety and appropriateness of emergency patient care are monitored and evaluated and that appropriate actions based on findings are taken.

      The Medical Director supervises mid-level providers (APRN/PA).

      (2) Responsibilities of Physicians and APRN/PA:

      Physicians, Physician Assistants, Advance Practice Registered Nurses are responsible for the medical screening exam (MSE) and further evaluation and management of all patients in the Emergency Department.

      Physician Assistants, Advance Practice Registered Nurses and House staff members work under the supervision of the ED attending on duty or in the presence of their supervisory attending present in the Emergency Department.

      Specialists are available on an established schedule to provide consultation or special services for the needs of emergency patients. An On Call list for specialty consultants is updated daily and listed in the department. The on call lists are available from the hospital operators.

4. Evaluation of Organizational Structure

The organizational structure reflecting the philosophy of the ED is reviewed as needed by the ED leadership. The organizational structure is approved by the Nursing Administrative Council and the Medical Board.

B. GOVERNANCE

1. Functions of the Unit

a. Institutional and Interdepartmental

Qualified nurses and physicians are selected to represent the ED on Hospital and Health Center standing committees based on the recommendation of the Nursing Manager, Medical Director. These recommendations are processed through the appropriate council for confirmation of committee appointments. Nurses may volunteer or be appointed by the Nursing Manager to unit committees. Refer to Department of Nursing Structure Standards, for the role and responsibilities on the stated Hospital/ Health Center Committees. Refer to Administrative Protocol: Committee/Council Membership for Department of Nursing.

b. Intradepartmental

The functions listed in the Department of Nursing Structure Standards are performed by the appropriate members of the nursing leadership group in the ED.

2. Nursing Direction

a. Type of Governance

The ED is decentralized and is consistent with the Philosophy of the Department of Nursing (Department of Nursing Structure Standards).

b. Unit Control

(1) The authority, responsibility, and accountability for assisting the Nursing Manager in directing operations of the ED to fulfill unit function is vested in the collaboration with the Medical Director and Vice President of Operations/Director of Nursing.

(2) ED Committees

(a) ED Nursing Staff Meetings

CHAIRPERSON: Nursing Manager/designee

MEMBERSHIP: ED Nursing staff: RN's, LPN', and MA's

PURPOSE: To enhance the flow of information to and from staff.

MEETING FREQUENCY: Monthly

AGENDA/ MINUTES: Agendas are developed by the Chair with input from staff. Minutes are in ink and filed on the unit. Minutes are kept posted for signature by all staff who are unable to attend

the meeting. Copies are circulated to the Divisional Director and VPO/DON.

(b) ED Staff provider Meeting

CHAIRPERSON: Medical Director, Emergency Medicine

MEMBERSHIP: ED Attending and Mid-Level Providers
Third Year Emergency Medicine Resident

PURPOSE: To review issues germane to the clinical practice of Emergency Medicine with emphasis to the needs of patient care and staff issues.

MEETING FREQUENCY: Monthly

AGENDA/ MINUTES: Medical Director, minutes by Department of Traumatology /Emergency Medicine.

c. Day-to-Day Operations

(1) Authority, responsibility and accountability for the day-to-day, shift-to-shift provision of nursing services is vested in the unit hierarchy.

(2) Unit Hierarchy

Each staff nurse is accountable to the charge nurse.

(a) Staff Nurses are responsible for:

* triage of all ill or injured patients to determine the priority with which patients seeking emergency care will be seen by a physician, based on written triage guidelines.

* initiate life-saving treatment.

* administering physical and psychological comfort to patients and families.
* assess, administer and supervise treatments, tests and medications ordered by the physician. This includes notification of the physician of any pertinent changes in the signs and symptoms of a patient.

(b) Assistant Nursing Managers/Charge Nurses

* are assigned by the Nursing Manager/Assistant Nursing Manager each shift for the purpose of decision-making and facilitating unit communication, coordination and delivery of patient care.

(c) Nursing Manager

* is responsible for the effective organization and management of the ED. Has 24-hour accountability for the effective functioning of the staff including their development and evaluation, the efficient functioning of

the unit subsystem, and the quality of patient care provided in the setting.

(d) Charge Nurse

* is responsible for giving and receiving report to and from the other shifts accompanied by rounds and chart review. Is responsible for Triage when there is no triage nurse. (See Administrative Protocol: Triage.) Ascertains that all ED equipment is available and functioning. Delegates to triage nurse callbacks. Is responsible for staff assignments and documentation on 24 hour report and replacement of nursing staff as need arises. Monitors floor activities, patient care and disposition and waiting room activity. Is the resource staff person for a float nurse or Nurse Pro working in the ED.

* Nurses who are assigned to charge will not be expected to float to another unit. Refer to Department of Nursing Administrative Protocol: Charge Nurse Responsibilities.

d. Support Services within the ED

(1) Preceptor

* refer to Orientation Protocol.

(2) Medical Assistants

- are available on day, evening and night shifts, to carry out all aspects of job description. Responsible to the Nursing Manager or designee.

e. Support Services within the Department of Nursing

(1) Nursing Supervisors

* are resources to the Assistant Nursing Manager or charge nurse (in the absence of the Nursing Manager) providing direction and support in the decision-making process during weekends, holidays and off-shifts. Refer to Department of Nursing Structure Standards.

3. Medical Direction of Patient Care

a. Medical Director's Role

Responsible for the medical administrative control of the unit and with advice from Clinical Department Heads, sets medical standards of care. In the absence of the Medical Director the attending physician on duty has the authority to make administrative decisions in consultation with other departmental physicians or nurses. Responsible to the Chief of Department of Traumatology and Emergency Medicine and to the Chief of Staff of John Dempsey Hospital.

b. ED Attending Physician's Role

(1) All ED patients will receive a clinical evaluation by an attending physician or qualified mid-level provider. Refer to the Department of Nursing Structure Standard.

(2) The ED has a licensed, Board certified or eligible Emergency physician on duty 24 hours a day. The physicians are members of the Division of Emergency Medicine, Department of Traumatology and Emergency Medicine. A faculty member is in attendance at all times for teaching/supervision of house staff rotating through the ED and to provide clinical care.

(3) On-call schedules for referral services are obtained from the hospital operator. The on-call list designates a responsible physician daily for each specialty service.

c. Physician Consultant

Refer to the Department of Nursing Structure Standards.

d. Teaching Staff

Refer to the Department of Nursing Structure Standards.

C. RESOURCE DEVELOPMENT/ALLOCATION/UTILIZATION

1. Financial

Refer to the Department of Nursing Structure Standards.

2. Facilities

a. Patient Care Areas

The Emergency Services of the John Dempsey Hospital is a JCAHO level II ED/Service with 24 hours/day care offered to patients of all ages. Qualified MD's, PA/APRN's, RN's and LPN's are on duty 24 hours/day. Specialty consultation is available within approximately 30 minutes.

(1) Visit

(a) Visit Criteria - The ED

The ED is a primary care unit. The department offers emergency health services 24 hours a day to patients of all ages. The department is responsible for the immediate treatment of any medical, surgical or psychiatric emergency, for initiating life saving procedures in all emergency situations and for providing care in a timely manner to all other patients that may present with less serious medical problems. All patients are properly assessed by qualified individuals. Diagnosis, treatment, admission and appropriate referral and follow-up services are initiated here. Intensive care for acute medical and surgical emergencies and emotional problems is provided on a short term basis until the patient is transferred to the appropriate in-patient area. The most critically ill patients receive the top priority care, determined by triage guidelines.

The Sub-Acute Area offers medical attention for minor medical emergencies and other illnesses. The scope of clinical services affords patients an immediate response to not only the minor medical needs, but the availability of full emergent care in the adjacent Emergency Room if the need arises.

The Sub-Acute Area is staffed with Nurse Practitioners and PA's who will deliver and/or supervise the services provided. They are supervised by ED physicians.

Patients treated in the Sub-Acute Area are referred back to their primary care physician for any required follow-up visits.

(b) Modes of Admission

Patients arrive to the ED via any of the following modes:
* Ambulance
* Walk-in
* Clinic referrals
* PMD referrals

(c) Relationship between Charge Nurse, ED Attending, Resident, Medical Director and Admitting:

The responsible ED Attending will communicate to the charge nurse dispositions on patients being discharged, transferred or admitted. If in the best interest of the patient they need to be admitted, the ED Attending physician has the right and responsibility to discuss the case with the senior resident or with the responsible attending on that service. Refer to Administrative Procedure: Admission to the Hospital of ED Patients. Patients are admitted, discharged or transferred. ED patients do not proceed to other area on campus unless one of above criteria has been met.

(d) Patient referral when ICU beds are full and cannot accept an ED Admission will be handled on a case by case basis after contact with the ICU. Transfer arrangements of the patient to another facility is arranged by the ED Attending. The decision to hold an admitted patient in the ED when beds on the inpatient units are not available. The decision for holding the patient in the ED is made by the Medical Director, in consultation with the Nursing Manager, Charge Nurse. They notify the Hospital Administrator on-call only if there are extenuating circumstances involved in admission/transfer. The nursing supervisor is consulted prior to any arrangements regarding diversion. Refer to ED Administrative EMTALA Diversion Protocol.

(e) Holding Area/Holding Patients

There is no holding area for patients in the ED. Exceptions to this include: long-stay psychiatric patients.

When the hospital census can no longer accommodate any more patients, patients may be held in the ED if the patient's condition and acuity permit adequate nursing care to be performed by the ED staff nurses until a bed can be made available.

The ED attending and the patient's attending agree to hold the patient in the ED. Admitting orders need to be done on admitted patients.

When more than one patient is being held and a bed becomes available, the ED charge nurse will give input into which patient is admitted first based on patient care and acuity and ED needs.

The number of patients, both psychiatric and med/surg, that can be held is a judgment made by the ED Nurse Manager/ANM and ED Attending and relates to:

- acuity of patients
- volume
- capacity
- staffing

There are certain circumstances when a patient should be observed for a period of time after treatment. Observation time should be based on patient need at the discretion of the nurse/physician.

(f) Transfers

The ED Attending will coordinate patient transfers in compliance with EMTALA law when appropriate beds are not available or the patient requires a Level I or II Trauma Center. Refer to ED Administrative EMTALA protocols.

Patients may be discharged to the clinic or sent to the clinic with a consultation form via the appropriate mode. Patients may be transferred to area hospitals and other medical facilities via car, taxi, ambulance or Lifestar.

Patients requiring treatment in hyperbaric oxygen chamber need to be transferred to a facility with such equipment.

[1] Taxi

When a patient can not provide his/her own transportation, a taxi will be called to transport patient either home or other appropriate place, i.e. shelter or significant other's home. Verbal approval must be obtained from the Nursing Supervisor on duty on off hours; Department of Social Services during work hours. The cab slips are filled out in duplicate. The taxi driver enters his/her own name and cab number on the slip. The original cab slip is given to the driver; the duplicate is sent to hospital accounting.

[2] Ambulance

ED patients who require an ambulance for discharge or transfer will be provided one by an ambulance service with which the hospital has an agreement. ED staff shall arrange for the ambulance and any special equipment needed for transport.

[3] Lifestar

When Lifestar is to be utilized as the mode of transport, the helicopter protocol is followed. Refer to HAM Helicopter Protocol.

(g) Deaths

Deaths occurring in the ED and patients dead on arrival (DOA) are pronounced by the ED physician. An ED chart is initiated for all DOAs. Refer to Hospital Administrative Manual. All cases are referred to Medical Examiner.

** "Do Not Resuscitate" orders in the Pre-hospital setting are recognized by JDH's medical control. Refer to Administrative Protocol: Do Not Resuscitate - Pre Hospital.

(h) Against Medical Advice

Patients who choose to leave the ED against medical advice will be asked to sign an AMA form. The patient who refuses to sign may do so without interference. Refer to Hospital Administrative Manual: Against Medical Advice.

(2) Utilization Crisis

Refer to Department of Nursing Structure Standards.

(a) Files

Tools for verification of skills/competencies are maintained in individual staff files located in Human Resources. Refer to Department of Nursing Structure Standards.

3. Human Resource Development

a. Orientation

(1) Health Center/Hospital

New employees attend an orientation session coordinated by the Educational Services Department (ESD). Refer to the Department of Nursing Structure Standards.

(2) ED Orientation

All new ED personnel will have orientation tailored to the individual. All new ED personnel are educated regarding EMTALA policies. All new ED staff are educated on Crisis Intervention Training Program. The specific content is outlined in the ED orientation plan, which is comprised of self-learning packets, clinical experiences and competency skill checklists. The

length of the orientation will be determined by individual competency. Central orientation may be waived for recent employment in the ED. If deemed necessary by the Nursing Manager, additional orientation time will be made available.

b. Staff Development

Unit decentralized development is the responsibility of the Nursing Manager, Clinical Nurse Specialist and Assistant Nursing Manager. The purpose is to facilitate clinical educational needs, based on input from the staff, ED attendings, and the NM. Health team members are utilized to instruct inservices as appropriate. All educational programs are documented, reviewed, and a record maintained by the Nursing Manager or designee. An educational activity record for each staff member is maintained as part of the annual evaluation process. All nurses and medical assistants are educated yearly on decontamination procedures and non-violent crisis intervention. All Department of Nursing programs, which include mandatory inservices, are coordinated through the Educational Services Department.

c. Continuing Education

Refer to Dept. of Nursing Structure Standards.
Support for staff nurses to attend outside programs is provided through the UHP and 1199 contracts.

d. Support Services

(1) Dental Services

Services available 24 hours/day. Individuals presenting to the ED for dental problems are referred to the Dental Clinic on days, Monday-Friday. On off shifts, weekends and holidays, they are seen and evaluated in the ED by the dental resident.

(2) Pre-hospital Services/Medical Control

Medical control is given to all ambulances bringing patients here and to those going to other hospitals when the receiving hospital cannot be contacted or for any reason can't supervise the en route ambulance. Currently all <u>paramedic</u> units are given direction by their receiving hospitals <u>only</u>. EMT intermediates may receive orders from the hospital to which they are bringing a patient. NCCEMS protocols are followed for advanced life support.

e. Consultants

(1) Medical Consult

In the provision of patient care, nursing consults with physicians on formal (e.g. clinical conferences) and informal bases. Refer to Dept. of Nursing Structure Standards.

(a) Small Bowel Obstruction

General Surgery is to be contacted when a patient presents to the ED and a diagnosis of a small bowel obstruction is suspected by the ED physician.

Unless there are clear and specific reasons to the contrary, the patient should be admitted to the General Surgery Service.

(b) GI Bleed

If a patient presents to the ED and a presumed diagnosis of GI bleeding is made, there may be a need for consults from General Surgery, Internal Medicine and/or Gastroenterology.

If a patient is hemodynamically unstable, regardless of the source of bleeding, or if there is bright red bleeding or "currant jelly" stool, General Surgery may be consulted.

(c) Abdominal Pain

[1] When the abdominal pain is the result of trauma, General Surgery may be consulted to examine the patient.

[2] Depending on the history and physical findings, there may be a need to involve Gynecology, Medicine, Urology, Pediatrics or General Surgery. When there is doubt over whom to contact, General Surgery is to be called.

[3] When there is a need to admit the ED patient, but it is not clear which service the patient should be admitted under, General Surgery will admit the patient.

(d) Trauma

To be in compliance with trauma regulations and to provide quality patient care, trauma patients that present to the ED are seen and evaluated by the ED attending and appropriate consultation services are requested. Patients requiring a level I or II Trauma Center may be transferred: Refer to EMTALA ADM PRO: Transfer of Patients.

(e) Psychiatric Consultation in the ED

The ED physician will physically interview the patient prior to requesting a consultation.

The ED physician will perform any medical evaluation that is indicated.

A physical examination and laboratory work if indicated is performed at this time.

The ED physician will write any history and/or physical examination that has been performed and note that he or she feels that this is at least in part, if not entirely, a psychiatric problem.

The ED physician will request an ED consultation.

The ED physician will talk with the psychiatrist or crisis worker on-call to explain the nature of the consult.

The patient receiving a psychiatric consultation will be changed into a hospital gown and have all clothing and belongings removed from room.

In cases that involve strictly the disposition of an alcohol-intoxicated patient the ED physician has the responsibility for making the disposition.

A patient who is considered to be an unsafe driver for any reason shall not leave the ED as a driver.

(f) Pediatric and Adolescent Psychiatric Patients

To provide optimal care to children (under 16 years) presenting to the ED with psychiatric complaints. It is possible to <u>consider</u> for admission to the in-patient psychiatric unit, youngsters 16 years of age and older. Suitability of this admission is decided on a case by case basis by the ED Attending and Psychiatry. The emergency care of younger patients will involve evaluation of physical status by the ED Attending to "medically clear" the patient.

Evaluation of the type and degree of mental illness by the psychiatry consultants.

Referral to outpatient services as appropriate.

When transfer is delayed, the patient will be kept in the ED with whatever protective measures are needed. Medical/Psychiatric supervision will be carried out.

Significant medical/surgical/psychiatric problems will be treated/ stabilized before consideration of transfer.

(g) Hand Injuries

When the ED physician on duty encounters a hand injury that requires consultation, the following guidelines are operative:

[1] If the injury is a major one with combined bone, soft tissue injury or is otherwise considered significant, call the Hand Service on-call, if they are not available, contact the on-call orthopedic surgeon.

(h) Facial/ENT Injuries

For cases with facial/ENT injuries where consultation is necessary, use the following guidelines:

[1] Patient with <u>isolated</u> mandibular fractures or fractures involving teeth should be seen by Oral Surgery.

[2] Patient with isolated nasal fractures should be seen by ENT. These patients often will need to be seen in the next Otolaryngology clinic, as the fracture may need to be reduced within ten days.

[3] For patients with extensive laceration or soft tissue facial injury, call either OMF or ENT or Plastic surgery at the discretion of the emergency physician.

(i) Outside Physician Referrals

Patients referred to the ED by physicians not on the hospital staff will be evaluated by the ED physician on-duty.

After evaluation, the ED physician should inform the referring physician of his findings and recommended disposition by phone and so indicate on the ED Record.

Arrangements for direct admissions must be made by the referring on staff physician with the appropriate in-hospital resident.

Telephone/Verbal orders from hospital staff physicians will be accepted by the Emergency Department Nursing Staff for admitted patients only and placed in the POE system.

An order must be in the chart of any patient receiving medications while in the Emergency Department. This order will be written by the Emergency Department physician, the resident being supervised by the emergency department physician or an APRN/PA.

(2) Nursing Consult

Additional nursing resources can be found on the units. Refer to Department of Nursing Structure Standards.

4. Materials Management

a. Equipment

Refer to Dept. of Nursing Structure Standards.
The following are specific equipment for the ED:

* Crash cart
* Intubation trays
* Philips external pacer and defibrillator
* Ambu bag resuscitators
* Dopplers
* Oxygen tanks
* TAT Restraints
* Slit lamp
* Dental equipment
* Blanket warmer
* Hare traction
* Steinman pin
* Cast cutter
* Finger traps
* Ring cutter
* C-med radio

- Pulse oximeter
- Fluid warmer (Hotline)
- Hypothermia thermometer
- Scale - Adult and Pedi
- Alaris pumps
- Supergurney (Ambulance stretcher with emergency equipment)
- Broselow Kit for Pedi resuscitation and intubation

b. Supplies

Refer to Dept. of Nursing Structure Standards.

c. Linen

Refer to Dept. of Nursing Structure Standards.

d. Product Safety Evaluation

Refer to Dept. of Nursing Structure Standards.

5. Evaluation of Resources

Refer to Dept. of Nursing Structure Standards.

6. Staff

a. Professional

Refer to Dept. of Nursing Structure Standards.

b. Status

Professional staff may be hired full or part-time, as determined by the Nursing Manager and based on unit needs.

Non-professionals may be hired as full-time, part-time. Refer to Dept. of Nursing Structure Standards for change of status.

c. Temporary Staff

(1) Agency Personnel
Refer to Dept. of Nursing Structure Standards.

(2) NURSE PROS

Refer to Dept. of Nursing Structure Standards.

(3) Travelers

d. Non-Nursing Staff

D. STAFFING

1. Responsibility for Providing Adequate Staffing

Refer to Department of Nursing Structure Standards.

2. Administrative Staffing

Refer to Department of Nursing Structure Standards.

3. Master Staffing

Refer to Department of Nursing Structure Standards.

4. Unit Staffing

Refer to Dept. of Nursing Structure Standards.

5. Patient Classification System - Acuity Tool

Refer to Appendix 4.

6. Shift Assignments

Refer to Dept. of Nursing Structure Standards.

a. Infection Control

Refer to Infection Control Manual.

7. Scheduling

a. Responsibility

Refer to Department of Nursing Structure Standards.

E. EMPLOYMENT

Refer to Dept. of Nursing Structure Standards.

IV. PROFESSIONAL PRACTICE POLICIES

A. NURSING PROCESS

1. Assessment

An initial triage assessment will be performed on each patient either by the triage nurse, charge nurse or nurse admitting the patient to a patient care area. Initial vital signs will be done during triage.

All pediatric patients will have a temperature, pulse, respiration and weight taken (when indicated). All patients older than 8 years will also have a blood pressure taken.

If vital signs are not done, reason for deferral must be documented on the patient's chart.

All patients who are hypertensive need to have a blood pressure repeated at least once prior to discharge or admission to the hospital. Refer to ED Protocol: Blood Pressure Screening for the Adult Patient.

Patients who are classified as Level 4 or Level 5 shall have vital signs repeated prior to disposition if initial vital signs were abnormal.

Patients who are classified as Level 3 shall have vital signs repeated at least once or more frequently as warranted by the Nursing/MD staff.

Patients who are classified as Level 1 or Level 2 shall have vital signs repeated frequently as warranted by the nursing/MD staff.

2. Planning

   Refer to Department of Nursing Structure Standards.

3. Nursing Interventions

   Refer to Department of Nursing Structure Standards.

4. Evaluation

   Refer to Department of Nursing Structure Standards.

5. Documentation/Retention of Records

   All patients in the ED have a triage assessment documented upon arrival, and reassessment, interventions, procedures, completion of orders will be documented in the electronic record. Documentation in the ED includes the ED electronic record and additional forms as indicated, i.e. ambulance run forms, consults, PEC. All documentation is signed electronically. Paper documentation sent to HIM to be scanned into the patient's record.

B. NURSING RESPONSIBILITIES

The role of the professional nurse at JDH is consistent with the scope of practice outlined in the State of Connecticut Nurse Practice Act (1975).

Registered Nurse and Licensed Practical Nurses are authorized to perform all JDH protocols and procedures contained in the Department of Unit specific manuals, along with identified procedures from the Lippincott Manual. Orientation programs, ongoing educational activities and completed annual evaluations, which include competency checklists, ensure individual nurses are competent.

The specialized, tertiary care setting demands assessment of specific nursing responsibilities in each clinical area. Therefore, Unit Structure Standards and Practice Manuals further define the professional nurse role in each area of nursing practice.

1. Emergency equipment is checked daily by an RN.

2. ED nursing staff may perform the following bedside testing:

   a. blood glucose

   b. urine chemstrip

   c. Hemocult slides, Gastroccult slides

   d. I-STAT

   e. urine pregnancy (Quick Vue)

   f. pH check

   g. rapid strep

3. Nursing staff at the change of each shift should perform room checks on their assigned area.

4. All treatments and/or medications ordered in the ED must be signed by the LIP.

   A verbal order is generally not given, however, in an emergency situation a verbal order is taken by nursing and the order shall be entered into the electronic record by the nurse. When the order is completed, the order shall be signed off by the nurse and co-signed by the LIP.

   It is the philosophy of the ED staff that we do not provide telephone advice. Callers are advised to call their PMD, or seek medical attention at a medical facility or ED.

   The ED is equipped and supplied so that most standard procedures can be performed when necessary to determine patient status. However, certain procedures should be performed where optimal conditions exist for the patient. Refer to Administrative Protocol: Procedures Not Performed in the ED.

   Refer to Department of Nursing Structure Standards.

C. PROFESSIONAL BEHAVIORS

Refer to Dept. of Nursing Structure Standards.

D. CREDENTIALING

Refer to Dept. of Nursing Structure Standards.

E. RESEARCH

Refer to Dept. of Nursing Structure Standards.

F. STANDARDS

Refer to Dept. of Nursing Structure Standards.
ED Standards are reviewed by the ED Standards Committee and the ED Advisory Committee.

V. CLINICAL POLICIES

Refer to Dept. of Nursing Structure Standards.