UNIVERSITY OF NORTH CAROLINA-CHAPEL HILL

DEPARTMENT OF EMERGENCY MEDICINE

Emergency Medicine
Policies and Procedures Manual

LAST UPDATED: July 27, 2009

All recent entries to this manual are with * NEW * at the bookmark area.

The policy manual may have been updated, revised or have a new addition. They will be marked "new" for up to 6 months after being added

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I. PREFACE

Additional reference manuals:

1. **Emergencies Department Nursing Protocol Manual**
2. **Safety Manual**
3. **UNC Hospitals Policy and Procedure Manual**
4. **UNC Hospitals Nursing Department Nursing Standards of Care Manual**
5. **UNC Hospitals Nursing Care Procedure Manual**
6. **Disaster Plans Manual**
7. **Bylaws, Rules, and Regulations of the Medical Staff**
8. **Infection Control Manual**
9. **Poisindex**
10. **Trauma Protocols Manual**
11. **Carolina Air Care Manuals**
12. **Hospital and University Human Resources Manuals**

This manual is designed as a guide for medical, nursing and administrative staff of the Emergency Department of the University of North Carolina Hospitals.

Information contained in this manual has been compiled by the Emergency Department Nursing and Medical Administration and approved by the Chairman, Department of Emergency Medicine.

Complete Manual 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**	**February, 1998**	
October, 1983	**January, 1994**	**January, 1999**	

Judith E. Tintinalli, MD, MS
Department Chair

Brian Goldstein, MD
Chief of Staff

Sandy Pabers, RN, CNS II

Department Nurse Manager

Ed Jackem, MBA

Department Administrator

James L. Larson, MD
Assistant Professor
Department Clinical Director

Jeff Strickler, RN, MA
Administrative Director
Emergency Department and
Carolina Air Care

II. MISSION STATEMENT

The Emergency Department is the private practice site for Emergency Physicians. We therefore depend upon good relationships with the University, the UNC Health Systems, community physicians, and citizens in our communities for a successful practice.

To function as an integral and responsible member of the University of North Carolina, Division of Health Affairs, School of Medicine, and the University of North Carolina Hospitals.

To provide patient care, service to the physicians, for the community, region, and state.

To teach the principles and practice of medicine and emergency medicine to health professionals, students, and house officers of all specialties, including emergency medicine residents.

To provide direction to the Emergency Medical Services of Orange County and the State.

To become an influence in local, state, and national emergency medicine academic and political activities.

To produce research in clinical care, basic science, and health care systems, both in emergency medicine and in interdisciplinary fields.

To produce national academic leaders in emergency medicine.

Judith E. Tintinalli, MD, MS Chairman
Dexter Morris, PhD, MD Vice-Chairman
Sandy Pabers, RN, CNS

Revised: 7/2000

III. KEY POLICIES

ACTIVATION OF TRAUMA SYSTEM

UNIVERSITY OF NORTH CAROLINA HOSPITALS
LEVEL 1 TRAUMA CENTER

Date	**08/21/03**	**Date**	**08/21/03**
Reviewed	**09/01/99**	**Reviewed**	**09/01/99**
	08/01/97		**08/01/97**
	05/28/96		**05/28/96**

Description: **Activation of the Trauma System shall be initiated prior to the arrival of an injured patient to the Emergency Department (ED) by ED personnel. The Pediatric Trauma Team will be called for patients less than 16 years of age and the Adult Trauma Team for patients 16 years of age and other.**

Purpose: **To notify and mobilize the Trauma Team based on physiologic and Anatomic criteria of the injured patient as reported by prehospital or emergency personnel.**

Procedure: **Trauma activation should be initiated based upon the trauma tier system criteria listed below:**

I. CRITERIA FOR TRAUMA SYSTEM ACTIVATION

To ensure that injured patients receive appropriate medical care, the following criteria shall guide health care professionals in rendering trauma care.

Criteria for Trauma Red Alert Activation

- Airway compromise/Respiratory distress/Intubated trauma patients
- Unconsciousness/decreased level of consciousness (indicator may include GCS$\leq$ 8)
- Shock (indicators may include clinical signs of hemodynamic instability, RTS $\leq$ 8)
- Spinal cord injury
- Crush injury to chest, abdomen, and/or pelvis
- Amputations or degloving proximal to knee or elbow
- Penetrating injuries to head, neck or torso

Special Note:
A Trauma Red Alert should be activated based on physiologic instability. If the patients' condition is uncertain; the charge Nurse or ED Attending should initiate a Trauma Red Alert.

Special Precautions:
Pediatric and geriatric population initiate Trauma Read Alert if unsure of patient status at any time.

Trauma Red Alert for Interhospital Transfer Patient Criteria:
- Multisystem injured patients who need surgical services upon arrival to trauma center
- Hemodynamically unstable patients
- Change in neuro status

Criteria for Trauma Yellow Alert Activation
- RTS 9-11

- GCS 9-14
- Pedestrian struck with RTS ≥9.
- MVC with ejection, rollover, death of another person at the scene with RTS ≥9.
- Injury with deformities noted to two or more long bone fractures.
- Crushing, amputation or degloving injuries distal to elbow or knee.

Special Note:
A Trauma Yellow should be initiated based on mechanism of injury and RTS/GCS in the physiological stable patient.

Criteria for Trauma Green (NO ALERT ACTIVIATION COMPUTER VIA COMPUTER IS NECESSARY)

- Hemodynamically stable
- GCS 15
- RTS 12
- Falls greater then 20 feet with a GCS 15 or RTS 12
- Patient traveling at a speed greater then 40 mph with a GCS 15 or RTS 12
- No obvious deformities
- Classified as green tag by EMS or Transferring agent

II. RESPONSIBILITY FOR ACTIVIATION OF A TRAUMA ALERT

Activation Prior to Patient Arrival to the ED

The Charge Nurse will activate the trauma paging system with a goal of 15 minutes prior to patient arrival. If there is significant forewarning (greater than 15 minutes) the charge nurse shall notify the ED Attending regarding the number of patients, type of injury and estimated time of arrival. The ED Attending shall notify the in house surgery residents.

Activation While Patient in the ED

If the patient status changes, the charge nurse shall activate the trauma paging system and document upgrade or downgrade status on the trauma flowsheets.

III. TRAUMA SYSTEM ACTIVATION NOTIFIES THE FOLLOWING TRAUMA TEAM MEMBERS:

TRAUMA RED ALERT TEAM MEMBERS

Red Team Members	***Red Specially Team Members**
Trauma Surgery Attending	Pediatric Surgery Attending
Anesthesiologist on call	Pediatric Surgery Chief Resident on call
Trauma Surgery Chief Resident on call	Pediatric Surgery Resident
Trauma Surgery Resident	Burn Surgery Attending
Radiology, CT Scan	OB Chief Resident
Critical Care Bed Commander	PICU Charge Nurse
Respiratory Therapy	
Critical Care Supervisor/House Supervisor	
OR front desk	
Transfusion Services	
Trauma Program Clinical Director	
Trauma Case Manager	
Emergency Medicine Attending	*Red specialty team members will be activated when trauma
Emergency Medicine Department Nurses	Involves their specialty.
Chaplain	

Physician Response

Trauma Resident (PGY4 or higher) will be present in ED prior to patient arrival or within 20 minutes of notification.
ED Attending will be in charge until Trauma Surgery Resident (PGY4 or higher) arrives.
Trauma Attending will respond within 20 minutes of activation.
Physicians are expected to sign Trauma Flow Sheet for accountability. Primary Nurse will record all other team members.

TRAUMA YELLOW ALERT TEAM MEMBERS

Yellow Team Members	***Yellow Specialty Team Members**
Emergency Medicine Attending	Pediatric Surgery Attending
Emergency Medicine Resident	Pediatric Surgery Resident
Respiratory Therapy	Burn Surgery Attending
Radiology, CT Scan	OB Chief Resident
Critical Care Supervisor	
Trauma Program Clinical Director	*Yellow specialty team members will be activated
Emergency Medicine Department Nurses	when trauma involves their specialty.

***Special Note:**

Trauma Surgery Service must be consulted for all Yellow Alert trauma patients who are admitted and prior to going to the operating room. The trauma Surgery Service team will receive a page by the alert system but will not respond to a yellow alert until called by the ED Attending.

TRAUMA GREEN TEAM MEMBERS

Green Team Members	***Green Team Specialty Team Members**
Emergency Medicine Attending	Trauma Surgery Attending
Emergency Medicine Resident	Trauma Surgery Resident
Emergency Department Nursing Staff	Pediatric Surgery Attending
	Pediatric Surgery Resident
	Burn Surgery Attending
	OB Chief Resident

***Green team specialty members will be consulted as needed by the EM Attending.**

CRITICAL ED STATUS

UNC HOSPITALS

MEMORANDUM

March 1, 2001

TO: All Medical, Nursing, and Administrative Staff

FROM: Stanley R. Mandel, M.D., Executive Associate Dean for Clinical Affairs and Chief of Staff SRM

RE: Hospital Policies - Emergency Department

Please find attached, Hospital policies on *Critical Emergency Department Status* and *Consults in the Emergency Department.* These policies were unanimously endorsed by the Medical Staff Executive Committee at the January and February meetings. These policies are effective immediately.

If you have any questions regarding the content, please do not hesitate to contact me. Thank you.

Post-it® Fax Note 7671	Date 3-22 # of pages ▶ 3
To DR. Tintinalli	From DR. Mandel
Co./Dept.	Co.
Phone #	Phone #
Fax # 63049	Fax #

The University of North Carolina Hospitals, 101 Manning Drive, Chapel Hill, NC 27514

1.E

CRITICAL ED STATUS

POLICY: Determination and Management of Patient Flow in Critical ED Status.
Critical ED status means that the addition of any new stretcher patients would jeopardize the care of that or other patients in the ED.

PROCEDURE:

1. The attending emergency physician and the ED charge nurse determine that the ED is in critical status. Critical status includes, but is not limited to, the following:
   Department overwhelmed by Level 1 & 2 ED patients
   Inadequate stretcher space for additional critical or stretcher patients
   Reasonable anticipation of multiple injured patients.
2. When critical ED status is identified, the following actions will be taken
   All admitted patients for whom a bed is available are to be sent to the floor or ICU, and the responsible resident/service so notified. If this action resolves critical ED status, no further actions are necessary.

   Admission decisions must be made on patients likely to be admitted. If no beds are available, transfer to other institutions should be considered.

   House nursing supervisor will be notified and assist in patient movement from the ED.
3. Orange/Chatham EMS, Chatham Hospital transfers, and scene and rural trauma calls will not be diverted from the UNC-ED. If no beds are available at UNC Hospitals, patients will be stabilized in the ED and options for transfer to other institutions explored. However, outside transfers from inpatient units or stable transfers will be delayed until critical ED status is resolved.
4. The following individuals will be notified of critical ED status when transfer of patients to other institutions is anticipated:
   CNC or Nursing House Supervisor
   Hospital Director on Call
   Chief of Staff
   Trauma surgery and Medicine critical care on call attendings

01/08/01
approved by Med. Exec Committee as Hospital Policy

renewed 6/28/01

CRITICAL BED STATUS PROCEDURE – UNC HOSPITALS POLICY

It is the policy of the University of North Carolina Hospitals to provide a systematic method for identifying critical bed status, to ensure that beds are being appropriately used during critical bed status, and to minimize the denial of transfers from institutions during periods of critical bed status.

PROCEDURE

The House Nursing Supervisor reports bed status to the Emergency Department physicians each day at the beginning of the afternoon shift. When "critical bed status" is reached, potentially impacting upon transfers, the Hospital Administrator On Call will also be notified by the House Nursing Supervisor and the critical units identified.

II. The House Nursing Supervisor will call the attending physician on call for the unit and ask the attending physician to reassess beds in his/her unit. Periodic reassessments will continue about every four hours during the period of critical bed status.

Ill. During the period of critical bed status, requests for emergency transfers will be determined case by case, in accordance with federal law (Emergency Medical Treatment and Active Labor Act-EMTALA). The attending emergency physician will discuss potential transfers with both the House Nursing Supervisor and the responsible faculty member on call before denying transfers. The unavailability of a bed and the inability to accommodate the transfer in any way shall be fully documented.

IV. Individual services will notify the House Nursing Supervisor when their units reach a critical bed status or àcritical bed status is imminent.

RESPONSIBLE UNIT
Medical Executive Committee

Reviewed and revised as necessary: 4/99
9/00
12/01

ED ACCESS AND DIVERSION OF TRANSFERS FROM OTHER HOSPITALS

The Emergency Department at UNC Hospitals maintains access to patients in our EMS catchment area and to Carolina Air Care scene calls. The below policy requirements are to be followed consistent with federal law on accepting transfers.

Trauma transfers from other emergency departments can only be diverted with the approval of the trauma attending on call and the chief of staff.

Acceptance or denial of transfers, of other types of patients from other emergency departments, are determined by the attending emergency physician. Such decisions are based upon the best information available from multiple sources including the patient's medical needs; OR, ICU, and floor bed capability and nursing resources; and the bed capacity and nursing resources in the ED.

Transfers from inpatient beds at other hospitals to UNC inpatient beds can only be accepted or denied by the attending responsible for that service.

Judith E. Tintinalli, MD, MS
Professor and Chair
Department of Emergency Medicine

June 25, 2001

July 2, 2001
Approved by UNC Hospitals Medical Executive Committee

Replaces Department of Emergency Medicine Policy originally written October, 1989; revised December, 1990; December, 1991; November, 2000

Reviewed and revised as necessary:
Dec. 2001

CHART DOCUMENTATION AND SUPERVISION STANDARDS ,EMERGENCY DEPARTMENT

Supervision Standards

All patients must be presented to the Emergency Department Attending. Medical Students present directly to the attending. Any cases supervised by a Resident must be examined by the Resident before approving the work-up.

Documentation Standards

The ED record documentation standards for all patients with moderate or high complexity problems are as follows:

1. Time of exam
2. ROS as appropriate
3. History and Physical Examination
4. Results of laboratory values that require medical action. Rote transcription of labs in WebCIS is not encouraged. The phrase "webcis reviewed" is preferred to transcription of lab values. This should reduce unnecessary work and errors.
5. Results of radiologic studies and EKG.
6. Procedure notes
7. Re-evaluation notes when appropriate.
8. Notes indicating time of consultations.
9. Condition on discharge.
10. Activity excuse notes.
11. Follow up instructions.
12. An attending note documenting the appropriate level of involvement with the case.

James L. Larson MD
Medical Director
UNC Hospitals Emergency Department
May 10, 2005

PATIENT FLOW IN THE EMERGENCY DEPARTMENT

EFFECTIVE: IMMEDIATELY

POLICY
It is the objective of the University of North Carolina Hospitals to provide efficient emergency department care for all patients.

PROCEDURE

1. Admission disputes between services need to be resolved within 2 hours. Designation of the admitting service will be delegated to the emergency medicine attending physician if a resolution is not made within 2 hours after the potential admitting services have been notified.

2. It is the responsibility of the accepting service to arrange an inpatient bed prior to transfer of an inpatient from another institution. Patients brought by ambulance will be assessed by the emergency department charge nurse and by the emergency medicine attending. The physician will verify the patient's stability, authorize transport to the inpatient bed, and will notify the appropriate admitting resident.

Patients will be registered in the emergency department if they are unstable or if the bed arranged is inappropriate for the patient's condition.

ORIGINATING UNIT
Department of Emergency Medicine

Administrative Approval: Todd Peterson 10/05/95
Director of Operations

Medical Staff Approval: Stanley Mandel 10/02/95
Chief of Staff

Reviewed: 6/28/01 Dr. Tintinalli
Revised: 9/08/03 Dr. Tintinalli

REFERRALS TO THE EMERGENCY DEPARTMENT

PURPOSE:

To insure attending-to-attending communication regarding emergency referrals and requests, and to insure adequate hospital resources for prospective admissions.

PROCEDURE:

Prospective telephone referrals from outside physicians, hospitals, or agencies should all be directed to the charge nurse or emergency medicine attending physician. Complex calls should be directed to the emergency physician. Calls from outside agencies or physicians should be directed to the emergency physician at UNC Hospitals. Bed status is maintained by the House Nursing Supervisor who will notify the ED Attending several times each day about bed availability. The Charge Nurse enters transfer information into the SMS system.

ED Referrals from Orange County, Trauma Referrals, Referrals from other Emergency Departments

All requests for emergency department patient evaluations from physicians or agencies in Orange County, or for scene trauma calls or acute trauma transfers, or from other Emergency Departments in the State, are accepted directly by the triage nurse or emergency physician.

Referrals from Inpatient Units to UNC

Requests for in-hospital transfers should all be directed to the Emergency Medicine Attending, who will then locate the attending on-call for the appropriate in-patient service. Only the inpatient attending can accept inpatients.

Transfer Denials

Only Attendings can deny transfers. The chief of trauma surgery is the only individual who can authorize adult or pediatric trauma transfer denials. A log of transfer denials due to insufficient ED hospital resources will be maintained by the ED Attending and submitted monthly to Hospital Administration.

Patient Transport to UNC-ED

The ED Attending can arrange Air or Ground transport through Carolina Air Care.

Judith E. Tintinalli, MD, MS
Department Chair

Revised 1/25/99
Revised 6/27/01

TRANSFER DIVERSION LOG : EMERGENCY DEPARTMENT

Policy: A transfer diversion log will be maintained in the Emergency Department, to document times and dates of diversion status.

Procedure:
Maintaining the Transfer Diversion Log. The transfer diversion log will be maintained in a looseleaf folder at the A side attending desk. Each faculty member should indicate diversion status as OPEN or CLOSED at the beginning of each shift, that is at 7AM, 4:30 PM, and 1:30 AM. The date and time should be entered.
When status is DIVERSION, the date and time of diversion and the responsible individual (house nursing supervisor, trauma attending) should be entered in the log. The Chief of Staff must be notified and that should also be entered in the log.
DIVERSION will normally last for the entire shift. Status should be rechecked at the beginning of each shift as indicated above.

Requests by individual faculty in departments other than Trauma for 'diversion'. When faculty from other Departments request diversion for cases in their specialty, that is to be documented in the Diversion Log, with the name of the specialty attending also documented. The Chief of Staff must be notified of such requests for diversion as well.

Documenting any refusals of transfers. In order to be in compliance with EMTALA regulations, when the ED is on DIVERSION or CLOSED status, if any cases are actually denied transfer, document the patient's name and clinical details, on form MIM #505, located in the first section of the Transfer Diversion Log.

Communicating OPEN or CLOSED status to the Emergency Department. A side faculty must also write OPEN or CLOSED for each shift on the large wax board in the Emergency Department .

Communicating with Hospital Administration. The ED Administrator will forward a copy of the diversion log to Sandra Evans, RN, MBA, on the first of each month.

Judith Tintinalli, MD, MS, Chair
James Manning, MD, Vice Chair

UNC HEALTH CARE *Excludes Rex Healthcare	Name of Policy	MANAGEMENT OF PATIENTS THAT FAIL TO RESPOND TO CALLBACKS
	Policy Number	
	Date This Version of Policy Effective	September 27, 2005
	Department Responsible for Review	Emergency Department

POLICY:

It is the policy of UNC Hospitals to provide a reasonable and appropriate period of time for patients to respond to callbacks from triage or Emergency Department staff.

PROCEDURE:

If a patient does not respond to a callback to triage or to the department, then Emergency Department staff will document "no answer" and the time on the computerized documentation system (T-system). Attempts will be made to callback the patient for a total of three times, approximately ten minutes apart, with each attempt documented as above. After three attempts, the patient will be documented as having left without being seen and discharged in the computer system (Siemens) by selecting the "left without receiving medical advice" option.

ENTERING PRE-ARRIVAL INFORMATION INTO THE COMPUTER

November, 2000

POLICY: Physician to physician information will be entered by the senior attending emergency physician into the triage referral system. It is the responsibility of the private physician, or other services within the UNC system, to communicate with the emergency physician or the ED charge nurse regarding pre-arrival information.

PROCEDURE: Pre-arrival information can be entered into the SMS system by the charge nurse, triage nurse, or senior attending emergency physician. Physician to physician calls will be entered directly by the senior emergency physician into the SMS 'triage referral' system. UNC Hospitals ISD system is responsible for maintenance of all SMS sites. There is no method to maintain a permanent record of pre-arrival information, as this is all located in temporary files.

The triage nurse or charge nurse must actively query the 'triage referral' screen in order to determine if pre-arrival information has been entered on the patient.

System errors which can result in loss or failure to capture pre-arrival information include: 1) patient arrives in the ED before the private physician or UNC service calls the ED; 2) nurse or attending physician is occupied with critical patient tasks and enters information after the patient has arrived; 3) private physician or UNC service does not communicate with the ED regarding pre-arrival information; 4) triage or charge nurse may fail to query the pre-arrival screen.

Judith E. Tintinalli, MD, MS
Professor and Chair

James L. Larson, MD
Professor and Clinical Director

MENTAL HEALTH EVALUATION IN THE EMERGENCY DEPARTMENT

November 3, 2000

POLICY: To prioritize and efficiently manage patients presenting to the emergency department with mental health problems, and to insure the provision of appropriate medical evaluation for all patients with mental health problems.
For purposes of this policy, patients with 'mental health problems' are those with a chief complaint of a psychiatric nature and with no acute medical problems identified at triage. These patients are triaged directly to the psychiatry crisis service in the ED.

PROCEDURE:

1. The American modification of the NTS (National Triage Scale, Australasian College of Emergency Medicine) will be modified to triage mental health patients as follows:

Level 1	not applicable
Level 2	Actual or potential violence or aggression, suicidal or homicidal ideation, suspected of being dangerous to themselves or to others
Level 3	Overt anxiety or agitation or intoxication, no suicidal or homicidal ideation
Level *4/5*	Stable, no overt anxiety or agitation, no suicidal or homicidal ideation

   The evaluation of Level 2 and 3 patients by psychiatry should begin within 30 minutes after psychiatry has been notifed of their presence.. They will be triaged to Rooms 16 and 17 in the ED or other appropriate acute care bed within direct visual range of nursing staff. Level *4/5* patients will be triaged to Minor Trauma, or Pediatrics if <16, when those areas are staffed, and evaluation by psychiatry should begin within 60 minutes after the psychiatry service has been notified.

2. All patients aged 60 and over with a psychiatric chief complaint, or any psychiatric patient with an acute medical problem suspected at triage, will be gowned and placed in an examining room for medical evaluation.

3. The psychiatry crisis service will be consulted for the evaluation of mental health problems when the patient is placed in an examining room, whether or not medical evaluation has yet been done. The primary care nurse will page the psychiatric consultant when the patient is placed in an exam room.

4. Emergency Medical evaluation is required for all mental health patients. It is the responsibility of the psychiatric consultant to inform the Emergency Medicine or Pediatric attending that medical evaluation is necessary, before patient disposition. In the case of patient transfer to an outside psychiatric institution, it is the responsibility of the psychiatric service to insure that all chart documentation, including transfer forms and documentation of medical evaluation, is complete before finalizing the transfer.

5. For psychiatric patients where more than a 60 minute delay in psychiatric evaluation is anticipated, it is the responsibility of the psychiatric resident to obtain additional assistance. For unusual delays or situations, or when the ED nursing staff identifies a critical psychiatric patient overload, the Emergency Medicine attending should notify the Psychiatric attending on-call.

6. Patients suspected of suicidal or homicidal ideation, or those with potentially aggressive or assaultive behavior, will be searched for weapons by UNC Hospitals Police. This should occur at the time of triage or when the patient is placed in a treatment room.

Judith Tintinalli, MD, MS
Department Chair

Sandy Pabers, RN, CNS II
Nurse Manager

R. Golden, MD
Clay Bordley, MD, MPH
L. Nicholas, MD

UNC HEALTH CARE *Excludes Rex Healthcare	Name of Policy	REFUSAL OF MEDICAL SCREENING EXAMINATION
	Policy Number	
	Date This Version of Policy Effective	
	Department Responsible for Review	Legal and Risk Management

POLICY:

It is the policy of UNC Hospitals to offer a medical screening exam for every patient who presents to the Emergency Department and other locations for emergency treatment. The purpose of a Medical Screening Exam is to determine if an emergency medical condition exists and to provide appropriate stabilizing treatment.

PROCEDURE:

Patients will be provided information regarding the need for their medical condition to be evaluated. Patients will be advised to inform the triage nurse if their condition changes or if they plan to leave without being seen. If a patient expresses the desire to leave, they will be advised of the risks of not having a medical screening exam done and will be asked to sign a “Withdrawal of Consent for Medical Screening Exam” form. If a patient refuses to sign, the triage nurse will document the patient’s refusal, sign and date the form. The form will be retained as a permanent part of the medical record.

University of North Carolina Hospitals

OBLIGATION TO PERFORM A MEDICAL SCREENING EXAMINATION

UNC Hospitals' obligation under federal law is to provide patients a medical screening examination and indicated stabilizing treatment. The purpose of a medical screening examination is to determine if an emergency medical condition exists and to provide appropriate stabilizing treatment. You will be evaluated and triaged as soon as possible based on the severity of your condition.

If you decide to leave the UNC Hospitals' Emergency Department, or other locations within UNC Hospitals where emergency care is provided, before receiving a medical screening examination by a physician, you are asked to notify the triage nurse prior to leaving. Leaving before receiving further medical examination would be against medical advice and may result in a worsening of your condition and could pose a threat to your life, health and medical safety.

PEDIATRIC RED (LEVEL ONE) TRAUMA RESPONSE COVERAGE
September 13, 2005

The Pediatric Surgery Service can not reliably provide attending coverage for pediatric red alert traumas within the required 20 minute time frame during off hours given the geographic constraints of covering WakeMed in Raleigh. The following changes in pediatric red trauma coverage have been developed to assure trauma attending presence within 20 minutes. In addition, red trauma criteria will be reviewed to reduce the number of unnecessary pediatric alerts.

The purpose of this arrangement is to provide an initial resuscitation consultation to maintain compliance rather than obviate involvement or assumption of responsibility by Pediatric Surgery.

Coverage of Pediatric Red Traumas

1. Pediatric Surgery will be the primary responder for all pediatric red alert traumas between 7:00am and 5:00pm weekdays. The adult Trauma/Critical Care team can provide backup if no attending pediatric surgeon is available during the day although it is anticipated that this will occur rarely, if ever. Should this be necessary, the Pediatric Surgery attending will personally call the Adult Trauma attending to communicate the need. Holiday coverage will be on a case by case basis.
2. Although all Pediatric Trauma patients (under 16 years) will be admitted to the Pediatric Surgery service (with PICU concurrent care when appropriate), the Adult Trauma/Critical Care Service will be the primary responders for pediatric red traumas on weekends (7 am Sat – 7 am Mon, and between 5:00 pm and 7:00 am weekdays.)
3. Pediatric Surgery attendings will continue to receive red alert pages and will respond as soon as available. If this response is anticipated to be longer than 40 minutes from the time of alert, the Pediatric Surgery attending will alert the Pediatric Surgery back-up attending so that they can respond. Pediatric surgery residents and the PICU fellow will respond to all pediatric red alert pages as part of the initial resuscitation phase.
4. The pediatric surgery attending will be available for phone consultations immediately and either the primary attending or backup attending will be physically present within 40 minutes for patients requiring surgery or those requiring ongoing evaluation or surgical care.
5. Pediatric surgery will assume management of the patient no later than the time at which the patient leaves the trauma bay or within 40 minutes, whichever occurs first.
6. The Ped Surgery service is responsible for writing admission orders
7. The Ped Surgery service is responsible for f/u on all consults/labs/scans/radiography done in the ED
8. The Ped Surgery service is responsible for interactions with the PICU including bed assignments.

REQUESTS FOR BLOOD ALCOHOL LEVELS

PURPOSE: North Carolina Statute requires that an opportunity be provided for individuals who have taken a breath analyzer ethanol test to obtain a blood ethanol level. As a state institution, we have the obligation to provide that opportunity on a 24 hour basis.

Procedure

1. Individuals who are charged with DWI and receive a breath analyzer test in Orange and Chatham counties will be advised that they can come to the emergency department at UNC Hospitals to have a blood ethanol level drawn, and that they will receive the standard emergency department and laboratory charges for the procedure

2. The individual reports to the Triage Desk with a form signed by the responsible police jurisdiction. Individuals who do not show this form are not eligible to have a blood ethanol drawn and fall under the ED policy "Requests for Diagnostic Studies Without Medical Indication".

3. The triage nurse will fill out the triage form and send the patient to ED registration.

4. A complete ED chart will be generated at registration.

5. The patient will return to the Triage Desk with the completed chart and have a blood ethanol level drawn (no alcohol swabs used) by the triage nurse.

6. The physician should document th~t the patient is medically cleared for ED discharge.

Judith Tintinalli, MD, MS, Chair
Sandy Pabers, RN, CNS II, Nurse Manager

Originated 9/14/94
Revised 1/28/99

REQUESTS FOR DIAGNOSTIC STUDIES WITHOUT MEDICAL INDICATION

PURPOSE:

To insure that diagnostic or interventional studies are performed only for medical indication.

PROCEDURE:

Requests for diagnostic or interventional studies without emergency medical indication are not performed in the Emergency Department.

Examples of such requests include but are not limited to requests by lawyers for blood ethanol levels for clients, requests by a parent for a routine toxicology screens on a child, and requests for routine HIV testing.

Judith E. Tintinalli, MD, MS
Department Chair

Sandy Pabers, RN, CNS II
Nurse Manager

SEXUAL ASSAULT EVALUATION

Department of Emergency Medicine

Policy: Sexual Assault Evaluation is accomplished by the SANE team. Physicians assist in the medical aspect of sexual assault care.

Procedure:

SANE role
- Collect forensic evidence
- General patient assessment
- Provide prophylactic treatment
  - STD, HIV, Hepatitis B, and pregnancy prevention
- Referrral to Infectious Disease, psychiatry, and social services as indicated

ED Physician role
- Review case presentation by SANE specialist
- Document on ED record that case was discussed
- Intervene or assist in examination if needed/indicated
- Sign prescriptions for prophylactic medications

October 31, 2002

Judith T. Tintinalli, MD, MS
Professor and Chair

Sandy Pabers, RN, CNS II
Nurse Manager

ER NURSES ROLE IN PELVIC AND SEXUAL ASSAULT EXAMINATIONS

PURPOSE

(1) To develop guidelines to assist the Emergency Department Nurse in delivering quality care to patients requiring pelvic and sexual assault examinations and forensic evidence collection.

(2) To clarify the role of the Emergency Department Nurse (male and/or female) in assisting in pelvic or sexual assault examinations and forensic evidence collection.

GENERAL STATEMENTS

(1) The North Carolina Board of Nursing does not differentiate the role of a nurse as it pertains to gender.

(2) The North Carolina Nurse Practice Act does not differentiate the role of the nurse as it pertains to gender in the delivery of nursing care.

(3) The University of North Carolina Hospitals does not differentiate or limit the role of the nurse as it pertains to gender in the delivery of nursing care.

(4) The University of North Carolina Hospitals Legal Department knows of no existing policy addressing gender in pelvic or sexual assault examinations and forensic evidence collection.

(5) The delivery of nursing care should be patient-based and should reflect the patient's needs and desires whenever possible.

GUIDELINES

(1) Prior to pelvic and/or sexual assault examinations and forensic evidence collection, explanation of exam should be given to patient and any questions answered. Explanation should be given in terms the patient understands.

(2) All patients should be informed as to personnel to be present during the examinations and as to their roles.

(3) In sexual assault cases, the patient should be informed of the availability of a rape counselor. At the patient's request, a rape counselor may be present throughout the examination.

(4) This Emergency Department policy and procedure will be reviewed periodically and updated as needed to reflect current nursing practice.

Revised: February, 2002

EMERGENCY DEPARTMENT STANDING ORDERS

The Clinical Operations Group of the Department of Emergency Medicine has developed standing orders for implementation by the nursing staff prior to the patient being evaluated by an emergency physician. These are guidelines for actions to be taken by nursing staff based upon the patient's chief complaint. These do not replace clinical judgment and should be used in conjunction with a patient's clinical presentation.

Vital Sign Guidelines:

Vitals signs may vary for each patient. Listed below are some general guidelines for each vital sign (for adult patients). If a patient falls outside of these, the patient should be placed on a monitor and a physician contacted immediately.

Temperature	< 38 C
Pulse	60 – 100 beats per minute
Respiratory Rate	12 – 20 breaths per minute
Systolic Blood Pressure	90 – 150 mm Hg
Diastolic Blood Pressure	60 – 90 mm Hg
Pulse Oximetry	≥ 96 %

Implementation Procedure:

After the nursing assessment of the patient, the bedside nurse may activate the standing orders most consistent with the patient's complaints and physical assessment. Again, any patient outside the norms for vital signs should have a physician at the bedside as soon as possible.

The nurse will document on an order sheet the standing order protocol implemented, notify the attending physician, and document the physician's name on the order sheet. For example: Abdominal Pain Standing Orders per Dr. Tintinalli. The HUC will then order the appropriate labs and studies per the protocol. The order sheet will become part of the medical record.

To reiterate: these are guidelines based upon the patient's chief complaint and intended to expedite care. The primary nurse is not being asked to make a diagnosis, but rather to assess the patient's complaints. These do not replace nursing or physician clinical judgment.

Judy Tintinalli, MD, MS
Chair

Jim Larson, MD
Medical Director

Abhi Mehrotra, MD
Assistant Medical Director

Sandy Pabers, RN
Nurse Manager

Jeff Strickler, RN, MA
Clinical Director

TREATMENT OF PATIENTS WITH EMERGENCY MEDICAL CONDITIONS

POLICY

It is the policy of the University of North Carolina Hospitals, that all patients presenting for examination or treatment, including women in labor, shall be given an appropriate medical screening examination by a physician to determine if an emergency medical condition exists. If the physician determines that an emergency medical condition exists, or that a woman is in labor having contractions, the patient shall be treated; the patient may be transferred or discharged only in compliance with the procedures detailed below.

Whenever a person who is within 250 yards of the Hospitals' buildings needs medical care, but is not inside a hospital building, 911 should be called promptly to provide the person with appropriate level of life support and to transport the person to the Hospitals' Emergency Department.

If a person comes to a hospital based clinic off the Hospitals' main campus, the health care providers at that clinic should perform a medical screening exam to determine if an emergency medical condition exists. If it does, then they should provide care within their capabilities in an attempt to stabilize the patient, and call 911 if it appears the patient cannot be stabilized. If the ambulance/rescue squad is going to bring the patient to the UNC Hospitals' Emergency Department, no formal transfer papers need be filled out, but the Emergency Department should be notified of the situation, If, however, the patient will be taken to any other hospital's emergency department, then the EMTALA transfer paperwork must be filled out, including calling that emergency department about transferring the patient.

For the purposes of this policy, an "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity such that the absenc~of immediate medical attention could reasonably be expected to result in: placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to any bodily functions; or, serious dysfunction of any bodily organ or part. With respedt to a pregnant woman who is having contractions, it means: that there is inadequate time to effect a safe transfer to another hospital before delivery; or, that transfer may pose a threat to the health or safety of the woman or the unborn child.

The terms "stable" or "stabilized" are defined in paragraph 7 below.

PROCEDURE

Medical Screening Examination

1. All patients presenting to the University of North Carolina Hospitals for examination or treatment, including minors without a parent and women in labor, shall be given an appropriate medical screening examination by a physician to determine if an emergency medical condition exists. The medical screening examination may include laboratory tests, radiology studies, or consultations, as appropriate.

2. The medical screening examination shall be performed without regard to the patient's ability to pay, and without regard to the diagnosis, financial status, race, color, national origin, disability, sex, or age. The medical screening examination and/or stabilizing treatment shall not be delayed in order to inquire about a patient's method of payment, insurance status, or payment authorization from a managed care plan.

3. If the examining physician or other staff determine a consultation is needed from a physician of a particular specialty, the physician on-call for that specialty service shall be called. On-call physicians are expected to call or come to the Emergency Department or other location as set out in the "Consults in the Emergency Department" policy.

4. If a physician determines that an emergency medical condition exists, appropriate treatment shall be offered to stabilize the patient's condition.

5. If a physician determines within a reasonable medical probability that a medical emergency condition does not exist, that conclusion shall be expressly stated in the patient's medical record, along with notes of that examination and the conclusion as to why an emergency medical examination does not exist.

6. A patient (or person acting on behalf of the patient) who has an emergency medical condition may, against medical advice, refuse to consent to treatment or transfer after he/she has been informed of the risks and benefits of the refusal of treatment or transfer. A report to the appropriate county Department of Social Services should be considered when care is refused on behalf of a patient not capable of making his/her own informed decisions.

Discharge or Transfer

7. If the physician determines that an emergency medical condition does exist, the patient may be discharged or transferred from UNC Hospitals when the patient has been stabilized. A final resolution of the emergency medical condition is not required before a patient may be discharged or transferred,however, the patient must be given a plan for appropriate follow-up care with discharge instructions.

a. "Stabilized for discharge" means, within reasonable medical probability, that no material deterioration of the condition is likely to result from or after discharge, and that the patient has reached the point where continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient. As to a pregnant woman having contractions, "stabilized" means that the woman has delivered the child, including the placenta. A psychiatric patient is stable for discharge when he/she is no longer considered to be a threat to

self or others.
b. "Stabilized for transfer" means, within reasonable medical probability, that no material deterioration of the condition is likely to result from or during the transfer of the patient to another facility, and that the receiving facility has the capability to manage the patient's condition and any reasonably foreseeable complications of that condition. As to a pregnant woman having contractions, "stabilized for transfer" means that the woman has delivered the child, including the placenta. A psychiatric patient is "stabilized for transfer" when he/she is protected and prevented from injuring himself/herself or others.

8. If the physician determines that an emergency medical condition does exist and the patient has not been stabilized, the patient may be transferred to another medical facility when either:
a. The patient (or legally responsible person acting for the patient when the patient is incapable of making an informed choice):
i. Refuses treatment after screening, further examination, and/or treatment was offered (and all of that is documented in the medical record); and
ii. Requests in writing, including the reasons, for transfer to another medical facility
a) after being informed of UNC Hospital's obligation to provide care without Fegard to ability to pay and obligation to stabilize the patient prior to transfer, and
b) after also being informed of the risks and benefits of transfer, or -
b. A physician has signed a written certification, including the risks, benefits and reasons fpr transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, and, in the case of labor, to the unborn child from effecting the transfer. A patient under psychiatric commitment who is not stabilized may be transferred to another facility when a physician has documented in the medical record the risks and benefits of transfer. Patients, except those under involuntary commitment, must consent to a transfer.

9. The transfer must be effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. For physician-initiated transfers for medical benefits, a re-evaluation of the patient must be performed
shortly prior to the actual transfer, and the findings documented in the medical record. If the patient has been stabilized or is unchanged, proceed with the transfer. If the patient's condition has declined, then the risks and benefits of the transfer should be re-evaluated and newly documented.

10. To transfer a UNC Hospitals patient who is ~ stabilized, the physicians must provide medical treatment within their capacity to minimize the risks to the patient's health, or to the health of an unborn child. The receiving medical facility must have available space and qualified personnel for the treatment of the patient, and prior to transfer, must have agreed to accept the transfer of the patient and agreed to provide appropriate medical treatment. The receiving medical facility's agreement to accept the transfer shall be documented, including the date and time of the agreement to accept the transfer and the name of the person accepting the transfer.

11. UNC Hospitals must send to the receiving medical facility a copy of all medical records available at the time of transfer related to the emergency medical condition for which the patient has presented, including records related to the patient's medical history, the emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests or diagnostic studies, and a copy of the patient's (or legally responsible person's) written request for transfer or the physician's certification. Test results that become available after transfer should be telephoned to, then mailed or faxed to, the receiving medical facility.

Accepting Transfers and Reporting Improper Patient Transfers

12. UNC Hospitals must accept the requested transfer of a patient who is in an emergency medical condition only when UNC Hospitals has the capacity and specialized capabilities which are not available at another hospital. UNC Hospital~ is not obligated to accept a transfer merely because the requesting hospital has no beds or is overcrowded, when the patient does not require specialized capabilities of UNC Hospitals.

13. Failure of a referring hospital to comply with its obligations referenced in paragrapl~s 8b, 9,10 and 11 above may be a violation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Any physician or staff member who believes that an outside hospital has transferred a patient with an emergency medical condition to UNC Hospitals in violation of the above EMTALA requirements shall contact the UNC Hospitals Legal Department. The Legal Department will investigate the circumstances of the transfer and, if a violation exists, report the matter to the North Carolina Division of Facility Services. Health care providers have a duty to assist the Legal Department in this investigation.

Reviewed and revised as necessary:
Dec. 2001

IV. Staffing Plans, Responsibilities and Resources

ALL PATIENTS IN THE EMERGENCY DEPARTMENT ARE THE CLINICAL OR ADMINISTRATIVE RESPONSIBILITY OF THE EMERGENCY MEDICINE ATTENDING PHYSICIAN.

PROCEDURE

The Department of Emergency Medicine provides medical supervision for the care of the Emergency Department patient by:

Assuring that standards of care are met
Providing medical oversight and quality assurance
Delineating clinical privileges for emergency department staff
Determining standards for chart documentation
Providing efficient patient flow, consultation, and disposition
Determining which procedures are not performed in the emergency department

These are: general anesthesia

Judith E. Tintinalli, MD, MS
Department Chair

Reviewed: 9/7/2001

CLINICAL STUDENTS/OBSERVERS IN THE EMERGENCY DEPARTMENT

Policy

All persons other then UNC Hospitals/School of Medicine employees, faculty, house staff, medical students, volunteers, patients and patient visitors who spend time in the clinical area of the Emergency Department may do so only as a part of an approved educational program, as outlined below.

Procedure

Students:

All students (including EMT, EMT-l, EMT-P) on clinical rotations in the Emergency Department will participate under a contractual agreement between their home institution and UNC Hospitals. Contracts will be processed through the Legal Department. Students will sign a Student Affiliation Agreement and a UNC Hospitals Confidentiality of Patient Information Statement prior to beginning their clinical rotations in the ED. The following requirements will also apply:

Name Tags: All students shall wear a name tag while in the department, either provided by the Emergency Department, or a school/EMS agency name tag.

Attire: Appropriate dress will include a uniform (if available) or dark or khaki pants, a solid-colored shirt, and flat, closed-toe shoes. Jeans are not acceptable.

Schedule: Student clinical rotations will be pre-scheduled and coordinated through the appropriate ED staff member, including:

Students	ED Coordinator
Orange County EMT, EMT-l EMT-P students	EMS liaison nurse clinician
EMS students - other counties	Outreach education nurse clinician
Other students	Outreach education nurse clinician

Insurance: UNC Hospitals does not provide insurance coverage for students on clinical rotations in the ED. Students are responsible for providing their own insurance coverage for any injury or damage they may sustain as students on clinical rotations in the ED.

Immunization: Students are required to submit to their home institution a completed health form and certify that they are free from communicable diseases (venereal disease, hepatitis, measles, mumps, rubella, varicella, and active TB), and have received OSHA-required education and training in HIV control measures. Students who require immunization must be vaccinated before beginning their clinical rotations.

Observers:

All requests for observation time in the department by anyone other than the students listed above will be approved and pre-scheduled by the Clinical Nurse Supervisor II, the Department Chair, or their designee. Observation in the ED will be approved only for appropriate educational purposes. Observers will have no hands-on contact with patients, or any contact with blood or bodily fluids. All observers will sign a UNC Hospitals Confidentiality of Patient Information Statement before beginning their observation in the ED. The following requirements will also apply:

Name Tags: All observers shall receive and wear a name tag while in the department.

Attire: Appropriate dress will include a uniform (if available) or dark or khaki pants, a solid-colored shirt, and flat, closed-toe shoes. Jeans are not acceptable.

Schedule: Observer clinical rotations will be pre-scheduled and coordinated through the appropriate ED staff member (Outreach education nurse clinician or designee).

Insurance: UNC Hospitals does not provide insurance coverage for observers in the ED. Observers are responsible for providing their own insurance coverage for any injury or damage they may sustain as observers in the ED.

Immunization: UNC Hospitals does not provide immunizations for observers. Observers will have no hands-on contact with patients.

Judith Tintinalli, MD, MS

Department Chair

Sandy Pabers, RN, CNS II

Nurse Manager

Written: October, 1992
Revised: October, 1983
November, 1986
January, 1993
February, 1996

EMERGENCY DEPARTMENT CONTINUOUS QUALITY IMPROVEMENT

February 14, 2001

PROCEDURE: Continuous Quality Improvement activities are fulfilled by the Patient Safety Board ("PSB") and the Department of Emergency Medicine Mortality/Morbidity ("M&M") Conferences. These Committees are created for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, pursuant to North Carolina's Medical Review Statutes. Activities of both the PSB and the M&M conferences are reported in closed session to the Department at Faculty Meetings of the Department of Emergency Medicine.

The Patient Safety Board consists of the Department Business Manager, ED Administrator, Head Nurse, the Department Chairman, a minimum of three faculty members, a Risk Manager and the Department secretary.

Items for the PSB can enter the system though a variety of sources: the chairman, business manager, ED administrator, head nurse, or individual faculty or residents, and reports from Patient Relations and Risk Management. Items will be logged into a quality improvement database maintained by the Department secretary. Items with risk management potential will be directed to the Risk Management office.

Judith Tintinalli, MD, MS
Professor and Chair

James Larson, MD
PSB Chairman

EMERGENCY DEPARTMENT FAMILY LIAISON VOLUNTEER

UNC HOSPITALS
VOLUNTEER SERVICES DEPARTMENT

ASSIGNMENT DESCRIPTION

ASSIGNMENT TITLE

Emergency Department Family Liaison Volunteer

PURPOSE

The volunteer serves as a liaison between the staff of the Emergency Department and the waiting families and visitors in the Emergency Department Waiting Area to help ensure that necessary information is communicated in a timely manner. The volunteers will facilitate family members visiting with the patient as appropriate.

SUPERVISING PERSONNEL

Director of Volunteer Services
Emergency Department Supervisor

TRAINING

General hospital volunteer orientation
Department specific orientation
Customer service training

DAYS, HOURS, LOCATION

Daily in 3 hour shifts: 9:00AM-12:00PM, 12:00PM-3:00PM, 3:00PM-6:00PM,
6:00PM-9:00PM (evening hours are flexible)
Emergency Department-Basement of Neurosciences Hospital

RESPONSIBILITIES

1. Greet patients and visitors who come to the Emergency Department.
2. Ensure patients sign in at Triage desk.
3. Communicate routinely between waiting visitors and ED staff.
4. Keep track of any patient who is waiting in the Triage Waiting Room to assure them they have not been forgotten.
5. Transport patients as requested by Triage nurse.
6. Provide directions to pertinent areas of the hospital including the coffee shop, hospital motel, cafeteria, telephones, restrooms and main hospital.
7. Ensure visitor passes are issued one to a family.
8. Round through patient care areas to greet patients and see if they need anything to maintain comfort.

9. Take mobile phones to patients as appropriate to talk with family members.

10. Escort family members to the appropriate waiting room if patient admitted for surgery or to an ICU.

PROCEDURES

1. Notify ED staff you are ready to work.
2. Get a printout of patients from ED clerk and report to Triage nurse.
3. Have ED patients sign in at Triage desk seat them in Triage waiting room. If it is busy, ask visitors of patients to sit in the Waiting Room, not the Triage waiting area. Reassure family and friends that they may go back to see the patient one visitor at a time, as permitted by treating physician.
4. Make sure every visitor has a pass visible at all times. Note on the pass if a second one has been issued.
5. Tell families and friends what is transpiring with the patient in general terms (i.e. in x-ray, doctor is with patient, having tests done, etc.). Visitors may not accompany patient to labs or x-ray, except with a pediatric patient.
6. Escort visitors to the Family Room, after getting permission from charge nurse or designated physician.
7. Be observant of luggage and items in the hallway.
8. Do not transport IV or oxygen patients.
9. Listen attentively to patients and visitors.
10. Notify patient's nurse if family in Waiting Room is either unruly or seriously distressed.
11. Replenish magazines for waiting room.
12. Maintain patient confidentiality by not giving out medical information about patient to anyone. Do not indicate that a patient may be admitted and do not evaluate patient condition when talking with family.
13. Notify Triage Nurse and Registration Clerk that you are leaving. Shred ED patient printout sheet.
14. IF YOU ARE UNABLE TO VOLUNTEER AT YOUR REGULARLY SCHEDULED TIME, TRY TO FIND A SUBSTITUTE; IF UNABLE TO FIND A SUB, NOTIFY THE CHAIRMAN.
15. IF YOU CAN'T GET A SUBSTITUTE, NOTIFY THE VOLUNTEER OFFICE AND TRIAGE NURSE.
16. NOTIFY THE VOLUNTEER OFFICE OF ANY CHANGES.

MINIMUM REQUIREMENTS

- Must demonstrate age specific and HEOSH competency.
- Must be able to communicate with diverse populations.
- Must be willing to follow directions from professional staff.
- Must be at least 18 years of age.
- Must be able to communicate with people of different educational levels.
- Understand the need for confidentiality and ability to maintain such.
- Willingness to meet, greet, escort or direct patients, families and visitors as requested.

- Knowledge of hospital layout, especially those areas accessed by visitors.

PERSONAL SKILLS, ABILITIES, KNOWLEDGE

- Must be self-starter.
- Need a friendly, positive attitude.
- Must be courteous and reliable.
- Ability to work with detailed information and follow directions.
- Maintain confidentiality.
- Good communication skills.
- Good organizational skills.
- Empathy and understanding of families in crisis.
- Good customer relations skills.

LENGTH OF COMMITMENT

One 3-hour shift per week.
Minimum one-year commitment.

Linda Bowles
Director, Volunteer Services

Sandy Pabers, CNS II
Nurse Manager, Emergency Department

Revised 5/00, 12/01

EMERGENCY DEPARTMENT MEDICAL DIRECTOR ON-CALL

PURPOSE

To insure administrative or clinical backup for the Emergency Department

PROCEDURE

The monthly ED clinical schedule will specify the ED Medical Director on call. Normally one attending will be on call for the week, and should be available by telephone or beeper.

Weekly call begins 7:00AM Sunday morning and ends at 7:00 AM the next Sunday.

Senior level faculty will be assigned on a rotating basis. Changes in the on-call schedule are the responsibility of the attending assigned. Changes should be written on the ED schedules posted in the Emergency Department and in the Administrative Office.

Judith E. Tintinalli, MD, MS
Department Chair

Reviewed: 9/7/2001

EMERGENCY DEPARTMENT RESPONSIBILITY AND RELATIONSHIPS WITH OTHER HOSPITAL DEPARTMENTS

Electrocardiography Services

The Electrocardiography Department provides services for the Emergency Department during days and evenings, Monday through Friday, 8:00 - 4:30 p.m. on weekends and holidays. During closed hours the Emergency Department nursing staff is responsible for electrocardiograms. The Department utilizes an ECG machine with transfer of BCG to the FCC lab by telephone computer. A copy of the electrocardiogram is maintained in the Emergency Department for physician use.

Chaplain

The chaplain is a member of the Emergency Department team and is available to give support to patients, families or persons accompanying patient and staff. The primary role of the chaplain is to provide support to families in times of stress and to help keep them informed of patient status. The chaplain should receive information reports from the physician and/or nurse. The chaplain does not inform families of death but is called to help families deal with grief. Before visiting any patient in the ED, the chaplain will consult with the physician or nurse responsible for the patient to determine if pastoral care is warranted. The chaplain is contacted by calling the Department of Pastoral Care or paging the on-call chaplain.

Laboratory Services

Clinical laboratories available 24 hours daily for the Emergency Department include Chemistry, Hematology, Blood Bank, Microbiology, Arterial Blood Gas, Coagulation, and Urinalysis. It is the responsibility of the Emergency Department physician to contact and receive approval. All STAT blood specimens must be marked as such by the Emergency Department nursing staff.

Obstetrical Suite

The Labor and Delivery Suite is available for any patient upon referral by the Emergency Department nursing staff. (See Policy regarding OB/GYN patient)

Operating Room

Operating suites are readily available to the Emergency Department upon request. On evenings, nights, and weekends the Operating Room maintains an in-house team for immediate patient care needs. Operating Room capabilities include cardiopulmonary bypass pump-oxygenator, operating microscope, thermal control equipment, fracture table, endoscopes (all varieties), and appropriate equipment for hemodynamic monitoring. Anesthesiology maintains personnel immediately available to the Emergency Department.

Radiology Services
Diagnostic Radiology Services are readily available to the Emergency Department for all routine studies utilizing the fixed equipment in the Emergency Department X-ray room, the portable x-ray machine as necessary, and x-ray equipment in the Radiology suite. The Radiology Department provides emergency services with designated technicians. The Emergency Department physician and nursing staff maintain the responsibility for the decision regarding studies done in the department or in the radiology suite. Nuclear scanning tomography, and angiography of all types are readily available to emergency services upon request of the physician staff.

Special Care Units
The Special Care Units available for Emergency Department patients include Coronary Care, Surgery, Neurosurgery, Burns, Respiratory, Medicine, Cardiothoracic, and Pediatrics. Admission to special care units is achieved through appropriate admitting residents.

Social Work
The Social Work Department participates in the care of Emergency Department patients upon request of the medical nursing staff. Social Work is available 9am — 9pm, 7 days a week with on-call coverage all other times to facilitate care regarding the psychological and social needs of Emergency Department patients.

Judith Tintinalli, MD, MS
Department Chair

Sandy Pabers, RN, CNS II
Nurse Manager

INTERNAL MEDICINE ABSENCE POLICY

All Residents rotating off their parent service are expected to meet the requirements established by the sponsoring department. If illness or unavoidable personal circumstances prevent a resident from meeting the clinical schedule established by the sponsoring department it will be the responsibility of the absent residents department to find a suitable replacement. Each department will maintain a back up roster to be used in the case of resident absences. Further, each department agrees not to utilize their residents off service month as the first option in the back up call roster.

Both the Department of Emergency Medicine and Internal Medicine acknowledge the difficulty of substitute scheduling on short notice. If needed both departments will work together to develop creative solutions to extremely difficult scheduling issues.

March 30, 2000

Judith Tintinalli, MD, MS
Professor and Chair
Department of Emergency Medicine

M. Andrew Greganti, MD
Professor and Acting Chair
Department of Internal Medicine

Robert Vissers, MD
Residency Director
Department of Emergency Medicine

Lee Berkowitz, MD
Residency Director
Department of Internal Medicine

Cherri Hobgood, MD
Education Director
Department of Emergency Medicine

NEW REGISTRATION PROCESS FOR VISITORS TO UNCHCS WHO WILL OBSERVE IN PATIENT CARE AREAS

Forwarded at the request of Dr. Brian Goldstein

MEMORANDUM

TO: Medical Staff, House Staff
FROM: Brian P. Goldstein, M.D. Executive Associate Dean for Clinical Affairs and Chief of Staff
DATE: September 22, 2004
SUBJECT: New Registration Process for Visitors to UNCHCS Who Will Observe in Patient Care Areas

CC: Clinical Department Administrators
In March 2004, the Medical Staff Executive Committee approved a new policy for registration of special visitors to UNCHCS, including and especially visitors who will be shadowing our clinicians and/or observing in patient care areas. The policy allows us to continue, in the age of HIPAA, to provide educational opportunities to members of the community while we ensure that patient privacy is respected and patient safety is optimized. The full policy is available at the following web page: http://www.unch.unc.edu/hospolcy/ShadowStudents_S10.pdf
Note that individual patient care areas are permitted to have their own policy that places stronger limits on visitors' observation of patient care.
The MSEC requested that the clinical departments, rather than a centralized office, coordinate the registration and preparation of special visitors observing in patient care areas. To make this as easy as possible we designed a web-based registration for these visitors. The address is http://shadow.med.unc.edu . Meanwhile, to comply with HIPAA we must also have each shadow student/visitor review, and attest to reviewing, a brief tutorial about privacy requirements. The same registration site also directs the shadow student or special visitor to complete the tutorial online. I have attached below more detailed instructions for the shadow student or special visitor to complete the online registration and tutorial.
What, then, are your responsibilities when you want to bring a student or visitor to shadow you or a colleague in a clinical area? They are:
1. Know who will be the identified individual escort, whether you or a colleague.
2. Make sure the shadow student/visitor reads and signs a Confidentiality Statement (copies will be provided to the Departments). The Department/division must send a copy of the signed Confidentiality Statement to Volunteer Services and will "log" completion of the form at http://shadow.med.unc.edu/admin/index.cfm
Note that the person who will access this web site will need a School of Medicine ID (SOMid). Complete instructions for using the log are also attached below.
3. Provide the visitor with an ID badge. Volunteer Services will supply blank badges.
4. Verify that the visitor has completed registration and the privacy tutorial within the past 12 months. This is easy to do - simply visit the same registration site that the visitor used -- http://shadow.med.unc.edu -- enter h/her name, and you can confirm.

If you have questions about the policy or about the information in this correspondence, contact your Department Chair or Sissy Holloman, Assistant General Counsel, in Legal Services at 6-3052. For questions about using the "log", see below and/or call OIS at 6-1325. Thank you.

UNC-SOM Shadow Student/Visitor Registration and Log Instructions

Student/Visitor Registration

Direct the student/visitor to the registration website - http://shadow.med.unc.edu. This site should be accessible from any computer. The student/visitor will enter her name. If the student/visitor has registered within the past 12 months, she will be asked to verify that the personal information is still accurate. Otherwise the student/visitor will be asked to proceed to a new registration form.

Upon submission of the registration form if the student/visitor has no previous compliance date in the database she is taken to a screen that requires her to open the HIPAA presentation for viewing, then allows her to attest that she has viewed and understood the information contained therein. If the student/visitor has a previous compliance date, that is compared with the next visit date. If the difference between the two dates is greater than 1 year she will be required to view the HIPAA presentation again. If the difference is less than 1 year the student/visitor can proceed without viewing the presentation again.

Administrator Search and Confidentiality Form Recording

Users are directed to the admin website - http://shadow.med.unc.edu/admin/index.cfm

The user will be required to login with his School of Medicine userid and password. Everyone affiliated with the School of Medicine should have a SOMid userid and password, though how often each person uses it to access SOM information varies. If you do not know your SOMid userid and password, call OIS at 6-1325 or visit http://www.med.unc.edu/ois/faqs/passwords/somidpassword.htm

The search form requires either a starting date or a span of dates to perform a search. Additionally a last name, a department, a visitor type or any combination of these 3 values is required. If the visitor is already in the database, there will be a radio button that indicates whether or not the department has a signed confidentiality agreement on file. This value is by default "no" for all new registrations. The departmental user would choose "yes" for a student/visitor who has signed the agreement and submit this to the database. Any future search would then indicate that this individual had signed the agreement.

NURSE ONLY VISITS IN THE EMERGENCY DEPARTMENT

A Nurse only visit is defined as one in which the patient has orders previously written by a health care provider that need execution at a specific time when the provider may not be physically present. A physician or nurse practitioner assessment is not necessary provided:

1. A nurse evaluates the patient and performs clinical assesment and determines that a nurse practioner or physician does not need to evaluate the patient.
2. There are orders for the patient.

Examples include but are not limited to Rabies series vaccinations, patients under the care of a neurologist and receiving solumedrol intermittently.

James L Larson
Medical Director

August 21, 2006

THE UNC HOSPITALS DEPARTMENT OF NURSING/INPATIENT CARE MANAGEMENT/EMERGENCY DEPARTMENT MASTER STAFFING PLAN – 2002

Service: Surgery\Burns\Emergency\Aeromedical\Rehab\Neurology
Unit: Emergency Department
Capacity: Main ED 24 beds, 8 Hallway beds, Minor Trauma 10 beds, Children's Urgent Care 9 beds, Medical Urgent Care 3 swing beds
Total FTEs: 77.3 (Includes CNSII and both Main ED and CUC)

MAIN ED STAFFING PATTERNS (INCLUDE CNSII):

Level	Days (0700-1200)	Evenings (1200-0000)	Nights (0000-0700)	Percentage of Staff
Nurse Mngr.	**2(WD)**	**1(WD)**	**1(WD)**	**10%**
Triage	**1.0**	**1.0**	**1.0**	**7%**
RN Staffing	**7.0**	**9.0**	**5.0**	**50%**
NA Staffing	**1.0**	**2.0**	**1.0**	**10%**
Processing Asst.	**2.0**	**2.5**	**1.0**	**13%**
X-ray Transporter	**1.0**	**1.0**	**1.0**	**10%**
Total	**14.0**	**17.5**	**10.0**	**100%**

CHILDREN'S URGENT CARE STAFFING PATTERNS

Level	Days (0830-1100)	Evenings (1100-2330)	Percentage of Staff
RN Staffing	**1.0**	**1.5**	**64%**
NA Staffing	**1.0**	**1.0**	**36%**
Total	**2.0**	**2.5**	**100%**

This master-staffing plan is for the current ED and Children's Urgent Care (CUC). This plan is reflective of minimal staffing required to operate both of these areas in the present facility. All patients are triaged by the main ED triage RN, classified appropriately, and then sent to the appropriate area.

Brief Description

The Emergency Department is a Level 1 Trauma Center. For the calendar year 2001 the main ED had 32,514 visits, Minor Trauma had 8,509 visits, and Children's Urgent Care had 9,152 visits with a total of 50,175 visits. Total triage for all areas, including Medical Urgent Care, was a total of 65,377 for year 2001. The ED is divided into areas: Main ED 24 beds plus 8 hallway spare beds, Minor Trauma 10 beds, Children's Urgent Care 9 beds, and 3 swing beds shared with Medical Urgent Care. The Minor Trauma Area is open daily 1200-0030. Approximately 36% of

ED visits are admitted to UNC Hospitals. The Children's Urgent Care area is a 9 bed facility (with 1 swing bed in Medical Urgent Care), 5 private rooms and 4 acute care beds.

1. Patient Flow has been historically trended over the 24-hour period to determine peak periods of patient activity. Nurse staffing is based on the minimum number of licensed staff required to meet the needs of the number of patients projected to be seen throughout the 24-hour day. Staff is staggered in at various times of the day to provide quality care during the identified peak patient period. This peak time begins at approximately 1100 and ends at approximately 0200. We attempt to drop to the minimum on the night shift at 0200. The Emerge Classification System has trended this data for us over the past year to provide us with accurate staffing requirements for the Main ED and CUC.

	ED	CUC
Days	6 until 1100 then 8	1 with a float in main ED
Evenings	9	2
Nights	7 until 0200 then 6	Closes 2330

2. Patient Population, which includes adults and pediatrics, is triaged into 5 categories: 1 being the most critical patient to a 5, which is the least sick. The Triage RN determines the triage category based on the number of resources that he/she feels the patient will require during that visit. Patients that arrive per EMS go directly into the patient care areas and the charge nurse classify them into the proper category and place the patient into the Tracking System.

3. Delivery: Nursing care is delivered using a Total Patient Care approach.

4. Patient Requirements: Care required of patients seen in this department varies markedly from the most simple first-aid type measure to the more complex, technologically advanced interventions such as those associated with resuscitation of multiple trauma victims or cardiopulmonary arrest. Care requirements are generally categorized by patient classification, such as stable (sore throat, otitis media, cold), emergent (Mild SOB, limb fracture, abdominal pain), and life/limb threatening (multiple trauma, Myocardial infarction, SIDS).

5. Staff expertise on this unit includes RNs who hold a valid North Carolina License, and NAs who are listed with the NC Division of Facility Services. Each staff member has successfully completed an orientation program. All RNs in the Main ED are expected to achieve BLS and ACLS certification within 6 months of employment. The department requires the achievement of TNCC and PALS/ENPC certification within one year of employment. All RNs in the Children's Urgent Care are PALS certified and certified in the Emergency Nurse Pediatric Course. All staff is further encouraged to pursue CEN certification by the end of the second year of employment. Registered Nurses are classified at the entry level as a Clinical Nurse I and the more advanced Clinical Nurse II level.

6. Geographical (include number of private and semi-private rooms): The Main ED has a total of 24 evaluation rooms and 8 hallway spaces. Minor Trauma area has 9 evaluation rooms. The Main ED has a total of 8 private rooms, 2 are isolation rooms, 2 OB/Gyn rooms, 2

cardiac resuscitation rooms, and 2 Psychiatry evaluation areas. The other 16 beds are open bay evaluation rooms, 3 are Trauma Bays. There are 22 wired sites in the Main ED available for cardiac monitoring (all except the Psychiatry rooms). Minor Trauma is all private rooms except for a 2 bay area. There are also 2 isolation rooms located in this area. CUC consist of 9 beds, 4 open bay and 5 private rooms. CUC also has 1 isolation room. Triage is centrally located between the Main ED and CUC, with 2 Triage equipped work areas.

1. Availability of Support Services: There are laboratory services, pharmacy services, radiology, central distribution, pastoral care, respiratory therapy, and clerical support available 24 hours per day. EKG services are available from 0800-2330, Monday-Friday and 0800-1630 on weekends and holidays. The Main Emergency Department has 24 hour\day attending coverage by a certified Emergency Medicine Physician. The CUC is covered by the Department of Pediatrics from 0900-2300, after 2300 the Emergency Medicine Attending provides coverage for all patients seen and evaluated in the Main ED. Consult services are available 24 hours per day to both areas such as general surgery, urology, cardiology, neurology, anesthesiology, trauma, gynecology, and psychiatry.

Sandy Pabers, RN, CNS II
Nurse Manager

SECTION: **Office Operations** **Effective Date:** **January 22, 1999**

SUBJECT: **Chart Retrieval** **Revised Date:** **Dec. 31,2001**

 Approval Signature: ***Lynn C. Guerrant RN MS***

POLICY:

Community Based Practice patients may go for Specialty Care and to the UNC Hospitals Emergency Department (ED) for care. Practice charts will be made available upon request to the UNC Hospitals provider within 1 hour of requesting during office hours and within 8 hours of the request of the record after hours.

PROCEDURE:

A. The Emergency Department staff will determine that the patient is seen at a UNCHCS Community Based Clinic (CBC) by:
   1. Searching for the patient in the SMS registration system and locating the primary care provider (See Attached Provider List)
   2. Search the Clinical Workstation, using the UNC Medical Record number or patient interview.

B. In order to standardize the dictation process all patients in the CBC practices obtain a UNC Medical Record number. The transcription service formats the progress note according to UNC guidelines to facilitate importing into the CIS. The following clinics have completed the CIS implementation process and have their progress notes online:

   1. Chapel Hill North Internal Medicine
   2. Chapel Hill North Pediatrics
   3. Chapel Hill North OB/GYN
   4. Chapel Hill North Cardiology
   5. Chatham Crossing
   6. University Pediatrics at Highgate
   7. Cary Oncology
   8. Specialty Women's of Raleigh
   9. University Pediatric Surgeons
   10. Chatham Primary Care

C. The following CBC practices have not completed the CIS implementation process. In the interim, if progress notes or additional information from the patient chart is required from one of these clinics, the CBC will be contacted by telephone. If the call is made after hours, the practice answering machine will direct all callers to HealthLink. EXCEPTION: Chatham Primary care (CPC) callers are directed to the Chatham Hospital Emergency Room, which is staffed by a CPC physician.

1. Durham Family Practice
2. Highgate Family Practice
3. Four County Family Practice
4. Pittsboro Family Practice

D. HealthLink will determine what chart information is needed by the UNC provider and will contact the practice designee as outlined in emergency call tree below.

E. The practice employee or on-call MD will obtain the requested information from the chart and either fax or deliver it to the UNC provider.

Chatham Primary Care
3111 Fir Avenue North, Siler City, NC 27344
Telephone: 919-742-6032
Fax: 919-663-3018
CHATHAM PRIMARY CARE PHYSICIANS ARE AVAILABLE 24 HOURS PER DAY AT THE CHATHAM HOSPITAL EMERGENCY ROOM (919) 663-2113

Chapel Hill North
1838 Airport Rd., Suite B19
Chapel Hill, NC 27514
Telephone: 919-960-7461
Fax: 919-960-0425

1st Contact	Pat Holder	Home: 919-596-9408
2nd Contact	Elizabeth Dyer, RN (OB/GYN)	Home: 919-732-6030
2nd Contact	Monica Isley, RN (Peds)	Home: 336-578-4064
2nd Contact	Kate Engebretson, RN (Int. Med.)	Home: 919-479-6767
2nd Contact	Terry Thomas, RN (Cardiology)	Home: 919-968-6889
3rd Contact	Chris Weathington, Regional Practice Administrator Home: 919-489-8091 Office: 919-843-5062 Pager: 919-932-0471 Mobile: 919-818-4606	

Chatham Crossing Medical Center
11312 US 15-501 North
Suite 308
Chapel Hill, NC 27517
Telephone: 919-960-6094
Fax: 919-960-9625

1st Contact	Shelia Crawford, RN	Home: 919-942-8381
2nd Contact	Trish Fitzgerald	Home: 919-933-9081
3rd Contact	Lundy Powers, Regional Practice Administrator Home: 336-581-4115 Office: 919-843-5062 Pager: 919-932-0449 Mobile: 919-210-2628	

Durham Family Practice
2609 N. Duke Street, Ste. 205
Durham, NC 27704
Telephone: 919-220-9800
Fax: 919-220-9500

1st Contact	Beth Ward, RN	Home: 919-383-1462
2nd Contact	Tammy Header	Mobile: 919-210-1926
3rd Contact	Lundy Powers, Regional Practice Administrator Home: 336-581-4115 Office: 919-843-5062 Pager: 919-932-0449 Mobile: 919-210-2628	

Four County Primary Care - Henderson
120 Charles Rollins Rd., Suite 102, Henderson, NC 27536
Telephone: 252-436-0440
Fax: 252-436-0480

1st Contact	Cathy Fogleman, RN	Home: 919-690-1809
2nd Contact	Lisa Haskins	Home: 252-492-5697
3rd Contact	Chris Weathington, Regional Practice Administrator Home: 919-489-8091 Office: 919-843-5062 Pager: 919-932-0471 Mobile: 919-818-4606	

Highgate Family Medical Center
5317 Highgate Drive, Ste. 117, Durham, NC 27113
Telephone: 919-361-2644
Fax: 919-484-0849

1st Contact	Holly Holzworth, LPN	Home: 919-303-4491
2nd Contact	Susan Hyers	Home: 919-942-1741
3rd Contact	Lundy Powers, Regional Practice Administrator Home: 336-581-4115 Office: 919-843-5062 Pager: 919-932-0449 Mobile: 919-210-2628	

Pittsboro Family Medicine
630 East Street, Ste. 9, Pittsboro, NC 27312
Telephone: 919-545-0911
Fax: 919-545-0096

1st Contact Lorraine Timmons, RN Home: 919-545-9189

2nd Contact Lynda Moore Home: 336-581-3642

3rd Contact Jennifer Toney, Regional Practice Administrator
Home: 919-383-3562 Office: 919-843-5062
Pager: 919-932-0463 Mobile: 919-630-2356

Sanford Specialty Clinics
1301 Central Drive
Sanford, NC 27330
Telephone: 919-718-9512
Fax: 919-718-9516

1st Contact Sonja Beavers, RN Home: 919-837-5549

2nd Contact Michelle Raymond Home: 919-777-5480

3rd Contact Jennifer Toney, Regional Practice Administrator
Home: 919-383-3562 Office: 919-843-5062
Pager: 919-932-0463 Mobile: 919-630-2356

Specialty Women's Center
3901 Computer Drive, Raleigh, NC 27609
Telephone: 919-783-8122
Fax: 919-783-8454

1st Contact	Eileen Peterson, RN	Home: 919-942-7011
2nd Contact	Hannah Washington	Home: 919-876-3193
3rd Contact	Jennifer Toney, Regional Practice Administrator	
	Home: 919-383-3562	Office: 919-843-5062
	Pager: 919-932-0463	Mobile: 919-630-2356

University Pediatric Surgeons
3901 Computer Drive, Raleigh, NC 27609
Telephone: 919-783-7809
Fax: 919-783-8454

1st Contact	Eileen Peterson, RN	Home: 919-942-7011
2nd Contact	Hannah Washington	Home: 919-876-3193
3rd Contact	Jennifer Toney, Regional Practice Administrator	
	Home: 919-383-3562	Office: 919-843-5062
	Pager: 919-932-0463	Mobile: 919-630-2356

University Pediatrics at Highgate
5322 Highgate Dr., Suite 143
Durham, NC 27713
Telephone:919-806-3335
Fax: 919-806-2355

1st Contact	Sharon Lloyd, LPN	Home: 919-542-0129
2nd Contact	Valarie Campbell-Clark	Home: 919-490-0571
3rd Contact	Chris Weathington, Regional Practice Administrator Home: 919-489-8091 Office: 919-843-5062 Pager: 919-932-0471 Mobile: 919-818-4606	

UNC COMMUNITY BASED PROVIDERS

1. **Cary Oncology**
   Mark Graham MD
   Paramjeet Singh MD

2. **Chapel Hill North Medical Center**

   Internal Medicine:
   Dan Reuland MD
   Dale Biebers MD

   Pediatrics:
   Dale Biebers MD
   Robert Goldbach MD
   Lynne Morgan MD

   OB/GYN:
   Mary Dolan MD
   Christine Munoz MD
   Mary Schelgel MD
   Susan Nickel CNM
   Kathy Higgins CNM

   Cardiology:
   Eileen Kelly MD

3. **Chatham Crossing**
   Maureen Andreassi MD
   Russell Harris MD
   Linda Kinsinger MD
   James Kurz MD
   Kimberly Kylstra MD
   Anna White NP

4. **Chatham Primary Care**
   William Carter MD
   Dorothy Effird NP
   Phil Sherrod MD
   Nandini Lahiri MD
   Anjua Sharma MD
   Donna Stone NP
   Adam Zoltar MD
5. **Durham Family**

Brian Benjamin MD
Mignon Benjamin MD
Mohan Chilukuri MD

6. Four County

Charlie Foster MD
Robert Gianfacaro MD

7. Highgate Family Practice

Evan Ashkin MD
Lauren Lingley MD
Roselyn Paggett NP

8. Pittsboro Family Practice

John Cory MD
Sonya Montgomery NP
Leslie Sharpe NP

9. Sanford Specialty Center

Elizabeth Fasy MD
David Ontjes MD
Alfredo Rivadenera MD

10. Specialty Women's of Raleigh

John Boggess MD
Wesley Fowler MD
Marc Fritz MD
Paola Gehrig MD
Mary Janelli MD
Jeffrey Kuller MD
Bruce Lessey MD
William Meyer MD
John Steege MD
Robert Strauss MD
Tony Visco MD
Leslie Walton MD
Ellen Wells MD

11. University Pediatrics at Highgate

Edward Pickens MD
Virginia Schreiner MD

12. University Pediatric Surgeons

Don Nakayama MD
Duncan Phillips MD

UNC DEPARTMENT OF FAMILY MEDICINE COMMUNITY PHYSICIAN LIST

This lists comprises the local physicians that our department has an agreement to admit adult patients for The UNC Family Practice Center physicians – attendings and residents – are not included on the list.

Carrboro Fam. Medicine	Chapel Hill Family Med	Chatham Primary Care – Siler City	Durham Fam. Practice
Phone: 929-1747 Fax: 933-5168 James Manor Bruce Wilks Elizabeth Edwards PA NP – Rebecca Hasmann	Phone: 967-8291 Fax: 967-3627 G. Pat Guiteras Jeffrey Furman Rebecca Tobin Barbara Bergdolt Lee Anne Bankaitis Barbara Haskell starts in May	Phone: 742-6032 or 742-1010 Fax: 663-3018 Anuj Sharma Philip Sherrod Nandini Lahari Adam Zolotor NP – Dorothy Efird NP – Donna Smith	Phone:220-9800 Fax: 220-9500 Brian Benjamin Mimi Benjamin Mohan Chilukuri
Highgate Family Med.	**The Family Doctor**	**Orange Family Medicine**	**Pittsboro Family Med.**
Phone: 919-361-2644 Fax: 919-484-0849 Lauren Lingley Evan Ashkin NP – Roslyn Padgett	Phone: 968-1985 ext. 131 Fax: 942-0038 Glenn Withrow Ann Chelminski PA – Peggy Robinson PA – Anne Vaillancourt PA – Steve Todd NP – Bill Powell	Phone 732-9311 Fax: 732-9315 Jonathan Klein Arthur Axelbank Diane Freund Dain Vines PA – Elizabeth Edwards PA – Mary Tassannante PA - Signe Wright PA - Mark Johnson PA - Jack Halpin PA - Wendy Goins	Phone: 545-0911 Fax: 545-0096 John Corey NP – Leslie Sharp NP – Sonya Montgomery
Brookhollow Fam Med.	**Timberlyne Fam. Med.**	**Village Family Medicine**	**Mark Eisen**
Phone: 563-8400 Fax: 563-8453 Kathryn Bliss Joel Kann NP - Sara Saunders	Phone: 942-8500 Fax: 933-3816 Richard Kennedy Jillian Aylward Margie Stetson David Klein	Phone: 968-4551 Fax: 929-7405 Margaret Foote Yvonne Luyando Wendy Edds	Phone: 967-9452 Fax: 932-5200 Mark Eisen
Sabrina Mentock	**Hillsboro Fam Practice**		
Phone: 544-6461 Fax: 361-2487 Sabrina Mentock PA – Kim Meyer	Phone: 732-8131 Fax: 732-6802 Todd Shapley-Quinn Daniel Crummet Jane Satter Coin Page Sara Ringel		Britthaven – FPC resident patients only. See list in call rooms
PHS – Carrboro CHC	**PHS – Moncure CHC**	**PHS – Prospect Hill**	
Phone: 942-8741 Fax: 942-1473 Sandra Clark Gayle Thomas Carol Klein Chris Tobin Cora Spaulding Carolyn Forbes PA Laurie Fox	Phone: 542-4991 Fax: 542-3726 Barbara Rowland Melissa Bishop Thomas Turk Jane Hollingsworth Deborah Porterfield David Tempest Susan Pitts Giselle Corby/Smith PA – Charlie Pulliam NP – Melissa Lang NP - Kelly Wilson	Phone: 562-3311, 1-800-898-9577 fax: 562-4444 Bill Selvidge Sylvia Becker-Drebs Ariana Pancaldo Glen Pickard Tracey Meyers NP – Marni Holder	Note: Glen Pickard – In internal medicine, but spends 20% @PHS. Patients who list Dr. Pickard as their primary MD, must list Prospect Hill/PHS as their clinic. No nursing Home Patienets of Dr. Pickard's are PHS, therefore not FPIS.

V. EMS

COMMUNICATION WITH GROUND AND AIR PRE-HOSPITAL TEAMS

PURPOSE: **To ensure appropriate transfer of medical information between medical control and the pre- hospital team**

PROCEDURE:

Orange County EMS – Emergency Department Communications

One VHF Radio, Channel 340 is used for routine non-ALS calls from providers. This can also provide communication between Orange Central and the Emergency Department. There is no telemetry.

Standard land telephone lines can also be used to communicate with Orange Central.

The ALS Medical Director is a faculty member of the Department of Emergency Medicine, and has a VHF radio that can communicate with the Emergency Department or Orange Central.

Emergency Department RNs and Physicians answer all radio calls.

Carolina Air Care – Emergency Department Communications

One 400 MHZ Radio is used for radio transmissions regarding incoming patient or medical orders. This radio can also provide communication between the Emergency Department and CAC Communications Center.

Ground ambulance communications is via VHF radio and cellular telephone to CAC Communications Center. Calls are then patched into the Emergency Department.

Judith E. Tintinalli, MD, MS
Department Chair

Jane Brice, MD, MPH
Director, Orange County EMS

Revised: December, 2001

EMERGENCY MEDICAL COORDINATOR

A. Responsibilities

1. Coordinate all emergency medical activities during Emergency Operations Center activation.

2. Develop plans for Emergency Medical Services response during disasters, including Mass Casualty.

3. Maintain a current list of all personnel, including First Responders, Rescue and EMS Personnel.

4. Develop a callback system for EMS Personnel.

5. Assist Medical Examiner in developing a policy for temporary morgue and body identification procedures.

6. Maintain a current list of equipment, supplies and vehicles.

7. Provide information to hospitals reference victims; such as, type injuries, number to be received, etc.

8. Request activation of hospital's external disaster plan and specify types of medical personnel and equipment needed to respond to and treat victims of disasters.

9. Provide upon request any resources needed by the hospital to treat, transport, relocate, or otherwise assist in the activation of the hospital's internal disaster plan.

10. Report to the Emergency Operations Center upon activation to coordinate emergency medical services operators.

PRE-HOSPITAL REQUESTS FOR ADVANCED LIFE SUPPORT ORDERS

Purpose: **To ensure consistency in communications with pre-hospital agencies.**

Procedure:

I. **Only Mobile Intensive Care Nurses (MICN's), ED Attending Physicians, and ED PGYII and above Residents may grant pre-hospital requests for ALS orders.**

II. **MICN's may only grant requests for ALS orders as outlined in the Orange County Emergency Medical Services and UNC Hospitals Advanced Life Support Protocol Manual.**

III. **MICN's must document the radio transaction as indicated on the Mobile Intensive Care Report form. The MICN granting the ALS orders request is required to obtain the ED Attending Physician's co-signature on this report form. The form is then filed in the MICN file box located at the radio.**

IV. **Requests for ALS orders from pre-hospital agencies, other than Orange County Emergency Medical Services, must be handled by an ED Attending Physician.**

V. **Requests for orders from Carolina Air Care personnel must be handled by an ED Attending Physician or PGY III Resident.**

VI. **Any deviations from the above protocols or procedures must be granted by an ED Attending Physician.**

Judith E. Tintinalli, MD, MS
Department Chair

Jane Brice, MD, MPH
Director, Orange County EMS

Revised: September, 1995
December, 2001

RESPONSIBILITY FOR EMERGENCY MEDICAL SERVICES

PURPOSE: **To define and demonstrate the commitment to, and participation in, the provision of emergency medical care based upon community need and hospital capability**

PROCUDURE:

I. Orange County ALS Direction

The University of North Carolina Hospitals, Department of Emergency Medicine, is the ALS sponsor for Orange County.

II. Orange County ALS Medical Director

The Chairman of the Department of Emergency Medicine is responsible for nominating the EMS Medical Director. The overall responsibility for the Orange County EMS and Orange County Disaster Program rests with the Orange County Director of Emergency Management Services and ultimately, the Orange County manager. (see attached organizational charts)

Responsibilities of the EMS Medical Director are defined by the State OEMS. (see attached)

The Department of Emergency Medicine will insure that the EMS Medical Director meets the objectives of UNC Hospitals, OCEMS, and the community, in terms of medical direction. The Department will participate in priority setting to meet these objectives.

The Department of Emergency Medicine will support the EMS Medical Director in the maintenance of minimum medical standards for the entire scope of pre-hospital care, and the continued incorporation of contemporary minimum standards of care into pre-hospital protocols.

III. Scope of Department's participation in EMS

Designated faculty, residents, and staff will participate in the ground and air EMS program. This includes:

Program	Participation
On-line medical control	MICN's and EM PGII and above
Student, Resident education	Residency Program Director
MICN, Staff education	EMS Nurse Liaison
Paramedic education	EMS Nurse Liaison
Disaster plan and drills	Disaster Committee Chairman Medical Control
Air, ground coordination	CAC Program Director

	Flight Medical Director **Chief Flight Nurse** **Lead Paramedic** **EMS Medical Director**
Quality Assurance	**CAC Program Director** **Chief Flight Nurse** **EMS Medical Director** **EMS Audit & Review Committee Chairman**
Facility categorization	**OEMS State Advisory Committee** **EMS Medical Director**
BLS, ALS, ATLS training	**Life Support Coordinator**
Research	**CAC Program Director** **Flight Medical Director** **EMS Medical Director**

IV. <u>EMT and Paramedic Education</u>

The Department will provide education to OCEMS personnel within the framework established by OCEMS and within the resources available to the Department.

V. <u>Research</u>

The Department will provide an environment for EMS research and the ability to participate in priority setting for research to meet the needs of OCEMS, the Department and the Hospital. The Department will insure that guidelines for confidentiality, authorship criteria, and ownership of data are developed and met.

Judith E. Tintinalli, MD
Department Chair

Jane Brice, MD, MPH
Director, Orange County EMS

Ed Jackem, MBA
Department Administrator

Revised: December, 2001

VI. Occupational Health

Please reference the UNCH OHS website for Blood / Body Fluid Exposure Protocols

NEEDLESTICK POLICY

Emergency Department – Overview Of Management For Bloodborne Pathogen Exposures Guidelines for Management of Contract Employees (not covered by UNCHCS/OHS)

1. Exposed contract employees are referred to the Emergency Department.
2. Upon arrival in the ED, contract employee should call his/her agency, report the incident and discuss appropriate follow-up per agency protocol.
3. Emergency Department MD assesses whether exposure has occurred to a potentially infective fluid – see attached tables (http://www.unch.unc.edu/expcntrl/pol-hiv.htm).

If exposure has occurred: Employee remains in ED and CDC guidelines are followed (see tables)	If no exposure has occurred: Employee obtains first aid and returns to work (if able).

4. SOURCE PATIENT TESTING-For all exposures, blood is obtained on all source patients for HIV, HBsAg, and anti-HCV
   a. The Emergency Department MD pages the Nursing House Supervisor at #347-1922 to obtain source patient testing.
   b. The Nursing House supervisor will be responsible for counseling the source patient (informed consent is NOT required). The source patient's attending physician or housestaff physician will co-sign the order.
   c. The Nursing House supervisor will call the Microbiology Laboratory (966-4053) and request that the source patient's HIV test be run STAT. In addition, the Nursing Supervisor will provide the name of ED physician taking care of injured employee.
   d. Source patient HIV testing is done 7 days/week. Monday-Friday at 8am, 3:00pm and 8:30pm, Saturday and Sunday at 12:00pm and 8:00pm. <u>However, the Microbiology Laboratory will provide STAT testing ONLY for contract employees be evaluated in the ED following a bloodborne pathogen exposure.</u>
   e. If there is blood in the lab, specimen will be brought to Immunology lab for testing on the next run. If there is no blood in the lab, the phlebotomist will go to the source patient and obtain the specimen.
   f. The Microbiology Laboratory will contact the Emergency Department MD and provide the results of the source patient's HIV test. The ED physician will provide the injured contract employee the results of the HIV test. If the HIV test is reported as positive (pending confirmatory tests) then for the purposes of providing post-exposure prophylaxis (PEP) the test should be considered positive.
5. FOLLOW-UP CARE
   a. Call the Adult ID Consult fellow (via 966-4131) to provide post-exposure management of all exposed persons. Provide the consult with name and unit number of the injured employee and source patient. The ID consult with see the injured employee in the ED if the source patient is HIV-positive (otherwise follow-up will be arranged in the ID Clinic within 7 days). PEP should be offered as detailed in the OHS Protocol and CDC guidelines www.cdc.gov/epo/mmwr/preview/mmwrhtml/00052722.htm or at www.unch.unc.edu/expcntrl/pol-hiv.htm.
      - Follow-up should include review of PEP for HBV, need for baseline HCV testing, and as needed additional tests if HIV PEP has been provided.
      - Obtain the following tests on the exposed person: HIV, anti-HBsAg (quantitative), anti-HCV. PEP for HBV can be provided within 7 days. PEP is not available for HCV. Anti-HBsAg (quantitative test #8220) should be obtained on all exposed employees ($\geq$10 mIU/mL protective).
      - If HIV PEP is to be provided the following baseline tests should be obtained: Pregnancy test if applicable, CBC with differential, renal function (BUN, creatinine), LFT's (ALT) bilirubin, amylase, and UA.

All appropriate policies are available on the hospital intranet WWW.UNCH.UNC.EDU/EXPCNTRL/OHS. Do not use confidential packets that are in the cabinet; these packets are only to be used for UNC Health Care System employees or Orange County employees.

VII. Safety and Legal Reporting

AMA PATIENTS LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is UNC Hospital Policy A-12.
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall.

UNC HEALTH CARE *Excludes Rex Healthcare	Name of Policy	**NEW**ED BEHAVIOR MANAGEMENT PLAN & PSYCHIATRIC EVALUATION AREA
	Policy Number	
	Date This Version of Policy Effective	June 1, 2009
	Approval	Jeffery Strickler, Clinical Director Emergency Services
	Approval	

This plan addresses Emergency Department (ED) procedures for handling patients who present to the ED with psychiatric/behavioral health related complaints or who exhibit behaviors that potentially place the patient or others at harm. Generally, psychiatric/behavioral health patients are managed in the ED Psychiatric Evaluation Area unless the patient is combative or the ED Psychiatric Evaluation Area is not open. This plan includes four classifications of patients.

No Hold

Patient is calm & does not express or exhibit suicidal/ homicidal/ violent behaviors.

- Patient movement is not restricted
- Patient may leave and sign out AMA
- Standard ED documentation and re-assessments apply

Precaution Hold only

Patient arrives with commitment papers, or patient expresses or exhibits suicidal/ homicidal/ violent behaviors

- Patient is not allowed to leave the ED
- All patients on precautionary hold are under surveillance by an NA
- Hold may be initiated emergently by RN. Hold order signed by ED MD/NP on standard ED order- example: “Precaution hold for SI”
- Nurse assessment is conducted initially to determine if the patient expresses or exhibits an active plan to hurt self or others and flight risk.
- NA will document q. 15 min patient safety checks.
- All precaution hold patients must be identified by a purple gown.
- Every 2 hour assessments required by nursing staff and documented in T-system.
- Precaution Hold applies to the psychiatric evaluation suite as well as any area in the ED.

Seclusion

Patient is locked in a room in an emergent situation when the patient is a danger to self or others. When the patient is barred or detained from leaving an area when they desire to do so but is able to move freely within the area and may be with other individuals this is not considered seclusion

- All elements of hospital restraint/seclusion procedure are followed.
- Seclusion can only occur in a room, not the hallway
- Patient is alone in room and not allowed visitors while in seclusion

Restraint

- All elements of hospital restraint/seclusion procedure are followed.
- Patient moved to acute area of ED while restrained.

Patients who present with complaint of suicidal or homicidal ideation, or who are under Involuntary Commitment (IVC) papers will be asked to undress and put on purple gown. Shoes and socks will be removed and examined and returned to the patient. Patient valuables will be sealed and placed with clothes in a belonging bag and stored in the appropriate area of the ED and personal belongings secured. If the patient refuses to undress then Hospital Police should be contacted to search the patient to ensure staff and patient safety.

ED Psychiatric Evaluation Area

Description of Facility - The ED Psychiatric Evaluation Area is located on the basement level of the Neuroscience Hospital within space occupied by the Department of Emergency Medicine. It is located adjacent to the Team C Nurse Station within the Emergency Department.

Staffing Plan & Hours of Operation - The evaluation suite will generally operate from 9 am until 2:00 am 7 days per week. The nursing staff responsible for the ED Team C will serve the area. The nursing staffing generally consists of two Registered Nurses and one Certified Nursing Assistant (CNA). Physician staffing for this area generally consists of either Emergency Medicine physician staff, Emergency Medicine Nurse Practitioner, or house staff participating in an Emergency Medicine rotation with support from an Emergency Medicine attending physician. For the psychiatric population, this staffing is augmented on a consultation basis by psychiatric specialty social work and psychiatric residents. Nursing Assistants will be stationed in the evaluation suite when there is a patient under precaution hold or seclusion order. ED Nursing Assistants assigned to the ED Psychiatric Evaluation area have participated in education specific to the ED psychiatric patient population and safety mechanisms in the area.

Patient Population Served - During the hours of operation, the majority of patients presenting to the Emergency Department with psychiatric/behavioral health related complaints will be evaluated in this area. Security enhancements in this area allow for priority placement in this suite to be given to patients under commitment, seclusion order, or precaution hold. Stretcher (restrained) patients will be located in the acute area of the ED. Patients under seclusion orders will be located in the ED Psychiatric Evaluation area when ever possible. This area will serve ambulatory patients complaining of depression, psychosis, persecution, visual/ auditory hallucinations, substance abuse, and patients who are a danger to self or others.

Safety & Security Features -

- **Access Control** – When patients under commitment or seclusion orders are in the suite a nursing assistant will be present in the ED Psychiatric evaluation area. Employees will need to enter and exit using the employee ID/access card. Patients not under precaution hold or seclusion will be allowed to enter and exit the unit by the nursing assistant. Patient room doors may be locked to affect a seclusion or on a temporary basis during a security emergency.
- **Emergency Access** – All employee ID/access cards allow access to this area. In addition, all hospital police and security officers carry a key that will open the entrance door. This door is also connected to the fire alarm system and unlocks upon activation of the fire system in the Neurosciences hospital.
- **Patient Identification** – To reduce the potential for elopement, precaution hold and secluded patients will be identified with a different colored patient identification armband specifically indicated for precaution hold patients.
- **Secluded Patients** – Patients with seclusion orders will be secured inside one of the patient rooms. The patient room door will be unlocked unless needed for the safety of the patient or others. CCTV and visual inspection through the window at least every 15 minutes will monitor the patient.
- **Visitors** – Due to space and security concerns, visitors to this unit will be limited to one per patient. Any staff member may restrict visitors that are disruptive to the patient's plan of care.
- **Duress Alarms** – Duress alarms have been provided at strategic locations inside the suite and should be utilized to obtain emergency assistance. Pendant duress alarms are also available and may be worn by staff members while inside the ED Psychiatric Evaluation area.

CCTV – Cameras viewing each room are monitored periodically by security or police officers. These cameras are also capable of being viewed in the Hospital Police Dispatch Center. Recordings of these cameras are maintained for seven days. Recordings are considered confidential patient information and are used as an after the fact investigatory tool to evaluate and assess improvements necessary in patient care or other legal reasons.

BLOOD TRANSFUSION, BLOOD AND BLOOD PRODUCTS

This is UNC Hospitals Policy B-3
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall.

CHEMICAL SAFETY/MSDS DATABASE

UNC-Chapel Hill has recently subscribed to a chemical safety information database service. This database is accessible from campus computers, and the link is on the Environment, Health & Safety (EHS) Chemical Safety page: http://ehs.unc.edu/chem/.

This service, titled the Academic Support Program and provided by the Canadian Centre for Occupational Health and Safety (CCOHS), includes the following features:

MSDS: The CCOHS database includes over 200,000 Material Safety Data Sheets for chemicals and commercial products, and is searchable by name, CAS number, partial name, phrase, or Boolean logic operators.

RTECSR: The Registry of Toxic Effects of Chemical Substances database provides critical toxicological information, including all investigated toxicity data, for over 160,000 substances in an easily searchable format.

CHEMINFO: This database contains chemical profile information (including fire and reactivity hazards and safe work practices) for more than 1300 important workplace chemicals.

The Academic Support Program is accessible from any computer connected to the UNC TCP/IP network. If you are working from home or are otherwise not connected to the UNC network, there are additional resources on the EHS Chemical Safety Page, such as the Vermont SIRI MSDS index, that are accessible from any computer.

The OSHA Hazard Communication Standard requires training for all employees about the hazardous properties of the substances they work with, and material safety data sheets must be available for each hazardous substance.
This new program should make it easier to access MSDSs. Please contact EHS if you have any questions about the CCOHS Academic Support Program or other items related to chemical hygiene.

Sponsored by: Environment, Health & Safety

CONSCIOUS SEDATION

This is UNC Hospitals Policy Sedation – Guidelines for by Non-Anesth. S-2
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall.

CPR

UNC Hospital Policy, Cardiopulmonary Resuscitation C-9
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall.

UNC HEALTH CARE *Excludes Rex Healthcare	Name of Policy	**NEW** Elopement
	Policy Number	
	Date This Version of Policy Effective	July 2009
	Department Responsible for Review	Emergency Department

POLICY

For patient safety and quality care we have an obligation to properly assess and adequately monitor patients at risk for elopement while in the Emergency Department.

ELOPEMENT RISK

- Patients should be assessed for elopement risk on admission to the ED and during routine assessments. Documentation of the assessment and appropriate intervention is required.
  - *Risk Factors for Elopement*
    - Psychological evaluation or commitment
    - Confusion related to physical issues
      - Dementia with history of wandering
      - Traumatic brain injury
      - History of alcohol or drug abuse
      - Metabolic changes
- Nurses will consider risk factors, patient condition and use professional judgment in collaboration with the Charge Nurse to identify patients at ***high risk*** for elopement.
  - Nurses who are concerned about a patient's risk for elopement will notify the other nursing staff on the ED team as well as the ED Charge Nurse
  - If a patient is identified as high risk for elopement, patient will be placed in a purple gown and assigned a sitter. Intervention must be clearly documented. If the patient is at any time no longer considered a risk for elopement then clear documentation of why and how that decision was made is required.
- ED Patients should not be allowed to leave the department for smoking or other reasons. Patients who do not have a medical/psychological reason to be held in the ED and want to leave must sign out AMA.
- All patients should be informed of the necessity to stay in the ED for the duration of medical care and to notify the nurse or provider if they wish to leave AMA.
- The following elopement procedure should be initiated for any high-risk patient that is found to be missing:
  - Notify the charge nurse & hospital police, fill out an incident report, notify DOC, page Emergency Services Director

PROCEDURE:

1. **Every patient is to be assessed for elopement risk**
   - **If determined to be at risk then charge RN should provide a second opinion assessment. Charge nurse will contact the Staffing Office or House Supervisor for possible sitter coverage (3-4416)**

2. **If at risk, do the following:**
   - **Document in T-System <u>"elopement risk & MD aware"</u>**
     - **Must document what interventions were initiated for prevention of elopement (sitter at bedside, or placed in psych holding area on precautionary hold)** ***May document under Falls Risk assessment on triage template or bedside procedures under progress template.***
     - **Must be documented at time of triage or primary RN assessment**
     - **For patient at risk but unable to ambulate or cooperative and accepting medical treatment – must document why the patient is not an "elopement risk**

   - **Place in comment section of T-System grease board "elopement risk" –** ***make sure this comment is in the front of the comment section***

   - **Place sitter at bedside or place in psych holding area if psych patient**

   - **Notify the MD of patient at high risk for elopement**

   - **Initiate a team safety huddle & discuss elopement risk patients with all team members**

<u>Examples of factors to consider when assessing your patient for elopement risk</u>

Elopement can be a planned or totally impulsive act. Some risk factors to look for to determine whether a patient is at risk and requires very close supervision:

1. **The patient <u>exhibits confusion related</u> to one or more of the following physical issues:**

   ***Dementia**

   ***Brain injury**

   ***History of alcohol or drug abuse**

   ***Metabolic changes**

<u>Consider:</u>

2. **The patient has a history of elopement in this or a prior hospitalization.**

3. **The patient or family members have been angry about care issues and have threatened to leave.**

4. **The patient has a history of substance abuse and may be craving the substance of abuse (drugs, alcohol).**

5. **The patient has a history of wandering.**

6. **The patient has been visited by friends or family who are encouraging him/her to leave for family or social issues.**

Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

EMERGENCY DEPARTMENT DATABASE ACCESS REQUEST FORM

Emergency Department Database Documentation

Confidentiality and Access

Name of Investigator: _____

Title of Project: _____

Purpose of Investigation: _____

_____

_____

Duration of Investigation: (How often and for what period will you be requesting data):

☐ Once ☐ Weekly ☐ Monthly from ___/___/_____ to ___/___/_____

In what format are you requesting the Data?

☐Excel Spreadsheet
☐Word document
☐Access Database
☐Other _____

How do you want to receive the Data?

☐Email
☐CD-R
☐Hard Copy (paper)
☐Needs to be password protected

When the study is over, will the data be destroyed or archived?

☐Destroyed ☐Archived

Does the data you are requesting require patient identifiers (unit numbers, names, etc.)?

☐Yes
☐No

What type of Investigation is being performed?

☐Internal Departmental QA Activity
☐Research Project

If the Project is a Research Project, has it been approved by the Internal Review Board on Human Experimentation (IRB) or received an exemption?

☐Yes Approval # _____
☐No

IRB approval is required for all Research Projects involving data containing patient identifiers unless the data is to be used for internal Departmental CQI activities.

By signing below you agree to the ED policies on the use of electronic data from the Emergency Department Database and the Medical Centers policy on confidentiality of patient information and utilization of electronic data.

_____ _____
Signature of Investigator **Date**

_____ _____
Signature of Chief, Division of Informatics **Approval Date**

Below are links to the Office of Human Research Ethics for forms and information
http://ohre.unc.edu http://ohre.unc.edu/forms.php
http://gcrc.med.unc.edu/investigators/admin/gcrcapp.htm
http://www.med.unc.edu/wrkunits/1dean/rschofc/researchresources.htm

PATIENT VALUABLES

UNC Healthcare Policy V-1
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall.

PHOTOGRAPHS AND MOTION PICTURES

UNC Healthcare Policy P-13
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall

RESTRAINT AND SECLUSION USE

UNC Healthcare policy R-5
(excludes Rex Healthcare)

This can only be viewed when within the UNC Hospital firewall

SECURITY POLICY : DEPARTMENT OF EMERGENCY MEDICINE

Effective Date:	**March 8, 2002**	**Section No:**	**III**
Distribution Date:	**March 8, 2002**	**Sheet No:**	**0476.1-3**

UNC HOSPITALS
POLICE DEPARTMENT
OPERATIONAL POLICIES and PROCEDURES

Policy:
It shall be the policy of UNC Hospitals to establish and maintain reasonable security measures for the emergency medicine department. Security measures that have been planned for and implemented include: Access control, emergency alert systems, closed circuit television, a patient Risk Assessment Protocol, and security patrols. This policy details specific operational issues regarding how the security procedures must work.

Objective:
The objectives of the policy are to provide specific guidelines for the implementation and maintenance of security procedures in the emergency medicine department and to provide the best possible patient care atmosphere.

Procedures:
The procedures section of the policy are divided into four (4) sections; access control, emergency alert systems, closed circuit television, and security patrols. Each area is listed and described below.
Access Control - Access into the emergency department is divided into three areas: Access through the emergency area for treatment elsewhere in the medical center, access for treatment in emergency medicine, and access into the emergency medicine treatment area.
a. Access for treatment elsewhere in the medical center - Access through the emergency medicine department for treatment elsewhere in the medical center should be discouraged. When other entrances are available and conducive with medical condition they should be utilized.
b. Ambulatory entrance and ambulance entrance - A card access staff entrance has been provided for employees and physicians to utilize for routine access into the building through the tunnel. Access to the emergency medicine department through the ambulatory entrance is monitored by the Hospital Police staff member and the triage staff. The ambulance entrance is provided with a remote door release monitored by the clerk. Access to the ambulance should be limited to: those seeking treatment; their visitors; support service workers; (police, fire, and ambulance personnel) or employees and physicians without access cards.

c. Treatment area access - Registration personnel will allow access into the treatment area through utilization of a remote door release system. Unauthorized persons gaining access should be asked to leave the treatment area. Hospital Police should be called to remove uncooperative visitors. Employee access shall be limited to those having a need for routine entrance in the treatment area. Others will not be programmed to enter using the card system.

Emergency Alert Systems - Panic alarms have been strategically located throughout the department to provide staff with a means of gaining emergency assistance when necessary. The overhead paging system may also be utilized for gaining staff assistance in unusual situations. Any staff member may activate the alarm system. Communications staff will then contact the Hospital Police Staff to respond to the location of the alarm. Communications staff will also contact the desk where the panic device was activated to obtain additional information for the responding officers.

Closed Circuit Television System - CCTV cameras have been installed and are monitored by Hospital Police and clerical staff.

Security Patrols - A Hospital Police officer has been assigned to patrol the emergency medicine department area 24 hours/daily. This officer's primary duties are to patrol the interior of the emergency medicine department, provide security assistance to the emergency medicine department staff and to assist patients into wheelchairs.

Weapons - Illegally possessed weapons, dangerous devices, contraband or suspected stolen property will be retained for disposition with Hospital Police. Properly identified law enforcement personnel may access the emergency medicine department with their weapons. Law enforcement officers receiving treatment shall deposit their weapons with Hospital Police. Hand held metal detectors are available for use by Hospital Police personnel. Anyone having reason to believe that an unauthorized weapon is present in the ED must contact Hospital Police for appropriate follow-up.

Supersedes Policy Dated: 9-29-97

Patient Risk Assessments - A policy and procedure has been established to identify, assess and react to situations that might impact patient and/or staff safety. Hospital employees who become aware of potential for violence or safety concerns should contact the Hospital Police Department and request a Risk Assessment (See Hospital Police Policy Section III, Sheet No: 0476).

LEVELS OF SECURITY
UNC HOSPITALS EMERGENCY SERVICES

LEVEL ONE:

Designated when:

- There is little or no threat present in the Emergency Department.

Security measures:

Security Guard or Police Officer is posted in the Emergency Department to provide surveillance.

LEVEL TWO:

Designated when:

- A patient is admitted to the Emergency Department who is a victim of violence.
- Agitated or hostile family members accompany a patient to the Emergency Department.
- Persons arrive who have indicators that arouse suspicion such as drugs and/or drug paraphernalia, or multiple alias names.
- An object is sighted that has the potential to be used as a weapon, such as a baseball bat, brass knuckles, etc.

Security measures:

- The person noting the threat informs the Police Officer and the Charge Nurse.
- The Police Officer informs the Police Supervisor of the potential threat and conducts a Risk Assessment.
- If the person is a victim of violence, or is considered suicidal or homicidal, the patient is placed on protective status. The Hospital Police Officer or Security Officer explains the protective status designation to the patient's family and obtains the names of three designated visitors. All other family members are asked to leave.
- The Police Officer, Police Supervisor, and the Charge Nurse assess the situation and determine if additional measures are warranted.
- The Charge Nurse informs the nursing and medical staff in the Emergency Department of threat, if appropriate.
- The Police Officer closely monitors all persons entering the area. All persons other than designated visitors are referred to Hospitals Police, who informs those persons of the visiting restrictions for the patient and asks that they leave.

LEVEL THREE:

Designated when:

- A victim of violence or VIP Patient is admitted to the Emergency Department who is attracting a great deal of media and/or community attention.
- Multiple family members arrive who are having difficulty controlling their behavior.
- Overt or covert threats have been directed at the staff, Police, and/or other visitors.
- Two victims of violence who were injured in the same incident are admitted to the Emergency Department.
- Police officers advise the staff that the patient and/or visitors have a history of disruptive or violent behavior.

Supersedes Policy Dated: 01-05-99

Security measures:

- The Emergency Department Police Officer and the Charge Nurse are alerted by the person noting the threat.
- The Nursing House Supervisor (NHS) or Service Supervisor is notified and arrives at the Emergency Department.
- The Police Supervisor is notified, and additional Officers may be requested. The Supervisor will respond to assess the circumstances.
- If additional Police personnel report to the emergency area, they are assigned duties by the Police Supervisor.

- The Police Supervisor and NHS (when appropriate) approach the persons who are presenting the threat and attempt to arrive at resolution. When appropriate, the persons who present the threat are asked to leave the area. If they refuse to leave, they are to be trespassed by Hospitals Police.
- All persons associated with the incident are screened with the hand-held metal detector prior to admission to the waiting or treatment area.
- The Hospitals Police Supervisor or Charge Nurse informs the ED Clerk to announce "Security Code III" over the intercom system.

LEVEL FOUR:

Designated when:

- The Police Supervisor, the NHS or Service Supervisor, or the Charge Nurse have determined that a level three situation is escalating out of control, and the persons presenting the threat refuse to leave.
- A gun or knife is sighted.
- An act of violence occurs in the emergency area.

Security measures:

- The Charge Nurse or Hospitals Police Supervisor informs the ED Clerk to announce "Security Code IV" over the intercom system
- Bystanders are removed to an area of safety. The persons presenting the threat should be removed to a secure area. All access doors to the treatment area are locked and or monitored by Hospital Police Staff.
- If not present, the NHS or Service Supervisor is notified and arrives at the Emergency Department.
- If not present, the Police Supervisor is notified, and additional Police personnel are requested. Additional Police Officers are posted under the direction of the Police Supervisor.
- The persons presenting the threat are removed by Police Officers upon the authorization of the Police Supervisor.
- Additional measures described in lower levels.
- Additional assistance from the Campus Public Safety or Chapel Hill Police Department may be requested as necessary.

Sandy W. Pabers, RN
Clinical Nursing Supervisor

Thomas A. Smith
Director of Hospitals Police

Signed 03/08/02

Supersedes Policy Dated: 01-11-99

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION FOR TEACHING/EDUCATIONAL PURPOSES

The undersigned is requesting access to the following types of protected health information:

___Paper Record ___Electronic Record ___PACS Records ___X-Rays Other:_____

for the following teaching/educational purposes: _____
_____

The undersigned is requesting access to or disclosures of information that may be individually identifiable, i.e. it may include identifiers of the individual, the individual's employer or the individual's household members, or the information may be completely de-identified information, i.e. information that does not contain any of the identifiers listed below with respect to the individual, the individual's employer or the individual's household members.

I, the undersigned, agree as follows:

- I agree that information described in this form will only be obtained directly from the data custodian through this Request for Access form each time information is required so that I can acknowledge my responsibilities.
- I will use and disclose this information solely for educational or training purposes, as included in the definition of "health care operations" under the Health Insurance Portability and Accountability Act of 1996, as amended, and its accompanying regulations ("HIPAA").
- If any of the information obtained contains any of the identifiers listed below, I agree to remove such identifiers before using or disclosing such information.
- I will not record or obtain copies of records of any information that includes any of the identifiers listed below.
- I will not review any information that is not necessary for the purposes stated in this request.
- I am aware that the data to which I have requested access is subject to HIPAA and other legal and regulatory protections and that violation of privacy and confidentiality protections for this data may incur civil and criminal penalties. I understand and agree to comply with the obligations listed in this request, and to inform all team members who may access this information of their responsibilities for compliance with these obligations.

I agree that UNC Health Care System can terminate my access to this information by written notice immediately if I breach any material obligation under this request, and I agree that, should this occur, I will return or destroy all patient information obtained through this request.

IN WITNESS WHEREOF, the undersigned has executed this Request this ____ day of _____, 200_.

_____
Signature

_____
Print Name

_____
Department

(a) De-identified Data

A de-identified data set **may not include** any of the following direct identifiers of the individual or of the individual's relatives, employers, or household members

• Names • Geographic subdivisions smaller than a state • Zip codes • All elements of dates except year directly related to an individual, including birth or death or dates of health care services or health care claims • Telephone numbers • Fax numbers • Electronic mail addresses • Social security numbers • Medical record numbers • Health plan beneficiary identifiers • Account numbers	• Certificate/license numbers • Vehicle identifiers and serial numbers, including license plate numbers • Device identifiers and serial numbers • Web universal resource locators (URL) • Internet protocol (IP) address numbers • Biometric identifiers, including finger and voice prints • Full face photographic images • Any other number, characteristic or code that could be used by the requester to identify the individual

Note: Although a de-identified data set cannot contain a birth date, it may contain the individual's age expressed in years, months, days, or hours, as appropriate, except for individuals who are aged 90 years or more. For persons aged 90 years and above, the age in a de-identified data set can only be stated as being within the category of age 90 or above.

ADDENDUM FOR DEPARTMENT OF EMERGENCY MEDICINE IRB REQUESTS

Name of PI, title, rank _____

Name of data manger, title, rank _____

Name of data abstractor, title, rank_____

PI, data manager, and data abstractor have taken PHI and IRB tests____

Will any PHI be transmitted by email, via web, or other electronic means? If so, describe the methods. Describe how security of transmitted PHI is maintained. If subjects are Survey respondents who are not patients, describe how their confidentiality is maintained.

Data Storage.

Electronic. Identify server/computer/memory stick. Describe secure access. How is loss/theft of the storage device minimized?

Paper. Identify location and method of storing hard copy. Who else has access?

Data Analysis.

Describe location where data collection, abstraction, aggregation, and analysis will be done. Will materials or personal computing devices be removed from this location at any time? If so, how is PHI and the storage device protected?

When will electronic or paper material with PHI/confidential information be destroyed? Who is responsible for the destruction of materials with PHI?

Does your study involve data from multiple institutions? If so, how will identify of the institutions be protected?

I agree to provide the Department of Emergency Medicine with a summary of any changes requested by the IRB, and will provide a finalized, completed copy of the IRB form to the Chair when approved. I will provide the Department with copies of any updates.

_____ _____

Signature (PI) Date

EVIDENCE

Any item(s) removed from a victim of an alleged crime, which might be used as evidence (clothing with bullet or knife holes, weapons, surgical specimens) should be preserved in the following manner:

1. A member of the ED staff, who is present when the article is removed, keeps possession of the article(s) at all times until he/she releases it to a member of the Safety and Security staff or to a law enforcement officer.

2. Security should be summoned to:

   a. Receive and secure the article(s)
   b. Provide information/advice as necessary
   c. Provide an evidence envelope if needed

3. All personnel handling articles of evidence must maintain a clear chain of evidence In writing. As few persons as possible should have possession of the article(s).

Revised: November, 1979
Reviewed: November, 1982
Revised: October, 1983
Reviewed: November, 1985
Reviewed: November, 1986
Reviewed: January, 1993

UNC HEALTH CARE *Excludes Rex Healthcare	Name of Policy	METAL SCREENING POLICY
	Policy Number	1210
	Date This Version of Policy Effective	January 11, 2005
	Approval	Thomas A. Smith Director of Hospital Police
	Approval	Jeffery Strickler, Administrative Director Emergency Medicine

Policy

It shall be the policy of the Hospital Police Department and the Emergency Department of UNC Hospitals to perform protective metal screening at the Emergency Department ambulatory entrance for the safety of patients, employees, and visitors. To facilitate this policy, only Emergency Department patients and visitors will be allowed to utilize the ambulatory entrance. All other pedestrian traffic must be sent to the entrance where they need to conduct business. The Metal Screening Policy applies to anyone utilizing the ambulatory entrance of the Emergency Department. All persons entering the Emergency Department shall be subject to search as a condition of entry to the property. Persons refusing search may be denied entry.

Objective

The intent of this policy is to reduce the potential for violence in the Emergency Department.

Procedure

1. All persons entering the Emergency Department ambulatory entrance will be required to pass through the detector unless medically unable to do so. Officers may use discretion and allow a patient past the screening in situations where a serious injury precludes the metal screening process. When appropriate a hand held screen should be utilized. Persons gaining access to the Emergency Department through other entrances are subject to hand held metal detection as a condition of their continued stay. Persons refusing to comply with the Metal Screening Policy will be asked to leave the premises.

2. Officers shall stand next to the metal detector when an individual approaches the entrance. After the patient / visitor has cleared the Patient Check In Station, the officer will request the individual place all metal items and electronic devices into the collection bin prior to passing through the metal detector.

3. Should the detector activate, the individual will be stopped and instructed to go back through the metal detector and once again the officer will advise the individual to deposit metal objects into the collection bin. Should the detector activate again, the officer will utilize the hand held metal detector to pin point the location of the metal on the individual in question.

4. If the metal detector does not activate and the individual has some type of carry item, such as a purse, suitcase or backpack, the officer will advise the individual that the carry item will need to be opened so a visual check can be made. Should the individual refuse to comply, the officer must instruct the individual that they will not be allowed to enter the emergency department with the carry item. If the individual refusing to permit inspection of the carry item is the patient and continues to refuse to either return the carry item to their vehicle or permit it to be searched, the officers should take custody of the carry item and log it on the weapons log sheet for return when the individual leaves the ED. If

the individual states that they are refusing medical treatment rather than have their carry item searched, an incident report should be filed (Information Only / Refused Metal Screening Categories) and the officer should notify the patient greeter that a person has refused treatment. If the patient's name is known the greeter should place the patient name on the ED Log, seek to have the patient complete an AMA form, and show the patient on the ED log as having left without being seen.

5. Individuals being screened may empty their pockets into the plastic container at the side of the unit and pass through the detector. Purses are to be placed next to the plastic container to be viewed and/or felt for contents. The purse may be returned to the person's vehicle if they do not want it searched. Officer should be cautious of sharp objects and avoid putting their hands into packages having unidentified contents. If the screening process results in an alarm, the officer may choose to use a hand held unit to locate the metal.

6. If a concealed weapon or other illegal substance is found, a Commissioned officer must be notified to take appropriate action.

7. Should an officer find any other item(s) that could be used as weapon, these items will be held for the individual until they leave the premises. These items will be logged on the weapons log sheet. The owner can pick their item(s) up once their business is complete in the hospital and they have signed the weapons log sheet.

8. EMS (High Risk) Patients – In those cases where EMS personnel suspect a level of risk or threat to the safety of staff and others, notification should be made to the Emergency Department staff prior to arrival. Once the ED staff is aware of the potential risk, Hospital Police personnel should be contacted to stand by at the Ambulance Entrance to manage the situation appropriately. This may include the utilization of a hand held metal detector to maintain a weapons free environment. The medical condition of the patient and threat presented must be considered when determining appropriate action.

9. Signs will be placed at entrances to the Emergency Department announcing metal screening is in operation.

10. If persons have items they do not wish to be screened, they may return the item to their vehicle.

11. Persons with illegal weapons (firearms, knives etc…) shall at a minimum be issued a uniform citation.

12. Only on duty police officers with appropriate ID will be allowed inside the ED with their weapon. Officers being treated as patients must secure their weapons with Hospitals Police or their own departmental personnel.

REPORTING OF ANIMAL BITES

POLICY

The treating physician is responsible for informing the patient that it is a state law that animal bites "shall" be reported by the victim and owner of the animal to the local health department and that a physician attending a person bitten by a potential rabies carrier shall report the name of the person bitten to the local Health Department.

PROCEDURE

Inform the patient of these laws. The physician or trainee, and the patient will contact the appropriate animal control officer. This will be documented on the ED record. Useful telephone numbers are provided below. After hours, bites can be reported to 911.

Alamance County Animal Control	**(336) 570-6302**
Carrboro Animal Control	**(919) 968-7709**
Chapel Hill Animal Control	**(919) 968-2760**
Chatham County Animal Control	**(919) 542-8208**
Durham County Animal Control	**(919) 560-0630**
Orange County Animal Control	**(919) 732-8181**

Judith E. Tintinalli, MD, MS
Department Chair

Sandy Pabers, RN, CNS
Department Nurse Manager

June, 1994
Revised: 9/7/2001

SEARCH AND PERSONAL INVENTORY POLICY

Policy: SEARCH--PATIENT SEARCHES
Searches of persons and their effects and personal inventories are two separate and distinct procedures. The procedures set forth below are designed to establish guidelines when searches and personal inventories are appropriate and to define the responsibilities associated with conducting these activities. Searches are generally conducted to provide increased safety or in conjunction with criminal activity. Personal inventories are implemented to identify patients and safeguard their personal effects.

Objective:
To provide care to patients who cannot identify themselves; to safeguard patient effects; and to protect patients, staff, and visitors.

Procedure:
Metal screening must be conducted an all patients that have expressed an intent to harm themselves or others. The triage nurse usually identifies the need for such a search. To improve safety and patient confidentiality, staff requesting a search should do so in a discreet manor to avoid forewarning the patient of the impending search. The search location will be determined by the hospital police officer or security officer, and should be completed prior to the patient proceeds to Registration. The search is to include use of a wand for metal detection as well as search of clothing and personal effects.

- Searches may be conducted under the following general circumstances:
    1. A patient or visitor displays, refers to, or is in possession of weapon(s)
    2. A patient or visitor expresses the intent to harm him / her self or others
    3. A patient or visitor acts in a criminal manner

- When asked to search a patient, Hospital Police Staff shall provide the requesting staff member with a copy of the Patient Search Request Form (see sheet 1400.2) and determine the reason for the search. The purpose of the form is to document the need for the request and to assist in monitoring this process. The Patient Search Request Form will be turned in with the other daily activity forms and stored in the Hospital Police Administrative Offices.

- Hospital Police personnel will normally conduct searches.

- The Hospital Police may request a female staff member to be in attendance during searches of female patients or visitors.

- Searches that are conducted as a result of suspected criminal activity will be documented in a UNC Hospitals Police Department Incident Report.

- Hospital Police will secure weapons or other contraband.

- Other items or personal effects will be secured in accordance with Emergency Department standard practice.
- It is the responsibility of any person who becomes aware of any of the three circumstances listed above to immediately notify the Hospital Police.

- Inventories may be conducted when:
    1. A patient is unable to identify himself
    2. A patient is unable to safeguard his/her effects because of injuries or impaired state

- Inventories are to be conducted by two members of the Emergency Department staff.

- If a weapon or other contraband is discovered, it should be removed (if possible and safely) and UNC Hospitals Police Department personnel should be paged immediately.

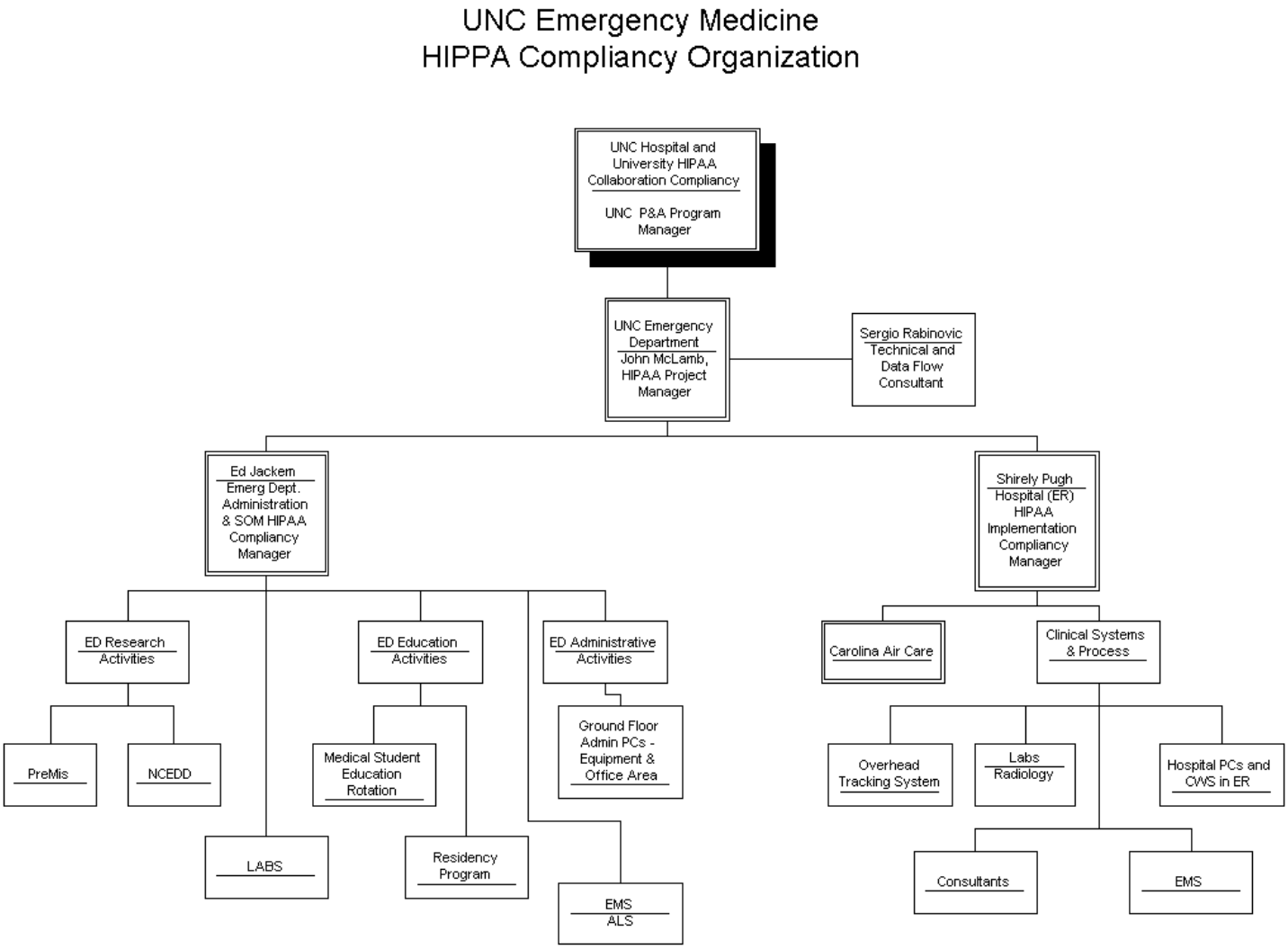
- The Charge Nurse will normally make the determination to conduct an inventory.

- The Hospital Policy regarding Inventory will be followed.
- All inventories are to be documented on the patient's medical record.

Judith Tintinalli, MD, MS	Sandy Pabers, RN, CNS II	Thomas A. Smith
Professor and Chair	Nurse Manager	Director, Hospital Police

Revised: 9/95, 2/28/01

UNC EMERGENCY MEDICINE HIPPA COMPLIANCY ORGANIZATION, ROLES, AND RESPONSIBILITIES



Roles and Responsibilities

John McLamb

- HIPAA Project Management for the ED
- Representing the ED on the UNC HIPAA Implementation Team
- Technical Consulting

Ed Jackem

- HIPAA project coordinator for the ED administrative unit
- Representing the ED on the UNC HIPAA Implementation Team
- Interpreting and implementing HIPAA policies, rules, and process changes as they apply to ED Administration

Shirely Pugh

- HIPAA project coordinator for the ED clinical unit
- Representing the ED on the UNC HIPAA Implementation Team

- Interpreting and implementing HIPAA policies, rules, and process changes as they apply to ED clinical operations in the ER

Sergio Rabinovich

- Technical consultant
- ED data flow consultant
- Data equipment physical security

WOUND REPORTING

North Carolina Statute 90-21.20 Reporting by Physicians and Hospitals of Wounds, Injuries and Illnesses requires that the physician discovering such wounds, injuries or illnesses must report as soon as it becomes practical, before, during or after completion of treatment, the results to the local police department. These wounds, injuries or illnesses which shall be reported by physicians and hospital include every case of a bullet wound, gunshot wound, powder burn or any other injury arising from the discharge of a firearm; every case of illness apparently caused by poisoning; and every case of a wound or injury caused or apparently caused by knife or sharp pointed instrument. The Emergency Department will notify the Security or Police Officer on duty who will report the following to the appropriate Law Enforcement Agency.

1. Name of injured or ill person
2. Age
3. Sex
4. Race
5. Residence or present location
6. If known, the character and extent of injuries

Any hospital, sanitarium or like institution or the director, administrator or physician participating in good faith in the report shall have immunity from any liability, civil or criminal, that might be otherwise incurred as a result of making the report.

Revised: September, 1982
Reviewed: October, 1983
Reviewed: November, 1985
Reviewed: November, 1986
Reviewed: January, 1993
Revised: March, 2002

VIII. Equipment and Supplies

AVAILABILITY OF CT SCANNER FOR TRAUMA PATIENTS

DATE: 2/1/02

The Dept. of Radiology will consider all trauma patients, code red and code yellow, as top priority cases. Although the CT table will not be held open for any specified period of time, it is understood that as soon as the trauma patient is ready for scanning the CT table will be made immediately available. A 10-minute warning should be given to the technologist at the control console via telephone (ext. 68852) or in person to facilitate clearing of the table and room preparation. The trauma team should not enter the scan room itself until the previous patient has been moved to the holding area or transported to his/her room.

Dr. Julia Fielding

Dr. Judith Tintinalli

Dr. Charles Baker

CLEANING AND DISINFECTION OF EYE EQUIPMENT AND ROOM

Department of Emergency Medicine
April 9, 2002

Procedure:

1. After each use of the slitlamp the pysician will indicate that the chair and lamp require cleaning.

2. The nurse working in minor trauma will clean or delegate the cleaning to appropriate staff.

3. Cleaning procedure includes the following:
    a. Change the tissue paper on the chin rest.
    b. Wipe the entire slit lamp and chair with a 1:10 bleach solution or 70% Alcohol solution after each use.

4. The Tanopen should be cleaned using an alcohol solution after each use.

James Larson, MD
Clinical Director

Sandy Pabers, RN, CNS II
Nurse Manager

EQUIPMENT AND DRUG MAINTENANCE

PURPOSE:

1. The adult and pediatric crash carts are checked daily by an RN to ensure the lock is intact. If the lock has been broken, an RN must check the contents of the cart at that time, and a lock reapplied.

2. The crash carts are opened monthly to check expiration dates of the contents.

3. All defibrillators are checked daily.

4. All medications are available 24 hours per day in the Pyxis Medstations located in the Clean Utility Rooms and in Minor Trauma.

5. An RN checks trauma Rooms, and Room 4 and 5 emergency airway equipment daily.

6. The Anesthesia Box is locked in the Refrigerated Pyxis. The box is locked with a plastic lock at all times. An RN checks the box after each use, lock reapplied, and then replaced in the locked refrigerator. This box is opened monthly to check expiration dates.

Revision: December 13, 1998
December 6, 2001
May 2002

EYE/ENT ROOM MAINTENANCE

PURPOSE: To stock and maintain a room for adequate examination and treatment of ocular and ENT emergencies

ACTION: The EYE/ENT room will be inventoried and stacked every Monday and Friday with replacement of used and expired medications, general cleansing and re-evaluation of specific needs. The attached list will be followed, dated and initiated by the person checking the room. All opened vial are to be discarded daily.

Sandy Pabers, CNSII
Nurse Manager

Judith Tintinalli, MD
Department Chair

Written: November, 1992

Eye/ENT Room cont'd

Wood's lamp - 1
Eye chair- assure lights working, (headrest and seat back working)
Slit lamp - assure light working
Fluorescein paper strips - 1 box
Fluress - 2 bottles
Rigid eye shields - 3
Tetracaine eye drops - 2 bottles
Single-use blister pack - Tetracaine #100
1% cyclopentolate (cyclogel) - 2 bottles
2% cyclopentolate (cyclogel) - 2 bottles
Neosynephrine ophth drops - 1 bottle
Mydracil 1% - 2 bottles
Dacriose irrigating solutions - 4 bottles
Pilocarpine 0.25%, 1% and 4% - 1 bottle each
Maxidex (dexamethasone) 1% - 1 bottle, 1.5 tube
Neodecadron ophth solution - 1 bottle
Neodecadron ophth ointment - 1 tube
Maxitrol - 2 tubes
Antibiotics - Genoptic (Gentamycin) drops - 10 bottles ointment - 2 tubes
Neomycin/polymitin B ointment - 1 tube

Bleph 10/sulfacetamide 10%) - 10 bottles
Erythomycin drops - 1 bottle 1 tube ointment

Hard contact remover
Cotton eye patches - small - 1 box large - 1 box
Tape - paper, silk - 11” x 3
Cotton applicators - 20
Opthalmic cautery - 2
Lacrilube - 2 bottles
Morgan lens - 4
Timotpic 0.25 %, 0.5% - 2 bottles each
Tongue blades - 20
Dental mirrors - 2
Ear currettes - 2
Ear wicks - 6
Hear mirror - 1
Head lamp - 1 (on wall)
Light source
Direct laryngoscope - 1
Otoscopes/Ophtalmoscopes on wall
Frazier Suction tip - #2, #8, - 1 each
Nasal speculum - 2 each large and small
Alligator forceps - in look-up
Tonometer - in lock-up
Eye burr and sterile tips - in lock up
Storz epistaxis catheters x 4
Bayonet forceps x 2
Water pik for irrigation
Cortisporin otic solution - 2 bottles
Auralgen 10cc - 2 bottles
Lidocaine 4% solution - 1 bottle
Debrox - 2 bottles
Domeboro - 1 box of 100
Otrivin - 2 bottles
Vaseline gauze packing - 2 packages
Nostril (0.5% phenylephrine) - 2 bottles
Silver nitrate sticks - 1 box
Tonsil suction x 2
1 Standard Bedside cart - stocked
Betadine
Saline
PEN TONOMETER AND TONOMETER TIPS

POWER INJECTOR CT AND IV ACCESS

To: AIG staff, all residents and fellows, Ms. D. Silberman, Dr. A. Mehrota

From: Dr. J. Fielding

Re: IV line access for power injection

Date: 8/18/06 (revised)

As you know, line caliber and location are important determinants for the use of power injection of intravenous contrast medium. With our nursing supervisor's help, I have developed the following list of lines suitable (and unsuitable) for power injection. This list is posted throughout the department and in the technologist's break room. All patients undergoing any type of angiographic procedure on the 16, 40 or 64 detector CT must have at least a 20g antecubital IV. This caliber is necessary for the high flow rates (3-5cc/s) and rapid, clear imaging required for angiographic work. In the absence of an antecubital site, an IJ introducer cordis sheath or purple power picc or power port line may be used. All are safe with 3-5cc/s injection rates. EJ lines are not to be used for angiography. When antecubital access is not available (3 failed attempts), an upper forearm vein may be used with a reduced rate of 2cc/s for abdominal studies such as dissection, stent graft and aneurysm studies. Hand veins are not to be used for angiographic procedures. For non-angiographic studies, antecubital and forearm veins are the preferred sites. If these are not available, then hand veins may be used at the discretion of the technologist and/or nurse with injection rates less than 2cc/s. For these studies, a 22g IV may be used if a 20g cannot be maintained. For appropriate central lines listed below, power injection rate is 2.0cc/s. If deviation from the above protocol is thought necessary, the technologist should contact the supervising radiologist.

Lines that you can use for power injection:

Hickman

Triple lumen

Single lumen cordis sheath

Power Picc, Port (purple, Bard)

Lines that you cannot use for power injection:	**Lines that you can hand inject:**
Dialysis catheters	Arrow single lumen central
Broviacs, Groshongs	Groshongs, Broviacs
PICC and Mid-lines	PICC and Mid-lines
Portacaths (except Power Port)	Portacaths

Hello colleagues,
Attached please find the latest revised version for IV access and CT power injection.
Some changes this year:
1. Power Ports will become our default port during the next 6 months. They can tolerate 5cc/s but do require a heparin flush post use. They can be used for CT angiography.
2. Power PICC lines will be used in some patients - these can also tolerate 5 cc/s so can be used for CT angiography.
3. For PE studies from the ER, we will continue to use either
   A. 20 g antecubital IV
   B. Cordis sheath (obtainable from ICUs)
4. The Arrow single lumen central line cannot be used for any type of power injection.
5. The triple lumen Arrow catheter can be used for power injection up to 2.5cc/s - but unfortunately cannot be used for angiography. This catheter has 3 smaller catheters
(2 18g and 1 16g) wrapped in firm blue plastic. Because we have not had any adverse results in the past 6 years with this catheter and because it is often the only IV site available in very ill, hospitalized patients, we will continue to use it for routine CT work.
6. For very obese patients and those with minimal access (22 g hand vein, etc.) we can usually perform a chest CT that will exclude emboli within the main pulmonary arteries and proximal lobar branches. We will dictate this as a limited PE study.
7. V/Q scan continues to remain an option for exclusion of PE.
--
Julia R. Fielding, M.D.
Associate Professor of Radiology
Director, Abdominal Imaging
UNC Hospitals

ROUTINE MAINTENANCE AND CLEANING OF STRETCHERS

Department of Emergency Medicine

PURPOSE: To insure appropriate cleaning and maintenance of stretchers to be in compliance with Infection Control policies and provide patients with a clean and safe environment during treatment.

LEVEL: RN and NA II

POLICY STATEMENTS:
1. It is the responsibility of the Emergency Department to provide clean and workable stretchers.
2. The mattress will be inspected for tears or imperfections.

Equipment
1. Cleaning cloth
2. Low level disinfectant

PROCEDURE:

NA II

Steps	Key Points
1. Mattress and side rails on the stretchers should be cleaned of all visible organic soil (blood, proteinaceous matter, debris, etc.) between each patient use.	1. All surfaces will be wiped down with a cleaning cloth and a low level disinfectant.
2. All surfaces of the mattress will be inspected for tears or imperfections.	2. Remove mattress from circulation, and notify ED charge nurse
3. Mechanics of stretcher (e.g. head lift, side rails, brakes, etc.) should be inspected for proper functioning.	3. Remove stretcher from circulation and notify ED charge nurse.
4. Stretchers will be numbered. At least one stretcher a day, except on holidays, will be sent to patient equipment for cleaning.	4. Records of the stretcher being sent will be kept on a log.

Charge RN

Steps	Key Points
5. Charge RN will notify CNS II or CNAS of need of mattress replacement.	5. Supervisor will replace the mattress from the ED equipment room ASAP. If supply is low notify ED Nurse Manager.
6. Charge RN will call Stryker for repairs.	6. Remove stretcher from circulation by placing a note regarding issue to be fixed.

ULTRASOUND USE

1. The ultrasound machine dedicated to the emergency department is for the use of members of the Departments of Emergency Medicine, Radiology, and OB/GYN.

2. Documentation of each use of the ultrasound is the responsibility of the individual departments.

3. The ultrasound machine is to remain in the Emergency Department unless it is removed for service. Any transfer of the machine out of the Department must be approved by the Attending on duty.

4. Procedure for cleaning/disinfecting of vaginal ultrasound probes.
    A. Remove the condom and wipe the probe clean with a fresh, clean, alcohol soaked cloth.
    B. Immerse the cleaned ultrasound probe in a closed container filled with 2% glutaraldehyde (Cidex), and soak for at least 20 minutes.
    C. Upon completion of the 20 minute soak cycle, rinse the proge thoroughly with tap water, and allow to air dry on a clean towel.
    D. This procedure must be performed after each patient use.
    E. A condom should be placed on the clean probe to confirm.

5. Non-endovaginal (abdominal, small parts) probes that <u>are not</u> exposed to bodily fluids (blood, urine) should be cleaned in the following manner:
    A. Any excess ultrasound gel should be removed from the probe.
    B. An isopropyl alcohol swab or soaked cloth should be used to clean the probe, and the probe stored for further use.

6. Non-endovaginal (abdominal, small parts) probes that <u>are</u> exposed to bodily fluids (blood, urine) should be cleaned in the following manner:
    A. wipe the probe clean with a fresh, clean, alcohol soaked cloth.
    B. Immerse the cleaned ultrasound probe in a closed container filled with 2% glutaraldehyde (Cidex), and soak for at least 20 minutes.
    C. Upon completion of the 20 minute soak cycle, rinse the probe with tap water, and allow to air dry on a clean towel.

Judith Tintinalli, MD
Department Chair

Jim Larson, MD
Department Medical Director

Revised 9/2000

IX. TRIAGE

EVALUATION OF OB PATIENTS IN THE ED

PURPOSE: To ensure proper evaluation of the pregnant patient in the ED

PROCEDURE:

1. It is the policy of the ER that all pregnant patients presenting for care will be treated in the ER unless they are beyond 20 weeks gestation and have a problem suggesting labor. OB patients with problems not related to pregnancy, such as colds, earaches, and other minor illnesses are not to be sent to Labor and Delivery. Patients in labor who are not in imminent threat of delivery are to be transported in a wheel chair to Ward F-3 OB. ER personnel will escort such patients after notifying the labor deck.

2. Patients presenting to the ER with imminent delivery are to be seen/evaluated in the ER. Call Labor and Delivery and request that they send the OB watch and an incubator to the ER stat.

3. Serious condtions in pregnant wornen to be considered are:
   a. pregnancy induced hypertension or toxemia, present with headache, elevated BP, abdominal pain, proteinuria, edema, seizures can occur up to 2-4 weeks after delivery.
   b. placenta previa with painless vaginal bleeding.
   c. placenta abruptio with painful vaginal bleedng, often in shock.
   d. uterine rupture with shock

4. It is the policy of the ED to maintain in the ER pre-packed OB kits suitable for the emergency care of obstetrical patients whose delivery is imminent. These packs may be of the commercial variety, or prepared by the ER, but should contain those items necessary to render a safe and sterile delivery in the ER when transfer to the Labor Deck cannot be accomplished.

October 26, 1992

Judith Tintinalli, MD, MS
ED Chair

Dexter Morris, MD, PhD
ED Vice Chair

Sandy Pabers, RN, CNSII
ED Nurse Manager

FAST TRACK TRIAGE AND TREATMENT GUIDELINES

The operating principal for the entire ED should be to see patients in the most efficient, safe way possible. The following apply to normal operating circumstances. The ED operates at full capacity much of the time and flexibility is necessary to ensure that care is optimized. A discussion between the leadership in the department at the time (Charge nurse and ED attending(s)) should be able to problem solve to ensure optimal care. This could include triaging patients to Fast Track who normally would not be triaged there. Please contact me or Sandy Pabers we can refine and resolve issues.

Cases not appropriate for Fast Track under normal circumstances:

1. Expected stay longer than 4 hours under normal conditions (requiring multiple consults)
2. Requiring continuous cardio-pulmonary monitoring
3. Expected need for moderate sedation example being shoulder or hip dislocation
4. Severe headache that is different from baseline headache with fever or history of fever
5. Trauma patients with significant pain or other worrisome findings should be discussed with an ED attending before going to Fast Track
6. Likely hip fracture
7. Unwitnessed fall in an elderly person (>65yrs) who does not remember the event

Cases appropriate for Fast Track under normal circumstances include:

1. Patients who may require a pelvic exam:
    i. Who are not known to be pregnant
    ii. Have no more than spotting if bleeding
    iii. Have minimal abdominal and pelvic pain (pain score <=3)
2. Patients who have a chronic complaint of abdominal pain that is not significantly different from the past (as expressed by the patient)

ED areas utilization:

When Fast Track is full and patients are waiting consider putting patients on the A and B side if conditions warrant. Similarly in the morning consider putting patients on the A and B side if this would increase throughput.

Sept. 6, 2006

James L Larson
Medical Director

TRIAGE AND REGISTRATION OF PATIENTS IN ED

November 1, 2000

Purpose

To clarify which patients, who present to the ED triage or charge nurse area, will be triaged only, or triaged and registered in the SMS computer system, or neither triaged or registered.

A. NURSING TRIAGE ASSESSMENT

1. Triage Assessment Function

All adult and pediatric patients who present to the ED will be initially seen by a registered nurse, except for the patients listed under the "No Triage or Registration" categories below. Upon completion of unit specific triage training and determining patient acuity utilizing the Emergency Severity Index system the RN will perform a triage assessment on the patient in the appropriate location:

a. In the triage area (Ambulatory and wheelchair patients, and infants/children carried to triage)

b. At the ED/EMT/PAC bedside (stretcher patients, and patients too ill/unstable to go through the triage area)

On ambulance stretchers (direct/indirect admits)

B. TRIAGE ASSESSMENT ONLY PATIENTS *(No Registration)*

Triage Assessment Only Patients
Patients triaged to Labor and Delivery (ambulatory, wheelchair or stretcher)

RESPONSIBILITIES

a. **Nursing Responsibilities**

Document the triage assessment on the ED nursing record to include EDC, prenatal care provider, status of membranes and reason for visit, assign a triage category, and sign the triage note. Send the original (white) copy with the patient for all patients being transported to Labor & Delivery.

b. **Outpatient Registration Staff Responsibilities**

Assign a Bates number and log the patients in the logbook. If Labor & Delivery calls back regarding a patient with no UNC medical record number (when Admitting is closed), as of 11/95: No registration or card printing will be done for patients sent straight to Labor & Delivery from ED.

TRIAGE ASSESSMENT & REGISTRATION

1. Triage Assessment and Registration of Patients

a. Patients Seen in ED

All adult and pediatric patients triaged to the ED, Minor Trauma, Peds Acute Care, or Medical Urgent Care have a Nursing Triage Assessment completed, and will be registered. Patients triaged to Peds Acute Care and Medical Urgent Care will have vital signs and completion of the triage assessment performed in the assigned area.

After the regularly scheduled hours of triage to Medical Urgent Care all patients with a triage assessment and designation appropriate for Medical Urgent Care will be triaged to Minor Trauma until the regularly scheduled closing time for that area.

b. Direct Admissions

All directly admitted patients (except those listed under "No Triage or Registration") will have a triage assessment completed. This is to include Direct Admits by Helicopter/Ground Critical Care Transport Services

Direct Admits to inpatient units, Labor & Delivery by other hospital-based transport services (e.g., Duke Life Flight, Eastcare, and First Health). If the patient does not have an ET/Referral case in the SMS computer system, notify Bed Control, and patient will have to be registered either by ED Nursing Staff or by Bed Control Staff, as determined by Bed Control.

Registration Function

All patients who present to the ED will be registered in the SMS system as ET (Emergency Temporary) cases, clinic code 074 for the Main ED, 086 for Minor Trauma (MT), 043 for Peds Acute Care (PAC), or 152 for Medical Urgent Care (MUC), (Service codes for these areas are ED-ERI, PAC-PD2, and MUC-MD2), except for the patients listed under "Triage Assessment Only" and "No Triage or Registration."

RESPONSIBILITIES

1. Patients seen in ED:

a. **Nursing Responsibilities:**

Patients placed in an ED/EMT/PAC bed according to the designated triage level and needs of the department as determined by the triage and charge nurse in consultation with the ED Attending MD if needed.

Outpatient Registration Responsibilities:

Register ED patients as ET cases (see registration procedures), except for disaster patients. Assign a Bates number and log the patient in the logbook. Print ED MD record and ID/stamper cards.

c. **Health Unit Coordinator Responsibilities**

Register disaster patients (See ED procedure manual), as ET cases.

2. Direct Admissions- Admitted patients who **do not** stay in the ED for care.

a. **Nursing Responsibilities - Charge/Triage Nurse**

Check the Referral list for a Bed Control Registered Case for the patient. Triage the referral case, perform a triage assessment, document on the ED nursing record, and when completion of the assessment is done on the last screen in ED Tracking the patients bed assignment will appear if the bed is ready for occupancy. If no bed assignment provided, call Bed Control to inform them of the patient's arrival and inquire into the details of how long it will be until the bed is ready. If the bed is unavailable, place patient in a ED Hallway Bed (or appropriate ED bed) and contact the admitting service. If the bed is ready call the inpatient unit and notify the nurse that the patient is en route to their unit, give brief patient report. Send the original (white) copy with the patient.

b. **Attending MD Responsibilities**

Briefly assess patient for stability and confirm the floor bed assignment is appropriate for the patient. MD assessment not indicated for patients to be admitted to an ICU.

Outpatient Registration Responsibilities

Assign a Bates number and log the patient in the logbook. *Change as of 11/95: No ED Physician Record is printed for direct admits who do not stay in the ED.

c. **Health Unit Coordinator Responsibilities**

Ensure nursing triage record is given to Registration Clerk.

3. Peds Floor Direct Admissions

In addition to steps above, call Peds Acute Resident or Attending MD who will briefly assess patient and confirm that floor bed assignment is appropriate.

4. Direct Admissions who Stay in ED for Care (Indirect Admits)

Admitted patients who are placed in a ED bed (because the previously assigned admission bed is inappropriate, or the inpatient bed is not ready) will be handled like all other patients who are seen in the ED. Triage/Charge Nurse will use the ET case (which should have been previously entered by Bed Control). When patient is moved to a ED bed, Health Care Coordinators will notify Registration to print an ED Physician record and ID/stamper card. The admitting service for that patient should be contacted and notified of the patient's presence in the ED.

No TRIAGE OR REGISTRATION

1. Carolina Air Care

*Change as of 11/95: Direct Admits to inpatient units, and Labor & Delivery by CAC staff will not stop in the ED unless patient is too unstable to go to the previously assigned unit, or the bed is not ready. If patient is put in ED bed for either reason, follow "Direct Admits stay in ED" procedure.

2. UNC Hospitals Ambulatory Care (ACC) Patients

Direct admissions to inpatient units from the UNC Ambulatory Care Center by ambulance stretcher (with ACC, CAC, and /or Orange County EMS staff).

3. Infants/Neonates in Isolettes

Direct admissions to Neonatal ICU (NCC4) or other Peds Unit.

a. **Nursing Responsibilities**

If transport team stops in ED and hasn't contacted inpatient unit while en-route to call report, RN will notify Bed Control of patient's arrival, confirm that bed is ready, and call inpatient unit and notify them that the patient is en route to the unit. If ED renders no patient care, assessment and/or documentation are not necessary. Transport team will give report on arrival to inpatient unit *As of 11/95, direct admits from ACC that already have inpatient bed assignments do not need to stop in ED for registration or triage.

Special Circumstances and Patient Populations Triage Policy

Purpose

To clarify specific actions and procedures to be utilized for specific patients presenting to triage.

1. Patients presenting to triage with **psychiatric complaints aged 60 or older**.
   - All patients age 60 or older with a psychiatric complaint will be triaged at all times to the acute ED area for medical evaluation. These patients are to be placed on a stretcher and instructed and/or assisted into a patient gown for medical evaluation by nursing and physician staff.
   - Psychiatry consult service is to be notified of the patients' presence in the ED upon bed placement in the ED, as per current policy. Psychiatric evaluation should occur parallel with the medical/ED evaluation.

2. All patients presenting with a mental health, behavioral or psychiatric complaint should be triaged according to the **Mental Health Evaluation in the Emergency Department Policy**.

3. Patients presenting to triage **under age 18** without parental or guardian consent for treatment.
   - All minor patients who present to the ED are to be triaged and assigned to the appropriate treatment area as per the nursing triage assessment. Designated area staff should be notified of patient's minor status so that the process for obtaining informed consent may be started. Triage or medical evaluation shall not be delayed while the consent for treatment is being obtained. *(see Triage and Medical Evaluation of Minors Policy for specifics)*

4. Patients presenting to the ED triage areas with a **greater than 20weeks** gestation pregnancy.
   - Patients presenting with a pregnancy related complaint either remote or specific should be sent to Labor and Delivery for further evaluation. Exception would be if the patient is in need of immediate medical attention or unstable from a non-pregnancy related complaint.

- Patients presenting with direct or indirect abdominal trauma should be triaged as high-risk, sent directly to the acute care area and the ED attending notified immediately.
- Patients presenting with a non-pregnancy related complaint should have a nursing triage assessment completed and assigned to the appropriate area for care. Patient <16 years of age may be triaged to Peds Acute Care for a non-pregnancy related complaint regardless of EDC. Patients >16 may be triaged to Medical Urgent Care, Minor Trauma or the Emergency Department Acute area for a non-pregnancy-related complaint regardless of EDC.

5. Patients presenting to the ED triage areas with a **less than 20weeks**-gestation pregnancy.
    - All patients regardless of age presenting with a pregnancy related complaint or threatened spontaneous abortion symptoms should be triaged to the Emergency Department Acute Area at all times.

6. Patients ≥16 years of age presenting and requesting to be seen by a Pediatrician.
    - Any guardian may request patient be seen by Pediatrics. Any patient still being followed by a Pediatrician should be triaged to EPED if possible.
    - Any patient followed by a UNC HealthCare affiliate or specialty (especially Hem-Oncology) should be triaged to EPED if possible. Patients followed by referring Pediatric practices should also be triaged to EPED if possible. ***See list of practices attached.***

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Dexter L. Morris, PhD, MD
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TRIAGE IN THE EMERGENCY DEPARTMENT: EMERGENCY SEVERITY INDEX

Emergency Severity Index

Categorization based on degree of urgency and ED resource consumption

Level 1 (red)

Life-threatening conditions which require immediate aggressive interventions.

Level 2 (pink)

High risk conditions, including immediate life/organ threat and high liability risk, which require high resource intensity.

Level 3 (yellow)

Conditions that have the potential for complications or increase in severity, which require medium resource intensity. May be associated with significant discomfort or affect ability to function or do activities of daily living.

Level 4 (blue) *

Conditions that have low potential for deterioration or complications, which require low resource intensity.

Level 5 (green) *

Conditions that are very unlikely to progress in severity or result in complications, which require minimal resource intensity.

Level 4 and 5 patients may be triaged to Urgent Care.

3/15/99

TRIAGE ASSESSMENT

1. Baseline Information

Baseline information should be obtained on all patients by the Triage Nurse (triage area patients), Charge Nurse (EMS patients) or Primary Nurse (patients taken straight to treatment):

A. (brief) History of Present Illness
B. (brief) Current Condition
C. Allergies
D. Medications (pertinent to chief complaint)
E. Past Medical History (pertinent to chief complaint)
F. Self-care Attempted

2. Additional Information

Additional information may be obtained at triage (ED). If not assessed in the triage area, then

this information must be obtained in the check-in room (UCC, PACS) or at the bedside:

A. Vital signs

B. Weight (pediatric patients)

3. Triage Nurse Determinations

The triage nurse must determine the following information during the triage assessment:

A. Chief complaint
B. Acuity level (Using ESI algorithm and chart)
C. Treatment area (ED Acute, Minor Trauma, Urgent Care or Pediatrics Acute Care)
D. If patient must go directly to treatment area

4. Pediatric Patient Triage

A. Algorithm for ages 14 and lessReplace the vital signs on the age >14 algorithm with those listed as outside normal
ranges, by age, on the attached pediatric vital signs parameters guideline.

B. Up-triage in clinical areaPediatrics patients' vital signs are not typically assessed at triage.
If unstable vital signs are obtained after triage, the RN or MD should be informed.
RN or MD may up-triage the acuity level as needed in the event of unstable vital signs.

TRIAGE OF PATIENTS AGE 60 AND OLDER WITH PSYCHIATRIC COMPLAINTS

Department of Emergency Medicine Triage Policy

January *25*, 2000

EFFECTIVE IMMEDIATELY

Policy: Triage of patients aged 60 and older with psychiatric complaints

Procedure: All patients 60 and older with psychiatric complaints will be triaged to the main ED for medical evaluation. They will be gowned and put on a stretcher for medical evaluation.

The psychiatry service is to be notified when the patient is placed in a bed, as is current policy, so they can begin their evaluation in parallel with the medical evaluation.

Judith Tintinalli, MD, MS
Professor and Chair

X. Registration

AUTHORIZATION FOR PAYMENT OF MANAGED CARE PATIENTS IN THE EMERGENCY DEPARTMENT

PROCEDURE

1. All patients presenting in the ED will be assessed first by a triage nurse and either directed to Registration or moved directly in a bed by the Triage nurse.

2. For all patients with managed care plans who arrive with pre-authorization for payment for care, the authorization number will be recorded and the patient directed for treatment as usual.

3. For patients with managed care plans who have no preauthorization for payment for care, the ED registration clerk will ask the patient to sign the "UNC Hospitals Waiver Form" to assume personal financial responsibility for payment for treatment, and the patient will be directed to treatment.

4. If the patient refuses to sign the Hospitals Waiver Form, registration personnel will document the patient's refusal and initial the form. The patient will then be advised that he or she may be personally responsible for the bill if their managed care plan refuses payment authorization, and the patient will be directed to treatment.

5. Patients will not be denied treatment if there is refusal of authorization for payment. Patients should be evaluated and treated as per standard practice.

6. Registration personnel will attempt to obtain authorization for payment after the patient has been directed to treatment. Denial or approval will be documented in the computerized record and on the waiver form. Waiver forms will then be forwarded to UNC P&A.

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Revised 2/15/99

CONSENT FOR TREATMENT- ADULTS

Implied Consent

In the Emergency Department there are situations where consent for treatment is not specifically expressed, but the patient may be said to have implied consent by the circumstances - his voluntary presence in the ED implies a desire to be treated. In addition, he implies consent when he voluntarily submits to treatment without expressly refusing it.

Expressed Consent

Gaining the patient's expressed consent for treatment is extremely important, whether the consent is written or not. An adult patient's consent for examination and treatment should be based on his full awareness of the proposed treatment and procedure, including the nature and consequences of the treatment and the risks involved. He must also be made aware of other treatment options. The physician has a responsibility to disclose necessary information to the patient.

Refusal to Consent

Both physicians and nurses must be aware that when the patient is conscious, competent and expressly refuses treatment, an express refusal overrides any implies consent. The patient may consent to most aspects of his care but refuse one specific procedure. If a rational, competent adult patient refuses consent and wishes to leave the Emergency Department against medical advice, the doctor or nurse should explain the consequences of his leaving and ask him to sign an "AMA" form releasing the hospital and the staff from liability for not treating him. If he refuses to sign the form, the facts should be documented in his medical record, signed and witnessed by the involved staff.

Consumption of drugs and alcohol does not necessarily render a person mentally incompetent. Judgment must be used in determining competency, but if the patient is able to communicate, understands the extent of his injury, appreciates the consequences of non-treatment and still refuses consent, he may be released "AMA". (See Operating Policy Manual - "Patients Leaving the Hospital Against Medical Advice)

Physical or Mental Incompetence to Consent (Including Unconsciousness)

If a patient is in immediate need of treatment in order to preserve life of prevent serious impairment of his health and it is impossible to obtain consent from the patient or from someone authorized to consent for him, he must be treated immediately to alleviate his emergency condition. "In such instances, medical/surgical treatment can be rendered (in the absence of proper patient consent) given a determination by the attending physician in charge that a medical emergency exists, and given the verification of that determination, through consultation of another member of the active attending staff, such

determination should be properly documented in the patient's medical record including a

description of all attempts to obtain a proper consent from the patient's legal representative."

Physical or Mental Incompetence to Consent (Including Unconsciousness)

The Director "on call" should be notified of the problem and may assist in trying to locate next of kin for obtaining permits, "Reference: Hospital Operating Policy Manual 1-20.

If the patient is adjudicated incompentent or is legally incompetent (alcohol, drugs, injury) to consent to or refuse treatments, and the circumstances of his injury or illness do not indicate an acute emergency, consent should be obtained from appropriate family member or legal representative. The patient should not be allowed to leave "AMA" if he is likely to harm himself or others. Reasonable restraint is indicated to prevent this harm. Consultation with the psychiatric staff is recommended in determining the degree of mental competence of the patient who rationality is in question.

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Revised: November, 1979
Revised: November, 1980
Revised: November, 1982
Reviewed: October, 1983
Reviewed: November, 1985
Reviewed: November, 1986
Reviewed: January, 1993

ED PATIENT RECORD PROCESSING AND COMPUTER DATA ENTRY

PURPOSE: To clarify the Health Unit Coordinator's (HUC) responsibilities for manual medical record keeping and SMS computer data entry for patients who present to the ED, including those who are triaged only, those who are triaged and registered in the SMS system, and those who are neither triaged nor registered.

PROCEDURE:

I. Ongoing Responsibilities

The HUC will make every effort to see that ED records are completed and broken down and data entered into SMS as soon as possible after the patient has been discharged from the ED.

A. Triage only patients *(Patients triaged to Labor & Delivery)*
   1. Registration assigns a log in number
   2. Medical Record: Triage note only, no physicians' record
      a. Original (white) copy – with patient to L&D
      b. Pink copy – file with ED records (to Registration)
   3. SMS: SMS case created for ED visit with data entry.

B. Triage and Registration Patients (*Patients seen in ED and Direct Admit Patients)*

ED Outpatient Registration will create an ET (Emergency Temporary) case for all patients seen in the ED. Bed Control will create an ET case for all direct admits who they expect to come through the ED.

1. Registration assigns a log in number
2. Medical Record:
   ED Patients: Triage and Physicians' records
   Direct Admits: Triage record only, no physicians' record
   a. Original (white) copy – with patient to inpatient unit (admitted patients) or to medical record (discharged patients)
   b. Pink copy – file with ED records (to Registration)
3. SMS: ED Patients: Enter data (see page 2)
   Direct Admits: Enter a patient disposition and data
4. Visit Data Entry: For patients seen in the ED, data will be entered into SMS by the HUC after the patient has been discharged from the ED. Data entered into SMS will include:

   (key PF24 for help screen explanations of all these items)

   a. Disposition
   b. Bed release date and time – when patient discharged from ED
   c. Triage time
   d. Patient placement time
   e. MD assessment time
   f. Triage category
   g. Primary service

h. Indirect admit
i. Ambulance trip number
j. Provider
k. Attending

C. Registration Only Patients (*Direct Admit patients transported by Helicopter/Ground Critical Care Transport Services, e.g. Duke Life Flight, Eastcare, Moore Life)*
1. Registration does not assign a log in number
2. Medical Record: No triage or physicians' record

II. Morning Shift Responsibilities

XI. Record Processing: First shift (morning shift) is responsible for resolving all visits of the previous day, including calling floors for ED charts sent up prior to completion by ED Attending.

XII. Computer Data Entry: After midnight, the morning shift HUC will check for unresolved ET cases in the SMS computer system for the previous 24-hour period. The HUC is responsible for reconciling unresolved cases by entering a disposition (on all triaged patients) and other appropriate ED visit data (on patients seen in the ED).

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Written: February, 1996
Revised: January, 2002
Revised: September, 2003

EMERGENCY DEPARTMENT REGISTRATION/TRIAGE LOG

Policy:

The Emergency Department Registration/Triage Log is a control register of all patients seeking treatment in the Emergency Department. The Manual Log kept at the Registration Desk consist of time Registration completed, patient name, medical record number, chief complaint, area patient triaged to, and the initials os the Registration clerk.

The computerized log includes:

Name
Medical Record Number
Age/DOB
Date of Arrival
Time triaged
Chief Complaint
Time Registration complete
Means of arrival: EMS, Police, Self
Time placed in a bed
Time MD evaluation begins
Disposition: Discharge, Admission to floor vs ICU, Expires, AMA. Transfer, Left without being seen

The Triage Nurse logs in time of arrival on the nursing record logs.

The Registration clerks are responsible for the manual log. The ED Computer Analysis keeps a separate computerized log. These logs are kept permanently.

SMS PROCESSING FOR DIRECT ADMISSIONS – ED OUTPATIENT REGISTRATION

1. Physician (or Carolina Air Care staff) calls Bed Control to notify staff of impending patient admission.

2. Bed Control creates an on-line referral, which creates an SMS case for the patient:
   A. OT Case - Direct admits to inpatient units:
      Carolina Air Care (to any unit)
      Ambulatory Care Center (to any unit)
      Peds ICU
      Neonatal ICU (NCC4)
   B. ET Case - All other direct admits to inpatient units:
      *Most come by ambulance and pass through ED en route to inpatient unit (for ED nurse assessment and confirmation of bed assignment/readiness)
3. *If patient has no Medical Record Number (not in PIDX),* Admitting or ED Registration (when Admitting is closed) registers patient.
4. Blue inpatient cards print in Admitting (or ED if Admitting is closed). Staff tube cards to inpatient unit.
5. Bed Control assigns patient to a bed.
6. When patient arrives:
   A. Carolina Air Care and ACC staff take direct admit patients to inpatient room (OT Case)
   B. Transport staff take PICU and NCC4 patients to inpatient room (OT Case)
   C. All other direct admit patients who pass through ED:
      1) ED nurse assesses patient.
      2) ED Outpatient Registration staff performs patient look-up on ED referral list:
         a. If there is an ET case, confirm that the patient is registered (and verify information). If the case is registered, then triage and register referral patient.

         b. If no case, create an ET case for the patient (triage and register patient).

         c. Assign Bates number, log patient, and create Medicus card (do not print ED card/chart).

      3) Patient sent to inpatient unit if bed is ready and appropriate for patient.
7. Bed Control places ET or OT case in bed.
8. When direct admit patients stay in ED for care:
   A. ED Outpatient Registration:
      1) If there is an ET case, triage the referral patient and place patient in an Emergency Department bed.
      2) If no case, create an ET case for the patient (triage and register patient).
      3) Print ED card and chart.
      4) Create Medicus card (if not already done).
   B. Bed Control:
      1) Place ET case in bed when patient is admitted from ED.

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Written: February, 1996

VISITATION POLICY

To better serve our patients and visitors in the Emergency Department as well as to maintain a safe and secure environment, the following visitation policy has been developed. Your cooperation and adherence to this policy is greatly appreciated.

1. Upon arrival visitors will be issued a visitors pass at the Emergency Department registration desk. The badge/pass must be worn in a clearly visible manner at all times. Only visitors with a visible ID badge will be allowed to visit patients in the patient care areas.
2. One visitor will be allowed to accompany the patient from the time of triage through the ED stay. The following exceptions may apply:
   (a) Pediatrics patients
   (b) Physically or mentally handicapped patients
   (c) Terminally ill patients with impending death in ED
   (d) Patients presenting with inevitable or incomplete abortion
   (e) Language interpretation purposes

   ID badges may be shared with other family members, however, visitors may not continue to move from waiting room to patient room as this causes disruption.
3. Visitors may be asked to leave the bedside during the performance of any diagnostic and/or therapeutic procedures.
4. No visitor will be allowed to accompany a patient out of the department for testing (example: to x-ray, CT scan, MRI) with the exception of Pediatrics.
5. Patients may specify who may visit them while in the department
6. The charge nurse or public safety officer on duty may authorize the clearance of any or all visitors from the department when the presence of such visitation infringes upon the appropriate management of the department or any visitor threatens the staff or orderly function of the department, or the rights of another patient.

7. Update reports of patient's condition should be given to other family members in the waiting room when appropriate by medical, nursing, or volunteer staff.

8. Children under the age of 12 may not visit in the ED unless permission is given by the charge nurse.

9. Due to limited space and safety considerations, the number of visitors per patient in the waiting room may be limited by the public safety supervisor or charge officer. Visitors may be limited to immediate family only (parents, siblings, grandparents)
10. Direction and implementation of the above regulations in the Triage and waiting areas are primarily the responsibility of the public safety officer on duty. Nursing /medical and clerical staff are primarily responsible within the patient care area.

11. If special circumstances arise please call the most senior nursing supervisor inhouse, ie.. child care issues. (Nursing manager/House Supervisor)

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Revised 10/28/98

XI. Clerical

DISASTER PATIENT QUICK REGISTRATION

PURPOSE:

To delineate the guidelines for SMS computer registration of unidentified ("disaster") patients brought to the UNC Hospitals Emergency Department (ED) for treatment. SMS registration is necessary to facilitate computer functions such as patient admission/discharge/transfer, order entry and results reporting, and billing.

PROCEDURE:

1. The ED Charge Nurse will determine the need to assign a Disaster Number to an unidentified patient, on or before the patient's arrival at the ED. (Or, when Carolina Air Care takes blood on a flight the red identification card will be brought to the ED by the flight team prior to the flight.)

2. The ED Processing Assistant will be notified by the Charge Nurse to prepare for a disaster patient. The Processing Assistant will select the next available Disaster Patient folder from the file.

Contents of the folder: Red ID band and imprint cards, red arm bracelet
Printed on cards: Medical Record Number, "Disaster PT" for last name, and Disaster Number for first name (example: D-93-123 is the 123rd disaster patient of 1993).

3. The red imprint card will be used to develop the medical record, to include stamping records and requisitions for patient orders. The red ID card, and a red bracelet will be given to the nursing staff responsible for the patient's care.

4. The ED Processing Assistant will initially noti1~i the Outpatient Service (ED Front Desk) Patient Relations Representative that the expected patient will be assigned a disaster number, and then notil~y them of the actual time the patient arrives in the ED.

5. When the patient arrives at the ED, the ED Processing Assistant will select the "D# Registration~~ pathway from the main SMS menu screen. The ED Processing Assistant will type in:

a) 3-digit Disaster Number (found on the red disaster patient card)
b) Patient's gender code (M or F)
c) ED Attending Physician's code

The Disaster Patient will then be registered in SMS as an Outpatient Active (OA) case, location: ED (ER 1), identified by the Medical Record Number printed on the red ID band and imprint cards.

6. The Disaster Patient's ED record will be generated by the printer in the ED Outpatient Registration area.

7. The ED Patient Relations Representative will log in the patient, stamp the ED record with the Bates number, and take the record to the ED patient care area.

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UNC HOSPITALS	**POLICY** Name of Policy	EMERGENCY DEPARTMENT T-SYSTEMEV & SIEMENS A2K DOWNTIME PROCEDURES
	Policy Number	
	Date Effective	November 9, 2004
	Date Last Reviewed	November 8, 2004
	Responsible Dept.	Emergency Services

Policy:

Downtime affects a variety of clinical and administrative systems. Scheduled downtime is a planned event to allow system updates to be performed. The date and time is arranged in advance with notification to the users of the expected system unavailability. Unscheduled downtime is an unexpected event with no advance notice to the users and an unknown end time.

For all unexpected computer problems the first step is to contact the Help Desk at 6-5647. This ensures Information Services is notified of all problems and can then take steps to correct them.

Procedure:

Electronic T-system (T-SystemEV) downtime

Unscheduled downtime

In the event of the T-SystemEV being down for unexpected problems, the first step is to contact the Help Desk(6-5647). Any documentation during scheduled and un-scheduled downtime will be via the T-System paper templates.

Resident physicians, nurses, and medical students - For downtime, patient information will be back entered into T-SystemEV when the system is available. For extended downtime, all remaining patient information will be captured on the paper template when back entering into T-SystemEV is not reasonable for length of downtime, patient acuity and workload. When T-System EV becomes available, a note will be entered in the chart indicating T-SystemEV downtime and to refer to the paper chart. For extended downtime, the T-System paper template in conjunction with any information charted prior to downtime in the electronic system will be the record of the emergency department encounter; therefore, the paper record will be part of the patient's medical record. When T-SystemEV becomes available, all open charts must be locked so they can be sent to WebCIS.

Attending physicians - WebCIS must receive an ED record for each patient seen. This can be accomplished either by completing a T-SystemEV chart when the system is available or by dictating the patient record.

Discharge instructions will be copied from the Exit Writer® master notebook.

Scheduled downtime

The procedure for scheduled downtime is identical to the procedure for unscheduled downtime except that HUCs will batch print all incomplete charts from T-SystemEV 30 minutes prior to the scheduled downtime to facilitate continuity of care.

Siemens A2K downtime

If Siemens A2K is down, T-SystemEV will continue to function as the Emergency Department documentation and patient tracking system. For those patients discharged or admitted during downtime, patient names will be placed on the downtime disposition clipboard. When Siemens A2K is available, HUC is responsible for manually merging any discharged or admitted patients. These patient's records will be found in T-SystemEV history. During this time, staff may lock their charts and disregard the warning about non-merged patient demographics.

I. Both systems down

As above, if both systems are down, any documentation will be via the T-System paper templates. For residents, nurses, and medical students, patient information will be back entered into T-SystemEV when the system is available if reasonable for period of downtime, patient acuity and workload. For extended downtimes, the paper template, combined with any information entered into T-SystemEV prior to the downtime, will be the record of the emergency department encounter. The paper record will be part of the patient's medical record. For all encounters, two copies of this record will be made – one copy for physicians and one copy for ED records. When T-SystemEV is available, all open charts must be locked in order to export chart to WebCIS.

For attending physicians, all ED records will need to be entered into WebCIS either by entering a T-SystemEV note or by dictating the patient record.

COMPUTER DOWNTIME PROCEDURES FOR HUC AND REGISTRATION STAFF

OVERVIEW

The UNC Emergency Department is a 24/7 facility that operates everyday of the year. Computer systems provide an integral part of operations including patient registration, tracking and providing clinical information from other hospital clinics.

However, due to the requirements of the hospital's legacy system the hospital Information Services Divisions must "take down" all computer systems in the ED once a week for maintenance. This downtime occurs every Saturday night around midnight and normally lasts a few hours. Usually, the system comes back up around 2 or 3 AM Sunday morning. Unfortunately this downtime is during the busiest period in the ED but is desirable because other clinics are 8 to 5 operations, Monday through Friday.

This downtime is disruptive to the flow of ED processes. In order to make the best out of this unavoidable situation, the ED has developed a standard process to handle downtime procedures. There are other unscheduled downtimes due to system failures and unforeseen problems. These unscheduled times are infrequent and the procedures to handle them are the same as regularly scheduled downtimes.

Purpose of this Document

The purpose of this document is:

- Document the computer system downtime procedures in the ED.
- Provide a resource document for training new staff.
- Standardize the processes to increase smooth operations and prevent errors during downtime.

Audience

This document is intended for UNC Emergency Department HUC staff, patient registration staff, nurses, and physicians.

Prepared by:
This document was prepared and is maintained by:
Alease Poteat, Registration Desk Manager
Thomas Watson, Health Unit Coordinator Manager
Sergio Rabinovich, Data Manager

Reviewed and Approved by:

John McLamb, Director of Informatics	1/31/2002
Sandy Pabers, ED Nurse Manager	1/31/2002

Computer Downtime Procedures
Patients that come through the TRIAGE (front) entrance

1. Patients are triaged and receive a handwritten chart from the triage nurse.

2. Registration Clerks will:
   2.1. Properly identify the patient – if possible, using the registration identification protocol
   2.2. Direct the patient to fill out a registration form.
   2.3. IF the patient has a medical record number, he/she is assigned a patient number from the *Manuel Number Book.*
   2.4. IF the patient has no medical record number, look for the patient's medical record number from the microfiche. After the medical record number is found, a patient number is assigned from the *Manuel Number Book.* If it is not found, a medical record number and a patient number are assigned from the *Manuel Number Book*.
   2.5. Manually create the Blue Identification Card.
   2.6. Manually fill out the physician's chart with the following information:

• Name	• Date of birth	• Sex
• Medical record number	• Race	• Address
• Telephone number	• Patient number	• Bates number
• Current date	• Time	

   2.7. Make a copy of the physician's chart (for use after downtime).
   2.8. Put the triage chart, physician chart, Blue Card, and arm bracelet into the **triage box.**
3. Nursing assistants pick up the charts as they get the patient to take into the treatment area.

Patients That Come Through The AMBULANCE Entrance

1. Ambulance personnel stop at the Charge Nurse station for triage into the system.
2. The Charge/Triage Nurse creates a handwritten triage record with the following info:

1. Name
2. Date of birth (if known)
3. Vital statistics
4. RN triage note

3. IF the patient is a DIRECT ADMIT
   3.1 Call BED CONTROL for a room assignment
   3.2 If the room is ready, send the patient to the room
   3.3 Triage note goes to the registration desk by placing the triage note in the lead clerical box
4. IF the patient is to be treated in the ED
   4.1. Patient gets placed into a ED bed
   4.2. Triage note gets placed in RN clipboard
   4.3. Charge RN or Lead Clerk notify registration staff of a patient that needs to be registered
5. The Registration Clerks will:
   5.1. Go to the patient's bedside and perform a patient interview seeking demographic information, a UNC Hospitals card or a picture ID.

5.2. New patient has a registration form filled out
5.3. Registration staff then goes back to the registration desk and follows the downtime registration procedures to create the physician record and blue card
5.4. Registration staff immediately places the completed forms and card into the lead clerical basket in the Main ED

6. HUC places chart in physicians slot. The card and bracelet are placed at the bedside or the HUC attaches the bracelet to the patient if possible using the hospital bracelet identification procedure

Post Downtime - When Computer System Come Back Up Procedures

1. ED HUC staff updates the ED census by discharging all patients treated and released/admitted, revising and entering the correct discharge time and disposition
2. Lead HUC will notify registration staff if any patients are a priority to register first
3. Priority list should include: Admitted patients that were not registered in the computer, disaster/ trauma patients and patients that are critical/coding
4. A list of all patients that come in through the ambulance entrance and patients that were directly placed into a bed is kept by the nurses and HUC
5. The registration staff has a copy of the patients chart that were triaged through the front triage area as well as the ambulance entrance.
6. Registration clerk will register and input correct triage and registration time. Registration time (a time after triage time, the time the registration clerk wrote down when the manual chart was issued) always has to be a time after triage time (time patient arrived in ED)
7. Registration staff follows their downtime entry protocol
8. After the registration staff registers the patient, the case is put in as a registered referral and placed into the referral list
9. ED clerical staff then places the patient into the appropriate ED bed and corrects the triage time if necessary
10. All patients (from the referral list) must be triaged in the computer and placed into a bed prior to being discharged out of the computer. This includes patients that were both checked in and discharged during downtime. A suggestion is to use the EINT beds for patients treated and already released.
11. Lead Clerk will notify registration staff of all patients currently occupying ED beds that have not been entered in the computer post downtime.

Disaster patients

1. HUC receive pre-registered Red Disaster Cards
2. HUC complete Red Disaster Card without a case number assigned
3. After Downtime, HUC register the disaster number according to *Disaster Number Protocol* which assigns a pre-assigned case number
4. During this registration the HUC must put in the *correct date and time* of the beginning of the visit

5. HUC calls the registration staff alerting them that a Disaster # was used. The registration staff proceeds with the ambulance protocol *WITHOUT* assigning a manual case number. When the computers are up, the disaster number notification prints at the registration desk.
6. If appropriate, after ID confirmation, registration staff merges Disaster # with the patient's information per registration identification protocol

EMERGENCY DEPARTMENT TRACKING SYSTEM PATIENT LOGS

Triaged Patients = All patients triaged, the first digital encounter for the ED Tracking system, no medical record number, but has been issued a Case number (also called a patient encounter number).

Treated Patients = All patients triaged, registered and seen in one of the ED areas. Exclusion Criteria: Discharge dispositions - L & D, Direct Admit

Non-treated Patients All Patients triaged away from the ED after a screening. Inclusion Criteria: Discharge dispositions out of the ED - L&D and Direct Admits.

A. Computer - Generated Logs (reports) - *Data displayed on report.*

Patient name, Medical Record #, Case #, Birth Date, Age, Sex, Case status, Attending #, Care Date, Triage time, Registration time, Patient disposition code, Clinic code #, Triage complaint and Triage category.
For each clinic area by code number there is:
Total L&D patients, Total Direct Admits, Total Patients Treated, and Total Patient numbers.

The Clinic Areas are: 043 - Pediatrics, 074 - Main ED, 086 - Minor Trauma, 152 - Urgent Care

1. Chronological List of all triaged patients for 24 hour period (00:00 *23:59)* by triage time.
    a) Print: ISD
    b) When: After Midnight
    c) Copies to: Data Manager, Registration, ED Administrative officer
2. Alphabetical List of triaged patients and Direct Admits for a 24 hour period
    a) Print: ISD
    b) When: After Midnight
    c) Copies to: Data Manager, Registration, UNC P&A /ED office use

B. Hand-written Logs

1. ED Registration - All triaged or registered patients (ED, MT, UCC), in a chronological 24hour period. Includes Pediatrics after 11 p.m. till 8 a.m. Data includes 'Bates' #(1-200), Name, Medical record #, Area of ED being sent to (ED, MT, UCC), Chief Complaint, initials of clerk from Registration
2. Pediatrics - All triaged patients, in a chronological, 24hour period. (Includes patients seen during the night in the main ED.) Same data as #1 without the "Area of the ED".

C. Monthly Statistical Reports (generated by the ED Data Manager from two weekly downloads)

1. A ***weekly*** download, which includes patients who have their ICD9 coding completed. This could be for any date range up to that date. Occurs on Monday mornings.
2. A ***weekly*** download of all patients treated during the prior week. This download occurs on Tuesday mornings. The data only includes patients that were triaged and registered and were not Labor and Delivery patients or Direct Admits.

Revised:
5/96, 1/99, 4/02sr

IDENTIFICATION OF PATIENTS & CORRECTION OF PATIENT IDENTIFICATION

Identification of Patients

It is the policy of the Emergency Department that all patients admitted for treatment will have an identification bracelet placed on an extremity. If all four extremities are inaccessible, ID band may be taped to head of bed. Removal of the bracelet can occur only at discharge time. All patients admitted to the hospital will retain the ID bracelets.

Unidentified (disaster) patients will wear red disaster ID bands until their true identity is confirmed. *See Unidentified (Disaster) Patient section of this policy.*

Correction of Patient Identification

Correction of patient identification involves specific responsibilities by Emergency Department staff as follows:

A. Secretarial responsibilities include:

1. Make necessary corrections on the ED record.
2. Initiate a corrected ID band and imprint card.
3. Destroy all previous imprint cards and any unused requisitions stamped with the previous imprint card.
4. Complete new requisitions with corrected information.
5. Communicate corrected information to charge nurse.
6. Communicate identification error to appropriate laboratories. In cases of error involving essential identification requirements (correct name and unit number), the physician must sign a release form (in laboratory) prior to completion of the test.

B. Nursing responsibilities include:

1. Replace incorrect band with correct band, after verifying accuracy of information.
2. Destroy all previous ID bands and any unused labels stamped with previous ID band.
3. Label all subsequent specimens, requisitions, and chart forms with the current ID band and imprint card.
4. Assure corrections on all documents prior to patient discharge from ED.

Unidentified (Disaster) Patients

Unidentified (disaster) patients will wear red disaster ID bands until their true identity is confirmed.

It is the responsibility of the senior Health Unit Coordinator on duty to attempt to identify the patient as soon as possible after the patient arrives in the ED. Confirmation of the disaster patient's identity will be done by one of the following means:

a) Patient interview (alert patients);
b) Matching the patient to a picture ID;
C) Positive identification by patient's family/friends.

Confirmation of the disaster patient's identity will be the responsibility of the senior Health Unit Coordinator on duty.
The Health Unit Coordinator will notify the Fiscal/Outpatient Service Registration staff that the patient's identity is confirmed. If the patient is admitted unidentified, Hospital Police should be

notified. Hospital Police will be responsible for the identification of all admitted patients.

The fiscal/registration staff will then follow the Disaster Patient Identification Procedure and update the computer record with the patient's true name and other information. It is preferable to update the computer record as soon as possible after the patient's true name and other information is confirmed.

- *Avoiding mis-identification:* When there is doubt about the patient's true information (e.g., questions about name spelling, address confirmation, etc.) or in situations involving multiple disaster patients and/or multiple motor vehicle accidents, disaster patient identification should be delayed until confirmation can be done with certainty.

When the Outpatient Service Registration staff updates the patient's computer record with the patient's true name and other information, new ID and imprint cards will be printed by the embosser in the ED. The secretarial and nursing staff will follow the procedures as outlined in the Correction of Patient Identification' section of this policy. (See also Department of Nursing Procedure Manual, Patient Identification procedure.)

Revised: November, 1979
Revised: November, 1980
Revised: November, 1982
Revised: November, 1983
Revised: May, 1985
Revised: November, 1986
Revised: January, 1993
Revised: August, 1995

TELEPHONE ADVICE FOR CONSUMERS AND PHYSICIANS

PURPOSE: To insure patient safety and protect against ED liability

PROCEDURE

1. Calls for advice from consumers
Telephone medical advice is not given to consumers by ED staff or physicians.

Calls for medical advice are handled by the ED Health Unit Coordinator. For any patient who states he/she is severely ill or injured, the HUC should tell the caller to call 911. All other calls are referred to Health Link (966-3820).

All other patients should be told to either (1) call their physician; (2) come to the ED, (3) or for patients 16 and under, the call should be directed to the pediatric on-call resident.

Consumers who persist in demands for telephone medical advice from the clerk should be directed to the attending emergency physician, who will not give medical advice but can direct the patient to the above-mentioned options.

2. Calls for advice from physicians
All physician requests for advice or information will be directed to the attending emergency physician.

Judith E. Tintinalli, MD, MS, Chair
Sandy Pabers, RN, CNS II, Head Nurse

August, 1994
May, 2002

UNIDENTIFIED (DISASTER) PATIENTS

Unidentified (disaster) patients will wear red disaster ID bands until their true identity is confirmed.

It is the responsibility of the senior Health Unit Coordinator (HUC) on duty to attempt to identify the patient as soon as possible after the patient arrives in the Emergency Department. Confirmation of the disaster patient's identity will be done by one of the following means:

a) Patient interview (alert patients)
b) Matching the patient to a picture ID
c) Positive identification by patient's family/friends

Confirmation of the disaster patient's identity will be the responsibility of the senior HUC on duty. The HUC will notify the Fiscal/Outpatient Service Registration staff that the patient's identity is confirmed.

If the patient is admitted unidentified, Hospital Police should be notified. Hospital Police will be responsible for the identification of all admitted patients.

The fiscal/registration staff will then follow the Disaster Patient Identification procedure and update the computer record with the patient's true name and other information. It is preferable to update the computer record as soon as possible after the patient's true name and other information is confirmed.

**** Avoiding mis-identification:*** When there is doubt about the patient's true information (e.g., questions about name spelling, address confirmation, etc.) or in situations involving multiple disaster patients and/or multiple motor vehicle accidents, disaster patient identification should be delayed until confirmation can be done with certainty.

When the Outpatient Service Registration staff updates the patient's computer record with the patient's true name and other information, new ID and imprint cards will be printed by the embosser in the Emergency Department. The HUC and nursing staff will follow the procedures as outlined in the "Correction of Patient Identification" section of this policy. (See also Department of Nursing Procedure Manual, Patient Identification procedure.)

Judith E. Tintinalli, MD, MS
Professor and Chair

Sandy Pabers, RN, PSM III
Nurse Manager

Revised: November, 1979
November, 1980
November, 1982
November, 1983
May, 1985
November, 1986
January, 1993
August, 1995
September, 2003

UNIDENTIFIED PATIENT(S) PROCEDURE

1. The secretary shall initiate a "D" record.

2. In the absence of a name, a description of the patient as to sex and race shall be logged. The written patient description shall be consistent on the log, all chart forms, labels, requisitions, etc. In case of more than one patient with the same sex-race, other distinguishing characteristics must be noted.

3. "D" folder shall be used; all materials are prenumbered and include: record sheet, physician's order sheet, arm bracelet with 16 labels attached for specimens such as blood, urine, etc., red SRP card, valuables envelope and appointment slip. An admitting tag, used in declared disaster only, is also attached.

4. An identification bracelet shall be attached to patient as soon as possible. The bracelet and all records, laboratory request slips, x-rays, specimens, etc. will be labeled with (1) the "D" number assigned to the patient and (2) descriptive information (e.g., elderly white male).

5. Prenumbered labels which are attached to the ID bracelet are to be used on all specimens. Each label must have identifying (sex, race, etc.) information written on it to be complete. (Blood specimens for type and cross-match must be labeled with extreme care!)

6. Requisitions must also bear ID (race-sex) information.

7. A log book is to be maintained by the Emergency Department secretary listing "D" numbers, name, sex, race, description of patient, date, time in and NCMH unit number. The purpose of this record is to prevent duplication or loss of 'D numbers.

8. When the patient is identified, the name and NCMH unit number will be used in addition to the "D" number and the description on all specimens and requisitions from the ED.

9. "D" numbers will be converted to regular (old or new) NCMH unit numbers by the Admitting Office when the patient has been identified. The Medical Records Department will be notified by the Admitting Office to convert the numbers on documents reaching Medical Records without having been previously converted. The Admitting Office will similarly notify Data Control in order that accounting records may be corrected.

10. Refer to section on "Consent for Treatment."

Revised: November, 1979
Reviewed: November, 1982
Reviewed: October, 1983
Reviewed: November, 1985
Revised: November, 1986
Reviewed: January, 1993
Reviewed: January, 1999

XII. Deaths

DNR PATIENTS

POLICY: Management of DNR Patients who expire en-route to the Emergency Department

PROCEDURE:

For the purposes of this policy, DNR patients are those who have completed the State and County approved forms allowing EMS personnel to implement the DNR request.

The DNR patient who expires at the scene is not brought to the UNC Emergency Department.

For the DNR patient who expires en-route or at the entrance to the Emergency Department, an ED record must be established. The physician then reviews the forms accompanying the patient in order to verify accuracy and pronounces the patient. The Emergency Department record should document the events.

Nursing staff will assist the family as appropriate.

Judith E. Tintinalli, MD, MS
Department Chair

Jane Brice, MD, MPH
Director, Orange County EMS

Sandy Pabers, RN, CNS II
Nurse Manager

Revised: January, 2002

POLICY FOR CERTIFICATION OF DEATHS

POLICY:
North Carolina law requires that deaths be registered by filing a certificate of death with local registrar of the district where the death occurred or where the body was found. Death certificates are required by law to preserve documentary evidence which protects the legal rights of individuals and to provide sound statistical information for health and social planning.

PROCEDURE:
I. Deaths which occur under circumstances specified below, or as a result of causes specific below, must be reported immediately to the Orange County Medical Examiner:

a. Homicide or Suicide
b. Trauma, Accident, Disaster
c. Violence
d. Unknown, unusual, unnatural or suspicious circumstances
e. In police custody, jail, or prison
f. Poisoning or suspicion of poisoning
g. Possible public health hazard (such as acute contagious disease or epidemic)
h. During surgical or anesthetic procedures
i. Sudden, unexpected deaths which are not reasonably related to know previous disease
j. Deaths without medical attendance

II. Certificate of Death

The medication certification of death shall be completed and signed by the physician in charge of the patient's care at the time of death, except when the deaths falls within the medical examiner's jurisdiction. The certificate may be completed and signed by a physician under the following circumstances: the physician has access to the medical history of the deceased; the physician has viewed the deceased at or after death; and the death is due to natural causes.

III. Physician Attending Patient at time of Death when Medical Examiner Notified

All information detailed below is the responsibility of the physician attending the patient at the time of death even if the Medical Examiner is notified. Forms must be completed and signed in **black ink.**

a. Obtain expiration forms from clerk
b. Complete the routing slip; the following information must be given:
    (1) Patient's name
    (2) Time of death
    (3) Name of Medical Examiner notified
    (4) Autopsy permission granted (yes/no)
c. Complete the autopsy form .~nLi information for Pathologist jf autopsy

permission has been given.

d. Complete the required Request for Anatomical Gifts

IV. Certifying Physician Cases NOT referred to the Medical Examiner

All information detailed below is the responsibility of the certifying physician. Forms must be completed and signed in **black ink**.

a. Obtain expiration forms from clerk
b. Complete the routing slip; the following information must be given
    (1) Patient's name
    (2) Time of death
    (3) Autopsy permission granted (yes/no)
    (4) Name of physician completing death certificate

THE DEATH CHART: STEPS TO PROPER COMPLETION

1.) The fields which are to be completed by the physician caring for the deceased patient on the actual death certificate are highlighted in yellow on the sample death certificate located in the red folder labeled "Death Certificates" at the clerks desk. This sample death certificate displays the appropriate areas that need to be filled out by both the clerk and MD. The areas which *must* be filled out by a physician are numbered on the death certificate as follows: 19a, 19b, 20a, 20b, 21a, 21b, 21c, 22, 23a, 23b, 24.
2.) The routing slip must be completed my the physician caring for the patient. Again, in the red folder labeled "Death Certificates" the areas that must be completed by a physician are highlighted in yellow on a sample routing slip. These areas include steps 1, 2, & *5*. Remember to complete step two fully as it requires more information than the other fields.
3.) The third form the physician caring for the deceased patient must fill out is the Anatomical Gift Form. The first step is to call COPA(1-800-252-2672) and provide them with the appropriate information needed for anatomical donation. As the MD is speaking with COPA, it is suggested that they keep the COPA paperwork with them so they can fill out the necessary fields. A sample of the COPA form and the areas that need to be filled out can be found in the red folder labeled "Death Certificates". The MD must transcribe on the COPA form the following: date/time of death, date/time of call to COPA, name of COPA/LifeNet Coordinator who handled referral, the name of Designated Requestor if request for donation is available, and the outcome of the referral to COPA; which can be four different outcomes: consent given for donation, donation declined, COPA determined patient to be medically unsuitable for donation, and other. If the outcome is other, this must be explained in writing on the COPA form.
4.) The last step the physician caring for the deceased patient is to complete the form titled UNC Hospitals Autopsy Request. This form must always be signed by the physician caring for the deceased patient *even* if it is a medical examiners case. The red folder labeled "Death Certificates" has a sample form with the appropriate areas highlighted that must be completed by the physician. If a request for an autopsy is granted the physician must complete the steps outlined on the second page of the form. The mandatory autopsy is not as extensive as it would be if permission were granted for autopsy by the family. The physician caring for the deceased patient must make sure that all forms are *signed* by-the appropriate next of kin before the family leaves the hospital. The Autopsy Request is a step by step form that requires all pertinent areas to be filled in before bed control will release the body. If the case is accepted by the Medical

Examiner and that physician confirms that they will be completing the death certificate, it is not necessary for the ER physician to complete the actual death certificate. All other steps should be completed regardless of who is completing the actual death certificate.

XIII. Nursing

ASSESSMENT AND TREATMENT OF THE PATIENT WITH ACUTE PAIN

UNC HEALTH CARE
DEPARTMENT OF EMERGENCY MEDICINE

March 14, 2001

Policy: Assessment and Treatment of the Patient with Acute Pain

Procedure: Each patient will be assessed for the presence/absence of acute pain on admission, after each intervention, and as part of the routine vital signs.

A. The Primary Nurse will assess for the presence or absence of acute pain associated with the chief complaint as part of the initial assessment.

B. An assessment will be repeated no more than one hour after each intervention or more frequently depending on the patient's condition or the agent used.

C. If patient is pain free, reassessment will be done every four hours as part of the routine vital signs.

D. It will be the Primary Nurse's responsibility to monitor and document the findings on the nursing record.

For further information regarding pain management, please refer to the UNC Health Care Policy and Procedure Manual.

Judith Tintinalli, MD, MS
Professor and Chair

Sandy Pabers, RN
Clinical Nurse Supervisor II

CHAPERONES FOR EXAMINATIONS IN THE EMERGENCY DEPARTMENT
11/93
UNC Hospitals
Department of Emergency Medicine

PROCEDURE:
During pelvic examinations, a chaperone must be present. Physicians can also request chaperones for any type of examination. A chaperone can be of either gender, and can be a medical student, house officer, attending physician, or a member of the emergency department nursing staff.

Judith E. Tintinalli, MD. MS
Professor and Chair

Sandy Pabers, RN, PSM
Nurse Manager

ASSESSMENT AND DOCUMENTATION OF DIRECT ADMISSIONS

July 16, 2002

Procedure:

Three classes of patients identified.

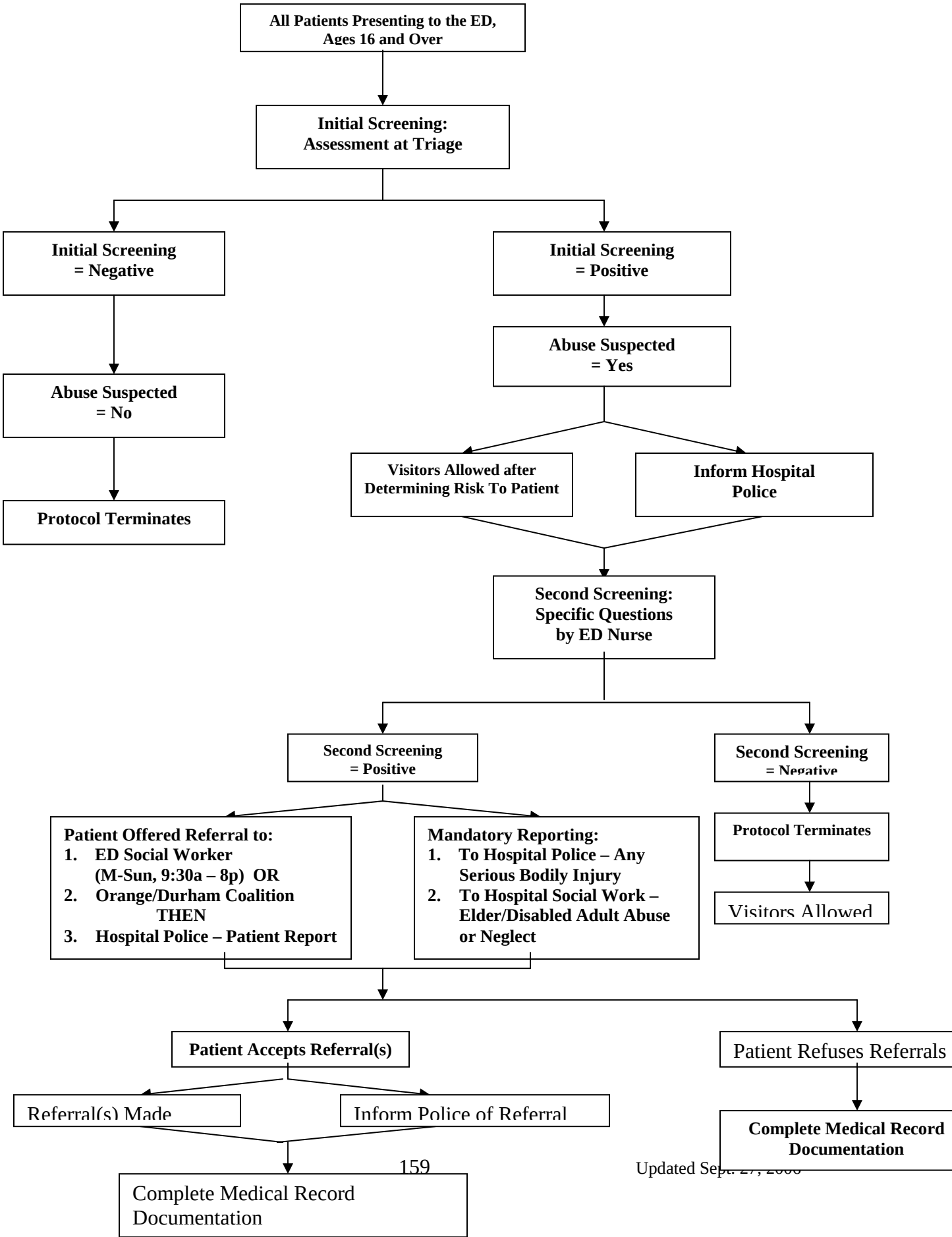
a) Patients medically appropriate for their assigned location as determined by the nurse. If appropriate, vital signs performed by EMS or vital signs performed in the ED will be evaluated. The accepting unit is notified and the patient is transported by the EMS unit that brought the patient to the ED. No action required by MD.
b) Patients not medically appropriate for their assigned bed. Pt. to stay in ED until a suitable bed is available. Treatment rendered as necessary. ED record generated.
c) Patients whom the nurse evaluating the patient requests an attending evaluation prior to admission. In this case the attending may choose to evaluate the patient in the ED and an ED record will be generated. Alternatively if the patient in is deemed medically appropriate for their inpatient unit the attending may write a note on progress paper to document the patient evaluation.

_____ _____

James Larson, MD Clinical Director Sandy Pabers, RN, Nurse Director

Last update 7/1/2004
Previous updates: 3/15/2002

DOMESTIC VIOLENCE/ELDER ABUSE PROTOCOL PATIENT FLOW CHART



Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

MEDICAL SCREENING EXAMINATION FOR SEXUAL ASSAILANTS

The Department of Emergency Medicine will obtain screening blood samples and perform SBI Evidence Kits and collections, as appropriate for suspected sexual assailants.

A medical screening examination is not necessary unless the suspected assailant offers a medical chief complaint.

Judith E. Tintinalli, MD, MS
Professor and Chair

Sandy Pabers, RN
Head Nurse

Effective: January 5, 2004

OBSERVATION OF PATIENTS RECEIVING PARENTERAL MEDICATIONS

All Emergency Department patients who receive parenteral (IV, IM, sq) medications must be observed by the Emergency Department staff for any allergic or adverse reaction for 30 minutes after administration.

At the discretion of the physician of record, observation is not required after the administration of tetanus toxoid.

Judith E. Tintinalli, MD, MS Professor and Chair	James L. Larson, MD Assistant Professor and Clinical Director
Jeff Strickler, RN, MA Administrative Director	Sandy Pabers, RN, PSM Nurse Manager

Origin: Emergency Department
Date: July 7, 2004

ORDERING OF TREATMENTS AND DIAGNOSTIC STUDIES BY ED NURSING STAFF
Policy:
July 25, 2002

Prodedure:

Nursing staff are authorized to order treatments and diagnostic studies appropriate to patient care prior to physician evaluation. This list includes but is not limited to:

- Albuterol/Atrovent nebulizer treatments and peak flow measurements
- Chest and extremity X-rays
- EKGs
- Laboratory studies
  - CBC and Chem 7
  - Coagulation studies if on anticoagulants
  - Cardiac enzyme profiles for ischemic chest pain
  - Medication levels
- Urine dip or urinalysis and urine pregnancy test-
  1. Nurses are authorized and expected to obtain a catheterized urine specimen if a clean catch specimen cannot be obtained within 30 minutes of ordering.
  2. Nurses are authorized and expected to obtain a urine sample for Urine pregnancy test in all females **with abdominal pain** age 16 to 50 (unless they have undergone hysterectomy) as soon as possible after admission to the emergency department.

Stat Head CT scans can be ordered according to the acute stroke protocol, but the attending physician must be simultaneously notified so he/she can also immediately evaluate the patient.

James Larson, MD
Clinical Director

Sandy Pabers, RN, PSM
Nurse Manager

Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

PEDIATRIC FEVER STANDING ORDER

Triage Nurse

Weigh Child
Administer Antipyretic
Notify Pediatrician
Recheck temperature in one hour if child still in waiting room

Primary Nurse

Re-check temperature one hour after administration of antipyretic
Consider tepid bath if child is less than two years old
Anticipate septic work-up if appropriate

TABLE REFERENCE

AGE	0 - 3 Months	≥ 3 Months
TEMPERATURE	≥ 38.0	≥ 38.5
Acetaminophen if 23 hours since last dose	No Notify Physician	15 mg/kg po/pr (maximum dose 975mg)
Ibuprofen if > 3 hours since last acetaminophen AND > 5 hours since last ibuprofen	No Notify Physician	10 mg/kg po
Tepid Bath if temp not < 40.1 one hour after antipyretic	No	Consider, if temperature not < 40.0 one hour after antipyretic
ADDITIONAL NOTES	Notify MD if temp < 36.0	Notify MD if temp > 41.0

Judith Tintinalli, MD, MS
Professor and Chair

Clay Bordley, MD
Director, Children's Urgent Care

Sandy Pabers, RN, CNS II
Nurse Manager

Revised: February 2002

POINT OF CARE TESTING

DEPARTMENT OF EMERGENCY MEDICINE

Policy: Point of Care testing is provided in the ED for the following: accucheck, urine dipstick, urine pregnancy test (ICON), and stool for blood.

Procedure:
Accucheck: Accucheck is done by ED nursing staff at the time of phlebotomy. See ED nursing manual for specific procedure.

Urine dipstick: Urine dipstick is performed by the RN or NA staff when the physician writes the order 'urine dip'. If the physician writes the order 'u/a' the specimen is sent to the laboratory. The results of the urine dip are to be printed out and taped to an ED progress note with the initial of the individual who performed the test written on the sheet. The documentation is part of the permanent medical record.

Urine pregnancy test: Urine pregnancy test is performed by the RN or NA when ordered by the physician as 'urine ICON'. See ED nursing manual for specific procedure. Results are entered into the ED Nursing notes, and the initials of the individual who performed the test are to be written on the nursing note next to the result.

Stool: The examining physician or student performs the Hemoccult test for blood in stool. For each determination, the positive and negative controls are to be noted. If the controls are not valid, the text must be repeated with another Hemoccult card. Results of the test will be entered into the ED record, after the prompt 'stool guiac' + - . Results are to be entered into the medical record. The examining physician or student's name is always entered on the bottom of the ED record.

James Larson, MD
Medical Director

Sandy Pabers, RN
Head Nurse

February 28, 2001
Revised: 6/17/02

SELF MEDICATION

POLICY
Patients can take their own medication in the Emergency Department

PROCEDURE
A physician's written order is necessary to give any medication. Patients may take their own medications if they are in properly labeled containers and as long as the RN or MD can verify the name of the drug.

_____
Judith E. Tintinalli, MD, MS
Professor and Chair

_____
James L. Larson, MD
Assistant Professor and Clinical Director

_____
Sandy Pabers, RN, PSMIII
Nurse Manager

Revised: September, 1995
November, 1995
February, 1996

SEXUAL ASSAULT EVALUATION

Department of Emergency Medicine

Policy: Sexual Assault Evaluation is accomplished by the SANE team. Physicians assist in the medical aspect of sexual assault care.

Procedure:

SANE role
- Collect forensic evidence
- General patient assessment
- Provide prophylactic treatment
  - STD, HIV, Hepatitis B, and pregnancy prevention
- Referrral to Infectious Disease, psychiatry, and social services as indicated

ED Physician role
- Review case presentation by SANE specialist
- Document on ED record that case was discussed
- Intervene or assist in examination if needed/indicated
- Sign prescriptions for prophylactic medications

October 31, 2002

Judith T. Tintinalli, MD, MS
Professor and Chair

Sandy Pabers, RN, CNS II
Nurse Manager

ER NURSES ROLE IN PELVIC AND SEXUAL ASSAULT EXAMINATIONS

PURPOSE

(6) To develop guidelines to assist the Emergency Department Nurse in delivering quality care to patients requiring pelvic and sexual assault examinations and forensic evidence collection.

(7) To clarify the role of the Emergency Department Nurse (male and/or female) in assisting in pelvic or sexual assault examinations and forensic evidence collection.

GENERAL STATEMENTS

(2) The North Carolina Board of Nursing does not differentiate the role of a nurse as it pertains to gender.

(2) The North Carolina Nurse Practice Act does not differentiate the role of the nurse as it pertains to gender in the delivery of nursing care.

(8) The University of North Carolina Hospitals does not differentiate or limit the role of the nurse as it pertains to gender in the delivery of nursing care.

(9) The University of North Carolina Hospitals Legal Department knows of no existing policy addressing gender in pelvic or sexual assault examinations and forensic evidence collection.

(10) The delivery of nursing care should be patient-based and should reflect the patient's needs and desires whenever possible.

GUIDELINES

(3) Prior to pelvic and/or sexual assault examinations and forensic evidence collection, explanation of exam should be given to patient and any questions answered. Explanation should be given in terms the patient understands.

(4) All patients should be informed as to personnel to be present during the examinations and as to their roles.

(3) In sexual assault cases, the patient should be informed of the availability of a rape counselor. At the patient's request, a rape counselor may be present throughout the examination.

(5) This Emergency Department policy and procedure will be reviewed periodically and updated as needed to reflect current nursing practice.

Revised: February, 2002

SIGNS OF CHILD ABUSE/NEGLECT (SCAN) – (PHYSICAL, MENTAL OR SEXUAL)

If SCAN is present, consult with Pediatrician regarding treatment and deposition. File FAR or notify Social Services. Notify Child Protective Services and appropriate authorities – NIS or CPD.

CPS…….477-8907, 8928, 8943-4
NIS …….339-3203, 7220
AFIS ……...363-2913
VARO…….via GPD…….472-8911
Med. Photo……..ext. 345 or via Chief of the day
GPO…….472-8911
Hospital Legal Officer……via Chief of the day
ALEE (Shelter for Women and Children……472-6729 or 9460

One should suspect abuse/neglect in children, adults, elderly, or spouses if the following are present:

STD in child
Failure to thrive
"Immersion" burns
Multiple or unexplained bruises, cord or bite marks
Strangulation marks
Multiple fractures
Unexplained or poorly explained head traumas
Retinal hemorrhage
Poorly explained abdominal, oral injuries
Delay in seeking medical care for injuries
Inadequately explained GU/rectal trauma
Munchausen's by proxy
Inappropriate sexual knowledge or behavior
Excessive fear
Runaway behavior
Suicidal ideation/behavior
Panic attacks

Spouse Abuse
Triage according to ESI scale, notify FAR or AWO. Evaluate and treat medically. Get MED Photo if needed. Notify Security of base involved, NIS< or AFIS, or GPD. Call VARO to provide emotional support

Medical Photos
1 set dispositioned

Revised: February, 2002

TREATMENT OF ABUSE VICTIMS

Purpose: The UNC Hospitals Emergency Department will attempt to identify all victims of abuse, as well as to assess, treat, and provide adequate follow-up care.

Procedure:
Treat according to injuries.

Ask the victim if he/she is amenable to facilitation a contract with a counselor from the Domestic Violence Program.

Allow the patient to discuss the battering incident if they wish. Make certain the partner is not in the room.

Document the incident.

Discuss immediate safety needs to wit, do you have a safe place to stay? If safety is a concern, there are several alternatives that you can help them pursue:

a. Lodging at the Hospital Motel Unit at $12.00 per night, per person, per bed.
b. If the patient is without funds, Social Work will sponsor and follow up on the next working day.
c. Contact the local Shelter for battered spouses/victims.
d. Additionally, Inquire:
    - do you have any plans for help if he/she tries to hurt you again?
    - Does your partner have a gun in the house or does he/she threaten you with a weapon?

Suggest legal action.

Provide information on resources/services available through the Domestic Violence Program. Counseling is available 24 hours a day to provide support and will also assist with housing or shelter arrangements, if necessary.

If the victim opts to return to the abusive environment and elects not to talk with the counselor prior to leaving the Hospital, give the victim information on the Domestic Violence Service closest to their community.

If the patient needs transportation, contact the social worker or provide a taxi.

Document your discussion with the patient in the medical record.

Judith Tintinalli, MD, MS
Professor and Chair

Sandy Pabers, RN, CNS II
Nurse Manager

Revised: February, 2002

TRIAGE AND MEDICAL EVALUATION OF MINORS**
**See UNC Hospitals Policy Treatment of Minors
http://www.unch.unc.edu/hospolcy/Minors%20-%20Treatment%20of%20-%20M-8.pdf

PROCEDURE:
Minors who present to the ED are to be triaged and assigned to a room for treatment.
The process for obtaining informed consent should be begun.

Medical evaluation should never be delayed while consent for treatment is being obtained.

Treatment decisions are the responsibility of the attending pediatrician or emergency physician. Treatment may be initiated without consent of a parent or guardian of the child when the attending and another physician state that any further delay in rendering treatment due to continued efforts to contact a parent or guardian would seriously worsen the physical condition or endanger the life of the patient. **

Any minor can give effective consent to a physician for medical health services for the prevention, diagnosis and treatment of venereal disease or other reportable infectious disease; pregnancy; abuse of controlled substance or alcohol; emotional disturbance. **

The treating physician shall not notify a parent or guardian, without the permission of the minor, concerning these medical health services unless the attending physician determines that notification is essential to the life or health of the minor.

Judith Tintinalli, MD, MS
Emergency Department

Sandy Pabers, RN, PSM III
Emergency Department

Ben Gilbert, Attorney
Legal Department

June 1997
February 1998 - Revised

VITAL SIGN DOCUMENTATION STANDARDS BY THE ED NURSING STAFF

Purpose

1. To ensure the safety of all patients being treated in the Emergency Department.
2. To be able to detect clinical conditions and or hemodynamic changes in the patient being treated in the Emergency Department.

Guidelines

1. Vital signs will be taken on all patients being dispositioned to EACU and EMT at time of triage.
   a. Patients arriving via EMS will be triaged by the charge nurse and vital signs will be taken at the bedside.
   b. Patients who are dispositioned to Children's Urgent Care will have vital signs taken in the Pediatric Treatment Room.
   c. Patients who are dispositioned to Medical Urgent Care will have vital signs taken according to the plan of treatment in that area.
2. Patients given an ESI triage level of 4 or 5 will only require vital signs every 8 hours except in the following cases:
   a. Medications are given to the patient for treatment (i.e. narcotics for pain)
   b. Abnormal vital signs are noted at the time of triage (abnormal to be defined by the ESI triage algorithm, but also to include temperatures <36 C and or > 38.5 C)
   c. Procedures are performed for necessary treatment of the patient
   d. A change in the patient's clinical condition
3. Patients given an ESI triage level of 1,2,or 3 will require vital signs more frequently due to acuity, the patient's clinical condition, and medical treatments that warrant more frequent vital signs. The standard minimum of documentation will be vital signs every 4 hours.

Dr. Judith Tintinalli
Department Chair
UNC Emergency Department

Sandy Pabers, RN
Clinical Nurse Manager
UNC Emergency Department

Written: January, 2002

PLEASE REFERENCE THE UNC HEALTHCARE POLICY MANUAL FOR THE FOLLOWING POLICIES:

Click on the name to take you to these specific policies.

All other UNC Healthcare policies click here (excludes Rex Healthcare)

AMA AMA Patients Leaving Hospital against Medical Advice – A-12

Blood Transfusion Blood and Blood Products – B-3

Conscious Sedation Sedation – Guidelines for, by Non-Anesth. S-2

CPR CPR Policy – C-9

Patient Valuables Patient Valuables - V-1

Restraint Restraint Use - R-5

Photographs and Motion Pictures - P-13

XIV. Physician Administration

ASSESSMENT AND DOCUMENTATION OF DIRECT ADMISSIONS

July 16, 2002

Procedure:

Three classes of patients identified.

a) Patients medically appropriate for their assigned location as determined by the nurse. If appropriate, vital signs performed by EMS or vital signs performed in the ED will be evaluated. The accepting unit is notified and the patient is transported by the EMS unit that brought the patient to the ED. No action required by MD.
b) Patients not medically appropriate for their assigned bed. Pt. to stay in ED until a suitable bed is available. Treatment rendered as necessary. ED record generated.
c) Patients whom the nurse evaluating the patient requests an attending evaluation prior to admission. In this case the attending may choose to evaluate the patient in the ED and an ED record will be generated. Alternatively if the patient in is deemed medically appropriate for their inpatient unit the attending may write a note on progress paper to document the patient evaluation.

_____ _____

James Larson, MD Clinical Director Sandy Pabers, RN, Nurse Director

Last update 7/1/2004
Previous updates: 3/15/2002

Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

CO-SIGNING ORDERS

October 10, 2000

Policy:
Residents in the emergency department at UNC are not to co-sign medical student orders. This policy is to avoid placing medical legal risk upon the resident.

Robert J. Vissers, MD
Program Director

James Larson, MD
Assistant Program Director

cc: J. Tintinalli
T. Morris
L. Biggs
L. Brown

FREEDOM HOUSE RECOVERY CENTER MEDICAL DETOXIFICATION OUTSIDE THE HOSPITAL

A. ADMISSION ELIGIBILITY CRITIRIA

1. Alcohol, cocaine, or mixed substance abuse.
2. The patient is *motivated* for treatment in an outpatient setting.
3. The patient has had a *thorough* physical examination which is essentially within normal limits for an outpatient setting.
4. The patient is not suicidal, homicidal, and not in need of an acute psychiatric evaluation/consultation.
5. Only mild to moderate withdrawal symptoms (I.e., tremors, anxiety sleep disturbances).
6. Lab studies as indicated; suggested labs include a CHEM-7, CBC, and URINALYSIS.

B. EXCLUSION CRITERIA

1. HISTORY OF WITHDRAWAL SEIZURES.
2. HISTORY OF *DELIRIUM TREMENS*.
3. HISTORY OF ADVERSE REACTION TO TRANXENE, LIBRIUM OR PHENOBARBITAL
4. CONCOMITANT ACUTE PSYCHIATRIC DISORDER.
5 ANY UNSTABLE MEDICAL CONDITION OR ALTERED MENTAL STATUS SUCH AS DELIRIUM OR PSYCHOSIS.
6 ADDICTION TO HEROIN, METHADONE, OR LONG TERM BENZODIAZEPINES.

lmr:revised31JUL96

Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

NURSE PRACTIONER SUPERVISION IN THE EMERGENCY DEPARTMENT

Nurse Practioners working in the Emergency Department will be supervised by Emergency Medicine Attendings for each case. A note from the Attending will document the supervision provided. Responsibility for care of the patient will be shared by the Attending of record and the Nurse Practioner.

James L. Larson MD
Medical Director

November 2, 2005

SCHEDULE MAKING - NURSE PRACTITIONERS IN ED

When- Completed at least 10 calender days prior to the month
Who- By agreement of the full-time NPs in the ED
Resolution- final decision rests with primary supervising physician

Define hours for each month that are required prior to leave-
The schedule will reflect 40hr/wk worth of effort minus any leave requested
Requesting leave hours
In writing or e-mail prior to that months schedule being made with a copy to the primary supervising physician and office manager (currently Gail Holzmacher)

James Larson MD
Medical Director

August 22, 2006

SICK CALLS BY NURSE PRACTITIONERS IN ED

Who to call- if possible the NP unable to work will contact the other NPs available to work and ask for coverage. The office manager will keep a roster of available NPs and their contact numbers. This should be updated every 6 months. If unable call to locate coverage:

Weekdays 9am-5pm- If unable call to locate coverage the NP should contact the office manager to find coverage.

Weekend/After office hours- If unable call to locate coverage the NP should contact the ED charge nurse who will work with the ED attendings to find coverage.

James Larson MD
Medical Director

August 22, 2006

XV. Clinical Pathways

ADMISSION CRITERIA TO THE UNC CARDIOMYOPATHY/TRANSPLANT SERVICE

TO: Cardiology Fellows
Cardiology Faculty
Internal Medicine Housestaff
Emergency Medicine Faculty
Emergency Medicine Housestaff

FROM: Patricia Chang, MD, Director, Cardiomyopathy/Transplant Service

DATE: June 24, 2004

The Cardiomyopathy/Transplant (CM/Tx) Service is available as a specialized inpatient cardiology service to specifically care for hospitalized patients with advanced or end-stage cardiomyopathy and for hospitalized heart transplant recipients. Beginning June 25, 2004, there will be one dedicated medicine resident working with the cardiology fellow and attending on the CM/Tx Service.

The CM/Tx service admits patients daily to the existing beds under cardiology, either through the Emergency Department, directly from the Admissions Office, or via hospital-to-hospital transfer. Because of the subspecialty nature of this cardiac care to be provided by only one housestaff on the team, the admission must be approved by the CM/Tx fellow or attending. We therefore ask admitting physicians in the ED or the on-call housestaff on the general cardiology service to call the CM/Tx fellow before officially admitting these patients.

In general, eligible patients for this service will include:

(1) established patients of the heart failure/transplant cardiologists (Drs. Kirkwood Adams, Carla Sueta, and Patricia Chang) who present primarily with heart failure or active cardiac issue,

(2) all heart transplant recipients followed at UNC with any medical problem, except when patient would clearly benefit from another medical service (e.g., combined heart-kidney transplant patient with acute renal failure should probably be admitted elsewhere),

(3) new patients with advanced or severe cardiomyopathy who are referred for heart transplant evaluation or who are refractory to standard medical therapy.

This CM/Tx service also provides inpatient consultation for patients who need subspecialty care with regard to refractory heart failure or heart transplantation evaluation or management. Consultation referrals can be called to the Cardiology Consult pager (# 216-3764) or directly to the CM/Tx fellow on call.

Please call with questions (843-5214). Thank you for your help in advance.

ADULT DKA TREATMENT PROTOCOL

Department of Emergency Medicine

August, 2004

Diagnosis: BS > 250, HCO3 < 15, venous pH < 7.3, + serum ketone level >1:4

Treatment:

Fluids

1. NS 500-1000 cc/h x 2 hrs
2. Then 0.45 NS at 250-500 cc/hr until BS < 250
3. When BS < 250, give D5/.45NS until DKA resolves

Potassium

1. Always get stat EKG in suspected DKA to r/o hyperkalemia
2. If K > 5.5, treat K if symptoms of hyperkalemia, or if no symptoms check K q 2 hrs
3. If K 4.0-5.5, give 20 meq K to each L of IV fluid
4. If K 3-4, give 40 meq K to each L of IV fluid
5. If K < 3, give po K 10 meq po q hr or 10 meq IV q hr, or as needed

Insulin

1. IV regular insulin: 0.1 units/kg body weight bolus
2. Then Continuous Insulin infusion at 0.1 units/kg/hr, accuchecks q 1 hr
3. When BS < 250 make sure you switch to D5/.45 NS
4. Optional SC insulin:

   Initial dose aspart insulin 0.3 units/kg, followed by SC aspart insulin 0.1 units/kg q 1 hour; check glucose q 2 hour until BS 300, then check q 1 hr so if BS < 250 you know when to switch to D5/.45 NS

CARDIOLOGY ADMISSION GUIDELINES

Guidelines for Admission to Family Medicine, Medicine or Cardiology

The ED attending determines the appropriate service for patient admissions. In general, patients who are followed by local community doctors (as designated by the list posted in the ED) will be admitted to the Family Practice or Hospitalist Service, with consultation as appropriate with Cardiology. **However, it is appropriate to admit patients directly to the Cardiology service in the following instances:**

1. Patients with symptoms of cardiac ischemia (CP, SOB, etc.) with ST-elevation myocardial infarction (STEMI) or LBBB	**Admit to CCU**
2. Patients with non-STEMI (elevated TnT) **and** clinical evidence of CHF or hemodynamic instability, hypotension or ongoing CP/ischemia	**Admit to CCU**
3. Patients who have been revascularized (PCI or CABG) within the last six months, who have symptoms suggestive of cardiac ischemia	**Admit to 3Anderson, ICCU or CCU**
4. Patients who have had a heart transplant with any medical problem.	**Admit to 3Anderson, CCU or ICCU**
5. Patients who are awaiting a transplant or are followed by the cardiomyopathy/transplant team (Drs. Adams, Chang, or Sueta) as outpatients with heart failure or active cardiac issue.	**Admit to 3Anderson, CCU or ICCU**
6. Patients with decompensated CHF requiring inotropic support (dobutamine, dopamine, or vasopressin)	**Admit to CCU**
7. Patients with ventricular tachyarrhythmia/ICD discharge, or bradyarrhythmias that may require emergent pacing	**Admit to CCU**
8. Patients who have a major cardiac problem and are followed by UNC cardiologists, defined as visits every 6 months or less at UNC Cardiology Clinic	**Admit to 3Anderson, ICCU or CCU**
9. Patients who express a strong preference for care on the cardiology service	**Admit to 3Anderson, ICCU or CCU**

CHEST TUBE INSERTION IN THE EMERGENCY DEPARTMENT

PROCEDURE:

1) **ACS 'Trauma Code' Patients**
Emergent chest tubes are placed by the trauma/ED service. The thoracic surgery fellow should be notified by the trauma team as soon as feasible.

2) **Unstable patients with Non-Traumatic Pneumothorax**
The emergency medicine service, under the supervision of the emergency medicine attending, places the chest tube. The thoracic surgery fellow should be notified as soon as feasible.

3) **Stable patients with Non-Traumatic Pneumothorax**
A stable patient should be able to maintain stable respirations and vital signs for 30 minutes. The thoracic surgery fellow should be notified, and the chest tube placed by the emergency medicine or surgery residents under the direct supervision of the thoracic surgery fellow. The selection of the learner, that is, either emergency medicine or surgery, is determined by the thoracic surgery fellow, in consultation with the emergency medicine attending as needed, depending on the needs of the learners involved.

Judith Tintinalli, MD, MS
Professor and Chair

Tom Egan, MD
Chief, Thoracic Surgery

February 16, 1998

REFERRAL OF DIABETIC (ADULT) PATIENTS TO HIGHGATE SPECIALTY DIABETES CLINIC

Department of Emergency Medicine
May 30, 2006

POLICY: Referral of Diabetic (adult) patients to Highgate Specialty Diabetes Clinic

PROCEDURE:

Patient selection: The following adult patients are candidates for Highgate Specialty Diabetes Clinic referral within 24 hours of ED visit:

1) New Onset Type I Diabetes
2) Recurrent, disabling hypoglycemia if requested by PCP or other UNC Service
3) Pregnant diabetic if requested by PCP
4) Symptomatic hyperglycemia (>350) if requested by PCP

Appointment procedure:

- During office hours, Highgate staff can be called 919-484-1015 to arrange urgent appointment in 24 hours.
- After office hours, on nights, holidays, and weekends, page the Adult Endocrinology Fellow to insure patient is properly selected for Urgent Referral and also to make sure the appointment is properly set.
- Always have the patient call first 919-484-1015 to confirm appointment.

Non-urgent procedure:

- Patients with a PCP, or with new, asymptomatic, moderate hyperglycemia, should be sent to their PCP or appropriate UNC clinic.
- Patients without financial means, and without an urgent condition, can be referred to their local health department.
- Pediatric diabetes should be discussed with the Pediatric Endocrinologist.

Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

EMERGENCY DEPARTMENT MODERATE SEDATION (CONSIOUS SEDATION) POLICY

April 10, 2002

1) Physicians providing moderate sedation must be credentialed in this.
2) Sedation/Analgesia Assessment and Procedure Record must be completed (by resident or attending) and signed by the ED attending before medications are given.
3) Medications for moderate sedation may only be given with an emergency attending or emergency resident (PGY II or PGY III) present.
4) The emergency attending may refuse moderate sedation in the ED if they deem it unsafe or inappropriate for the clinical setting.

Judith Tintinalli, MD, MS
Chair
Department of Emergency Medicine

James Larson, MD
Clinical Director
Department of Emergency Medicine

Sandy Pabers, CNS II
Nurse Manager
Department of Emergency Medicine

Robert Vissers, MD
Assistant Professor
Department of Emergency Medicine

EVALUATION OF OB PATIENTS IN THE ED

POLICY: EVALUATION OF OB PATIENTS IN THE ED

PURPOSE: To ensure proper evaluation of the pregnant patient in the ED

PROCEDURE:

1. It is the policy of the ED that all pregnant patients presenting for care will be treated in the ER unless they are beyond 20 weeks gestation and have a problem suggesting labor. OB patients with problems not related to pregnancy, such as colds, earaches, and other minor illnesses are not to be sent to Labor and Delivery. Patients in labor who are not in imminent threat of delivery are to be transported in a wheelchair to Ward F-3 OB. ED personnel will escort such patients after notifying the labor deck.

2. Patients presenting to the ED with imminent delivery are to be seen/evaluated in the ED. Call Labor and Delivery and request that they send the OB watch and an incubator to the ED stat.

3. Serious conditions in pregnant women to be considered are:

   a. pregnancy induced hypertension or toxemia, present with headache, elevated BP, abdominal pain, proteinuria, edema, seizures can occur up to 2-4 weeks after delivery.

   b. placenta previa with painless vaginal bleeding.

   c. placenta abruptio with painful vaginal bleeding, often in shock.

   d. uterine rupture with shock.

4. It is the policy of the ED to maintain in the ED pre-packed OB kits suitable for the emergency care of obstetrical patients whose delivery is imminent. These packs may be of the commercial variety, or prepared by the ED, but should contain those items necessary to render a safe and sterile delivery in the ED when transfer to the Labor Deck cannot be accomplished.

_____
Judith E. Tintinalli, MD, MS
Professor and Chair

_____
Sandy Pabers, RN, CNS II
Nurse Manager

_____
James L. Larson, MD
Clinical Director

October 26, 1992

Revised: May 19, 2004

FETAL MONITORING FOR TRAUMA IN PREGNANCY

POLICY: FETAL MONITORING FOR TRAUMA IN PREGNANCY

PURPOSE: To insure application of monitoring and observation as quickly as possible for patients at or greater than 20 weeks gestation.

PROCEDURE:

1. **TRAUMA CODE:** For all patients at or greater than 20 weeks gestation who meet the criteria for a TRAUMA CODE, the Obstetrics Chief Resident is to be notified and paged for the trauma alert. The obstetrics Resident will be responsible for fetal and maternal monitoring and evaluation.

2. **NON TRAUMA CODE <u>but</u>:**
   - Direct or indirect abdominal injury
   - Major burns
   - Electrical injury
   - Deceleration injury

   The Emergency Medicine Attending will be paged to triage and assess the patient.

   If treatment of the patient's injuries can be deferred, the OB Chief Resident should be notified and the patient sent to Labor and Delivery for monitoring. After monitoring, the patient can return to the Emergency Department for injury evaluation. If injury evaluation and treatment deserves priority, the patient should remain in the Emergency Department and the Obstetrics Chief Resident paged to assess fetal-maternal well-being.

   Steps for actual or potential abdominal trauma > 20 weeks gestation:
   1. Triage nurse notifies EM Attending
   2. Patient triaged as acute, FHT taken
   3. If further ED evaluation needed, call L&D nurse to apply tochodynamometer, and call OB Resident for US
   4. Patient to L&D as soon as possible

3. **GENERAL CARE:** All patients should have fetal heart rate determined. The patient should be monitored in the left lateral decubitus position, or if on a backboard, a wedge should be placed under the left side or an individual can be assigned to manually deflect the uterus to the left. A type and screen and Kleihauer-Betke test should be drawn. RhoGAM administration should be considered if the mother is Rh-negative.

   Length and type of monitoring is the responsibility of the Obstetrics Chief Resident.

   Discharge from the Emergency Department should be a joint decision by Obstetrics and Emergency Medicine.

Judith E. Tintinalli, MD, MS	James L. Larson, MD
Professor and Chair	Clinical Director

Revised: December, 1992

GUIDELINES FOR HELICOPTER TRANSFER OF ACUTE STROKE PATIENTS

From: Sen, Souvik [mailto:SenS@neurology.unc.edu]
Sent: Friday, December 17, 2004 8:20 AM
To: Faculty; fellows; residents
Cc: Judith Tintinalli; Michael Harrigan; Jlarson
Subject: Guidelines for helicopter transfer of acute stroke patient

We have been encountering an increase in number of acute stroke patients that are transferred by helicopter from outside hospitals. Here are some guidelines for the transfers.
Ideally IV TPA should be started at the outside hospital, the patients may be transferred while the TPA is running. To reduce the rate of TPA complication:
1) Verify time of onset
2) Verify no bleeding diathesis, trauma/surgery, normal PT, PTT, PLT, Glucose, CT head
3) Alteplase (ACTIVASE) is being administered at 0.9 mg/Kg (NOT Retavase or others)
Things that benefit enrollment in the acute stroke studies (ONO and SAINT)
1) Patient transferred rapidly <60 minutes-Call stroke attending as soon as you hear abt the case
2) Informed consent: If patient can not consent if NOK is available on phone/cell phone (Since NOK can not travel in the helicopter this can be a significant delay)
3) Labs and reports are faxed to us while we wait here.
I would cite last night's case where everything went well and Duke Helicopter brought us a patient from Johnston Memorial in 40 minutes time. IV tPA was still infusing, family got here 20 minutes later. IV tPA + ONO + Insured patient to UNC!!! All while UNC helicopter was bringing another stroke pt. from elsewhere.

GUIDELINES FOR MANAGEMENT OF MASSIVE PULMONARY EMBOLISM

Department of Emergency Medicine

August, 2004

Guidelines for management of massive pulmonary embolism

Definition: >50% obstruction of pulmonary bed, refractory hypoxia, BP <90

Diagnosis: Chest CT scan, elevated troponin

Management steps:

NS 500 cc bolus

Pressors, primarily norepinephrine to minimize tachycardia

Heparin bolus and infusion

Page cardiology fellow to get stat echocardiogram to determine RV pressures (cardiology fellow will call in tech from home after hours)

Simultaneously page VIR fellow for possible intervention

If RV strain, call VIR fellow to evaluate for catheter-directed lysis

If patient deteriorates or intervention delayed or impossible AND no contraindications, consider administration of systemic lytics*

*Literature is controversial about the ultimate effect of systemic lytics on outcome.

INITIAL ED MANAGEMENT OF HYPERGLYCEMIC, NON-DIAGNOSED DIABETICS

Department of Emergency Medicine
UNC Hospitals

July, 2001

Policy: Initial ED management of hyperglycemic, non-diagnosed diabetics

Procedure:

I. **Random BS 160-250**

Followup instructions for screening with FBG

II. **Random BS 250-350** (no acute dietary indiscretions such as drinking quarts of sugary drinks or IV containing glucose)

Treat in ED with first dose of Glucotrol (glipizide) 5 mg or Amaryl (glimepiride) 2 mg po; contraindication to both drugs is SULFA allergy

Give prescription for Glucotrol (glipizide) 5 mg po qd or Amaryl (glimepiride) 2 mg po qd to begin next day

Followup 24 hours with PMD

III. **Random BS >350**
Treat in ED with regular insulin, 0.1unit/pound, accucheck in 1 hour to determine effectiveness

Give prescription for Glucotrol (glipizide) 5 mg po qd or Amaryl (glimepiride) 2 mg po qd each morning.

Followup 24 hours with primary care MD or call endocrine fellow to arrange followup.

Judith Tintinalli, MD, MS
Professor and Chair

Approved: Faculty Meeting, July 10, 2001

MANAGEMENT OF AGITATED OR POTENTIALLY DANGEROUS PATIENTS

Emergency Department, UNC Hospitals

Policy: Management of Agitated or Potentially Dangerous Patients*

1) All patients actually or potentially dangerous to themselves or others are to be managed as follows:
    a. Searched for weapons by hospital police.
    b. Receive medical evaluation to identify an organic cause

2) Medical-surgical restraint applies to patients with likely medical problems.
3) Behavioral restraint applies to patients with likely psychiatric problems.

4) The following steps are to be followed in such circumstances:
    a. Verbal reinforcement.
    b. Written order by the physician is necessary to ensure patient does not elope from the ED. Observation by qualified personnel will be used to prevent elopement prior to evaluation.**
    c. Physical restraints applied according to hospital guidelines require a written physician order
    d. Medication should be given to control behavior that is dangerous to the patient or to others
    e. In rare circumstances, locked seclusion in Rooms ___ or ___ may be necessary for dangerous behavior while resources are mobilized for restraint or sedation. There must be a written order by the physician for locked seclusion. If locked seclusion is necessary for the protection of the patient or others, assessment for medical treatment should be done as soon as feasible by the ED or psychiatric staff, whichever is more appropriate. If locked seclusion is absolutely necessary, UNC Hospitals police must be in sight of the patient and nursing staff must provide documentation according to the UNC Hospitals behavioral restraint policy.

*please also refer to restraint policies, and vital signs policy for specific guidelines on patient monitoring.

**please note that 'suicide precautions' is not a valid medical order

Judith E. Tintinalli, MD, MD	Sandy Pabers, RN
Professor and Chair	Head Nurse

MANAGEMENT OF PATIENTS WITH INVASIVE DISEASE DUE TO NEISSERIA MENINGITIDES

UNC Hospitals Occupational Health Service link

Links may not be accessible from outside the UNC Hospitals area.

http://www.unch.unc.edu/expcntrl/ohs/Policies/POL-Meningitis.htm

Department of Emergency Medicine
University of North Carolina Health Care System, Chapel Hill

TRANSFER OF PATIENTS REQUIRING ORTHOPEDIC CARE

May 25, 2002

This policy is to ensure the appropriate and timely evaluation of patients with orthopedic injuries referred to UNC Hospitals.

1. Calls primarily fielded by the Orthopedic service- If a patient is appropriate for evaluation in the UNC Emergency Department, notification of the staff in the Emergency Department will occur to ensure that resources are available to treat the patient. No inpatients at other hospitals will be accepted to the Emergency Department without approval of the Emergency Department attending.

2. Calls primarily fielded by the Emergency Department staff- If a call is received regarding the transfer of a patient for orthopedic care, and there are no other significant traumatic injuries requiring a trauma center (determination is at the discretion of the Emergency Attending) the physician requesting transfer will be referred to the orthopedic resident on call. Denial of transfer will be the decision of the Orthopedic attending on call. In cases where the referring physician cannot obtain a timely response from the orthopedic team, the transfer will be accepted. In cases where other significant traumatic injuries cannot be excluded, the patient will be accepted if resources are available.

James L. Larson MD
Medical Director- Emergency Department

Louis Almekinders MD
Professor Orthopedics

XVI. Consultation and Consent Services

XVII. Disposition

ED HOLDING PATIENT CRITERIA LOCATED WITHIN CDU (6 WEST)

In effort to provide a more comfortable location for patients awaiting inpatient bed placement, the CDU will accommodate 2 ED Holding patients. EDH patients will remain in "outpatient" status until transferred from 6 West to an acute, inpatient bed.

The following will apply to all patients placed on 6 West as in ED holding (EDH) status:

- The patient may be placed in any CDU bed.
- The ED Charge Nurse will call the CDU Charge Nurse to discuss the patients. The CDU charge nurse will assign the room for the patient. **YOU MUST CALL BED MANAGEMENT WITH THE ROOM NUMBER IN ORDER FOR THE PATIENT TO BE TRANSFERRED.**
- The CDU documentation forms will be used for EDH patients.
- 6 West RNs will obtain all labs and EKG for all patients.
- 6 West staffing will be based on the volume and acuity levels and is generally targeted at a 1:5 nurse to patient ratio
- All patients must have orders written prior to arrival transfer to the 6 West. These orders do not have to be re-written prior to transfer to the inpatient unit.
- Patients placed in an EDH bed on 6 West will retain the same priority as the ED patients awaiting inpatient placement. 6 West staff will verify an active bed reservation status with Bed Management. **A request must be entered into the system upon arrival to the unit.**
- Should an EDH patient meet discharge criteria prior to transfer to an inpatient unit, the patient maybe discharged from 6 West as they would from the ED.

The following are examples of the types of patients who may be placed in the ED holding beds:

- Single lobe pneumonia (no respiratory compromise) for IV antibiotic administration
- Dehydrations for IV fluid replacement
- Sickle Cell Crisis with PCA pain management
- Stable Neurological patients (R/O Stroke, TIA) not requiring step-down or ICU status and has not received TPA
- Stable hypertension not requiring IV drip medication
- Asthma exacerbation with oxygen saturations greater than 90% not requiring continuous pulse ox monitoring

- Stable small bowel obstruction (NGT to low wall suction, routine abdominal exams)
- Cellulites (non-draining)
- Simple UTI/Pyleonephritis for IV antibiotic administration
- Stable lower GI bleed not requiring frequent HCT checks (less than Q6hours). Excluding active upper GI bleed requiring NG lavage (will be determine on case-by case basis)
- Epistaxis without respiratory compromise
- Stable, non-penetrating abdominal trauma (HCT checks no more frequent than Q6hours)
- Extremity trauma without vascular compromise
- DVT treatment with Heparin (PT/PTT lab draw no more frequent than Q6 hours. Admitting team must follow-up on lab results and adjust drip rates accordingly)

Examples of patients who may not be placed in the EDH beds:

- Patients requiring ICU or step-down status
- Acute MI/borderline enzymes with EKG changes
- Patients requiring isolation
- Chemo administration
- Penetrating trauma to neck, abdominal, pelvis or spine
- Diabetic requiring insulin drip for DKA
- Patients requiring vasopressor drips, specific pulmonary or diuretic infusions
- Patients with any respiratory compromise or new tracheostomy
- ENT patients with potential for respiratory compromise
- Patients requiring peritoneal dialysis
- Patients needing frequent bathroom access.

UTILIZING CDU FOR HOLDING OF ED PATIENTS

1. Any admitted ED patient who meets the established criteria can utilize one of the ED Holding beds in CDU provided that they are under a minimal set of admission orders. Primarily, the CDU beds should be utilized for patients who will have extended Emergency Department stays due to waiting on inpatient beds. Operationally, we are saying that any patient that is expected to have an ED wait for a bed in excess of 6 hours is a candidate for CDU. Patients who are expected to get a bed in less than 6 hours should remain in the ED.
2. If there is a patient that meets the above criteria, the ED charge nurse can look on SMS to see if the CDU has availability. The charge nurse should than call the charge nurse in CDU to discuss the case to see if the patient can be moved to CDU.
3. ED staff will page the admitting service as a courtesy to let them know that the patient will now be located in CDU. CDU will let the teams know when the patient is on the unit, and when the patient receives an inpatient bed.
4. CDU will call Bed Control to give them the room number and Bed Control will enter the room number in SMS.
5. ED will transfer patient out to CDU.

XVIII. Follow-up

CULTURE FOLLOW UP

1. **Potentially Emergent Cases called to a physician in the ED**- need to be followed up by the physician taking the report. This could include calling the patient back to the ED, calling the patient's primary care provider or taking no action depending on the circumstances. Discuss with the attending of the day if you cannot contact the patient or if you have any questions. Record your actions (or appropriate lack thereof) by searching for the patient's visit using the History function and using the addenda charting feature in the T system. A certified letter may be sent if the patient or their PMD cannot be contacted.

2. **Non-Emergent Cases that are reported from the Lab-** These come down as printed reports. These will be followed up by Barb Overby with medical backup from Dr. Larson or the attending on the A side. Actions to be recorded using the addenda charting feature in the T system.

James L. Larson
Medical Director

1/10/2005

PROCEDURE FOR COPYING XRAYS

August 4, 2004

Policy: Obtaining films as CD or hard copy for patient care

Procedure: see below

From: Perkins, Yvonne
Sent: Wednesday, August 04, 2004 8:47 AM
To: Pugh, Shirley
Subject: RE: x-ray copies

1. Film Management will not burn a CD for a patient without a written release from the patient or the facility requesting the films. This is HIPAA requirements. The CD maybe picked up in Film Management in the basement of Womens Hospital or the CD will be mailed or Fedex to the requesting facility.

2. It is a HIPAA requirement to have a release. It is not necessary to use that particular form, as long as we have the necessary information, such as the patient's name, requesting facility, requesting physician and address. If address is unknown, we will look it up for the patient.

3. If techs are printing you a hard copy of the xray and you are presenting it to the patient, it is not by policy.

4. There is no charge to the patient unless it is for personal use. The charge is $25.00 for a CD and $9.00 per sheet for hard copy film. The policy is in the Film Management Policy Manual.

5. Providing the equipment is working properly, it takes 10 to 15 minutes to burn a CD. We only need the written request with the proper information.

Yvonne Perkins
Film Management Supervisor

Judith Tintinalli, MD, MS Professor and Chair	James Larson, MD Medical Director

PROCEDURES FOR CULTURE FOLLOW UP

1) The reports are currently generated Mondays and Thursdays and arrive via the tube station around 8 am.
2) The clerk should supply the senior resident here for the teaching shift with the culture results and the corresponding ED record for that day.
3) Review the record of treatment for the patient. If the pt. has been properly treated (i.e. a non-resistant antibiotic was prescribed for a UTI) then you don't have to do anything except mark that on the culture report. If the patient was admitted care was transferred to the admitting physicians and you do not have to do any more. Discuss with the attending if you have any questions. Keep all the culture reports sent by the lab and mark them even if nothing is required. Place the completed reports in the front inside pocket of the culture log book.
4) If the patient requires follow up for a culture that was not treated, proceed with the following:
5) Call the patient and arrange for appropriate treatment. This could include calling in a prescription, having them see their primary care provider, or having them return to the ED for further evaluation.
6) Record your actions on the **"Emergency Department Culture Follow-up Form"** form which can be found in the culture log book. Record the patients name, MR# and date of action on the form. Submit the white copy to medical records (through the clerk). Keep the blue copy in the Culture Log.
7) In cases where no contact is made with the patient a form letter should be sent return receipt to the patient asking them to contact the ED for further information. Make an entry in the Culture Log Letter List, this will assist us if the patient calls back. Place the letter to be sent in the front inside pocket of the culture log for processing.
8) Correnthia Hill, Administrative Assistant, on Mondays and Thursdays will collect the culture sheets from the lab, the ED Culture Follow-up Forms, and assist in sending any certified letters.
9) Correnthia Hill will ensure that the culture log has been completed and keep records.
10) **Initial the front of the culture log next to the corresponding date after you are done.**

Communicable diseases

We must report certain communicable diseases that are found in culture follow up (STDs mainly) Reporting consists of filling out the North Carolina Communicable Disease Report Card now located in the back of the culture book or with the clerks. This card should be sent to Hospital Epidemiology (1001 West Wing). Also note that some diseases on the card need to be telephoned to the Orange County Health Department 967-9251 within 24 hrs of discovery.

James L. Larson MD Medical Director
Revised 4/22/04

RADIOLOGY REREADS/FOLLOW-UP

March 10, 2003
Rev. Sept. 27, 2006

POLICY

In order to improve communication between the Department of Radiology and the faculty in the Pediatric Emergency Department and Emergency Department, between the hours of 10 P.M. and 9 A.M. the following protocol will be adapted:

PROCEDURE

Definition of an x-ray reread

An x-ray re-read is any interpretation which differs from the interim interpretation verbally communicated by the ED radiology resident, or any request for additional films after the patient has been dispositioned from the Emergency Department, or a change from the original RTAS dictation. The interim verbal interpretation is recorded on the ED record by the resident or ED attending who receives the interim verbal communication. If there is no ED chart documentation of verbal communication of a radiology report, then the original RTAS dictation will be assumed to be the interim interpretation.

Acute Emergency Department and Fast Track

The emergency medicine attending will be given a written report by the radiology resident or attending indicating the change in interpretation. Verbal re-read reports will not be accepted, the attending will attempt to contact the patient by phone or letter and record his actions in the Tsystem chart for that patient.

Pediatric Emergency Department / Follow-up and Documentation

For all rereads of x-rays generated from the Pediatric Emergency Department that occur between the hours of 10 P.M. and 9A.M., the Radiology resident or faculty of the Department of Radiology will verbally contact the 2nd year night Pediatric ED resident as identified on the SMS hospital computer system. The radiologist will deliver the *Radiology Interpretation and ED Follow-up Form* to the 2nd year Pediatric ED resident. an addendum will be made to the original CIS radiology report regarding the reread including the name of the resident notified of the reread after the follow-up form has been delivered to the pediatric resident. The 2nd year night Pediatric ED resident will obtain and review the patient's pediatric note in context of the new radiological findings. If the new finding is felt to be possibly emergent, the resident will discuss the case with the Emergency Medicine Faculty and develop an appropriate plan. If the new findings are not emergent, the 2nd year night Pediatric ED resident will discuss the case and the new radiological findings with the Pediatric Acute Care attending the following morning and develop an appropriate plan.

All of the action plans will be documented on the *Radiology Interpretation and ED Follow-up Form*. This will be signed by the resident and appropriate attending It is the responsibility of the Department of Pediatrics as the administrative departments for Pediatric Acute Care, to keep a file of the radiology re-read cases, and to distribute a copy of each incident to Risk Management.

Approval – 05/22/03
Joseph Lee, M.D.
Radiology Department Chair

Approval – 09/27/06
Cheryl Jackson, M.D.
Director of Pediatric Acute Care

Approval – 05/09/06
James Larson, MD
Medical Director, Emergency Department

XIX. Disaster Management

Please reference the *UNC Hospitals Disaster Manuel* for further Disaster Management

ENHANCED DECONTAMINATION PROCEDURE

Policy for Evaluation of Suspected Victims of Biological or Chemical Warfare

1. If the patient presents to triage, have the patient step out of the building immediately (if the patient presents to the EMS entrance, begin at step 3 below).
2. The triage area should be closed immediately after patient departure in step one above. The entire immediate area should be promptly evacuated to the outdoors (this includes the waiting area, security station and registration area). HVAC should be immediately shut off by the nearest available personnel. The area must remain strictly closed and isolated until cleared by Haz-Mat.
3. Notify Hospital Public Safety immediately.
4. Personnel should observe the following precautions (NOTE: this equipment may only be available from Fire Department and/or regional Haz-Mat teams):
    a. Self-contained breathing apparatus
    b. Butyl rubber gloves and gown
    c. Rubber boots
5. Escort the patient(s) to the decontamination shower.
6. Remove all the clothing (the alert patient may do this themselves)
7. Place all clothing in a biohazard plastic bag for discard (again, the alert patient my do this themselves). Seal the bag and place it in a secure area for law enforcement.
8. Instruct the patient to GENTLY scrub all areas of the body, including hair with one of the two following solutions.
    a. If there is no blistering of the skin, open wounds, or signs of severe skin irritation, then use a 0.05% sodium hypochlorite solution (commercial bleach (Clorox) is 5% sodium hypochlorite, so dilute 1 part commercial bleach to 9 parts warm water). This will apply to those with liquid exposure to a nerve agent such as sarin or VX.
    b. If there is blistering of the skin, open wounds, or signs of severe skin irritation, then use warm water only. This will apply to those with liquid exposure to vesicants such as mustard gas.
9. Eyes should be irrigated with normal saline. NEVER USE A SODIUM HYPOCHLORITE SOLUTION IN OR NEAR THE EYES.
10. Directly observe the patient to ensure all areas are adequately cleaned.
11. For a patient in extremis, quickly shaving hair and using more than one health care worker to assist with decontamination may be helpful.
12. Once the patient has been adequately decontaminated with the appropriate solution from step 8 above, they may be dried with a standard towel and clothed in hospital scrubs.
13. The decontamination room should be scrubbed with 2% sodium hypochlorite solution after each patient. This may be accomplished by nursing personnel or environmental services and should take no longer than 30 seconds. For patients in extremis, this step may be omitted.

Once the patient has been decontaminated, they may enter the Emergency Department. Patients exposed only to chemical weapons (and not biological weapons) that have been thoroughly decontaminated

STANDARD DECONTAMINATION PROCEDURE

Policy for Evaluation of Suspected Victims of Biological or Chemical Warfare

1. If the patient presents to triage, have the patient step out of the building immediately (if the patient presents to the EMS entrance, begin at step 3 below).
2. The triage area should be closed immediately after patient departure in step 1 above. Any areas of patient contact should be scrubbed with antimicrobial agent and/or warm soap and water. Re-opening of the area will be at the discretion of the charge nurse, attending emergency physician, and public safety. Patients in the waiting room should be escorted to minor trauma waiting if there is no evidence of contamination or outside if there is any evidence of contamination. If there is any doubt, escort the patients outside until further assessment can be completed in conjunction with the Emergency Department Attending.
3. Personnel should observe the following precautions:
   - HEPA mask (same as for TB precautions)
   - Gown
   - Gloves
   - Shoe covers
4. Notify Hospital Public Safety immediately.
5. Escort the patient(s) to the decontamination shower. Use the route OUTSIDE the hospital. Potentially contaminated patients must never be routed through the Emergency Department.
6. Remove all clothing (the alert patient may do this themselves).
7. Place all clothing in a biohazard plastic bag for law enforcement (again, the alert patient may do this themselves). Seal the bag and place it in a secure area for law enforcement.
8. Instruct the patient to GENTLY scrub all areas of the body, including hair, with warm soap and water. Harsh scrubbing may increase the absorption of certain agents.
9. Eyes should be irrigated with normal saline.
10. Directly observe the patient to ensure all areas are adequately cleaned.
11. For a patient in extremis, quickly shaving hair and using more than one health care worker to assist with decontamination may be helpful.
12. Once the patient has been adequately decontaminated with soap and water, they may be dried with a standard towel and clothed in a hospital gown.
13. The decontamination room should be scrubbed with warm soap and water after each patient. This may be accomplished by nursing personnel or environmental services and should take no longer than 30 seconds. For patients in extremis, this step may be omitted.

Once the patient has been decontaminated, they may enter the Emergency Department. The continued type of precaution will be dictated by the presumed underlying diagnosis (see Biological Weapon Isolation Precaution Flowchart).

RADIATION INCIDENT MANAGEMENT PLAN
CODE TRIAGE – CODE WHITE

ACTIVATION OF THE PLAN FOR RADIATION INCIDENTS:

When the Emergency Medical Service System notifies the University of North Carolina Hospitals Emergency Department of an incident involving radioactive isotopes, the ED Attending will contact Hospital Police (911) to secure the ED. The ED Attending and/or Hospital Police will contact the Radiation Safety Officer (962-5507) and the Director on Call to decide whether to implement the radiation incident plan. If activated:

Communications will notify the following to report to the Command Center located in the Emergency Medicine Conference Room (Ground Floor Neurosciences Building):

A. Director On-Call if not already on site
B. Health Physicist On-Call (Radiation Safety Officer) if not already on site
C. Nursing Administration
D. Plant Engineering
E. Radiology Consultant On-Call
F. Director, Environmental Health & Safety
G. Industrial Hygienist

The following sections outline the responsibilities for the designated individuals.

ED ATTENDING

1. Attempts to determine the number of radiation incident victims and the nature of their injuries
2. Designates a physician to take charge of the victim(s) as a member of the decontamination team.

NOTE: Acute Cardiac Room 4 is the primary radiation decontamination room. Acute Cardiac Room 5 will be used as another radiation decontamination room if there are multiple victims.

HEALTH PHYSICIST (Radiation Safety Officer)

1. Regardless of whether the incident occurs on or off site, determines the following information from the scene of the incident:
   A. Number and condition of uncontaminated patients.
   B. Number and condition of contaminated patients.
   C. Type of radioactive isotopes involved.
   D. Type of radiation incident:
      1. Irradiation
      2. Contamination
      3. Incorporation

2. Prepares the Emergency Department for the arrival of victims according to outline under "Prepration for Arival of Victims".
3. Designates person with a survey meter to stay at the entrance of the decontamination room to monitor personnel and equipment leaving the radiation decontamination room.
4. REAC/TS (Radiation Emergency Assistance Center/Training Site) is available to answer question as needed during the daytime at 865-576-3131 and 24-hours at 865-576-1005.
5. Supervises the survey of patient decontamination and care team from the arrival of the patient through the decontamination and care proceedings and including the surveying and monitoring of all personnel after care is provided.

A. Surveying:

1. Ambulance and attendants
2. Route from ambulance entrance to radiation decontamination room
3. Radiation decontamination room, patient and personnel

B. Decontamination of areas in A 1, 2, 3, above, if found.

C. Analysis of all specimens taken of potentially contaminated items or water.

D. Examination of all dosimeters and proper follow-up if indicated.

ENVIRONMENTAL HEALTH AND SAFETY

1. Assists the Radiation Safety Officer with his/her determination of extent of contamination.
2. Acts as liaison between Radiation Safety Officer and Incident Commander and all other Hospital employees.

EMERGENCY DEPARTMENT NURSE MANAGER

1. Evacuates all patients to a safe area within the ED.
2. Designates a RN and nursing assistant for participation in the decontamination team.
3. Provides liaison with the Command Center for additional support as necessary.
4. Gets the radiation equipment necessary from the storage areas for implementation of the plan.
5. Designates a nursing assistant to assist in preparing route of entry to decontamination area.

HOSPITAL POLICE

1. Cordons off suitable Ambulance Entrance area near the entrance to the Emergency Department.
2. Assists in ensuring that nonessential personnel remain clear of this entrance-way and the radiation decontamination area within the Emergency Department.
3. Assists the charge nurse in the evacuation of the Emergency Department.

4. Secures doors from stairwell and outside.

DECONTAMINATION TEAM

1. Physician

   A. Designated by Emergency Department Attending.
   B. Takes charge of the medical/surgical problems of the patient, determines need for consultation regarding medical/surgical problems, directs decontamination procedures with the assistance of the Health Physicist.

2. R.N.

   C. Set up the room according to potential/actual patient injuries including radiation.
   D. Assists physician in the medical care of the patients
   E. Collects all specimens including type and cross, CBC and urine.
   F. Swabs contaminated areas under the direction of the Health Physicist for subsequent survey.
   G. Monitors vital signs and records data.

3. Circulating Nurse/Nursing Assistant

   A. Assists team as necessary
   B. Labels all specimens provided by the RN.
   C. Obtains all needed supplies from outside the decontamination area from persons stationed at the entrance.
   D. Records on chart areas the levels of contamination as measured by the Health Physicist.

4. Health Physicist or Representative

   A. Monitors patients and decontamination team during the care of the patient.
   B. Is responsible for all surveys of the contaminated areas and patients.
   C. Directs the collection of the samples for subsequent analysis
   D. Is responsible for the proper collection and management of any radioactive wastes (solid and liquid) generated during the decontamination process.

5. Radiology Technician

   Ensures that portable x-ray machine is available to decontamination team.

DECONTAMINATION TEAM PREPARATION

1. Use restroom.

2. Attach monitoring badge to clothes after clearly printing name on badge provided by Health Physicist.

3. Dons full surgical dress including:

   A. Surgical trousers and scrub shirt.

   B. Surgical hood

   C. Waterproof shoe covers

   D. Surgical gown

   E. Surgical gloves taped to sleeves & cuffs to shoe covers

   F. Second pair of surgical gloves (non taped) change as needed if torn or contaminated

   G. Surgical mask

4. Attach outside dosimeter (provided by the Health Physicist).

   Read at intervals during decontamination; report readings to the Health Physicist as directed.

<u>PREPARATION IN THE EMERGENCY DEPARTMENT FOR ARRIVAL OF VICTIMS UNDER THE DIRECTION OF THE HEALTH PHYSICIST:</u>

NOTE: Acute Cardiac Room 4 is the primary radiation decontamination room. Acute Cardiac Room 5 will be used as another radiation decontamination room if there are multiple victims.

1. The designated nursing assistant(s) should:

   A. Cover floor. The entrance route of the patient will be through the Ambulance Entrance of the Emergency Department and the entire decontamination area shall be covered with heavy-rolled plastic taped to the floor. A strip of red tape shall be placed on the floor at the entrance to the radiation decontamination room separating this from the remainder of the Emergency Department care area to delineate the contaminated side from the decontaminated side (this is to be designated “the clean line”).

   B. Assist in the preparation of decontamination area.

   C. Remove all nonessential equipment placing it in heavy, clear plastic bags marked “non-contaminated”.

   D. Cover all nonexpendable items such as monitors that cannot be easily removed, with clear, plastic bags and tape.

2. Charge nurse ensures that decontamination table (morgue table with trough and liquid waste buckets) is obtained. Decontamination team (R.N., N.A.) are assigned as well as a

designated nurse to assist in obtaining supplies for the decontamination team from the Emergency Department.

3. Designated RN(s) should set up the room according to potential/actual patient injuries to include radiation contamination/injuries.

PREPARATION FOR PATIENT ARRIVAL

1. Physician and Health Physicist leave the emergency area gowned as described to examine the patient in the ambulance on arrival.

   A. Physician determines if the patient is critically injured:

      1. If the patient is critically injured, the patient is moved directly to the decontamination area whether or not clothes have been removed.

      2. If patient is not critically injured, his/her clothes are removed in the ambulance and he/she is gowned in a disposable paper gown.

      3. If the patient is dead on arrival, he/she is left in the ambulance and the medical examiner is contacted.

   B. Health Physicist determines by survey if the patient is contaminated:

      1. If patient is contaminated and is not critically ill, he/she goes to decontamination after clothes are removed.

      2. At the discretion of the Health Physicist, any uninjured but contaminated patients can assist with their own decontamination by utilizing the shower room located next to the ambulance entrance.

      3. If patient is not contaminated, he/she goes still dressed to the uncontaminated side of the emergency care area through regular channels.

2. The decontamination table (morgue table with trough) is brought to the ambulance to receive any contaminated patient(s):

   A. Patient is transferred to the decontamination table and;

   B. Patient is covered with a cloth sheet.

3. Ambulance attendants stay by the ambulance until they and the ambulance are surveyed for possible contamination by the Health Physicist or designee:

   A. If not contaminated, they are released for further duty.

B. If contaminated, they follow the Health Physicist's instructions for decontamination procedures.

PROCEDURES FOR DECONTAMINATION OF PATIENT

1. Physician does rapid initial assessment of airway, breathing and cardiovascular status as in any multiple trauma patient. Appropriate emergency stabilization maneuvers are instituted and initiated; essential medical, laboratory and radiographic data are obtained.

2. Secondary assessment with the assistance of a nurse and Health Physicist is performed, the patient's clothing (if not removed in the ambulance) is removed and placed in plastic bags marked "contaminated" and sealed.

   A. A general physical exam for further injury is performed.

   B. Cotton swab samples of ear canals, nose and mouth are obtained and placed in glass containers labeled with patient's name, site and time. If deemed necessary, urine and blood specimens are collected, as well.

   C. Glass containers are placed in a lead container for later analysis according to instructions from the Health Physicist.

   D. The Health Physicist monitors the entire patient including back.

   E. The nursing assistant/circulating nurse notes and records areas and amounts of contamination as given by the Health Physicist on standard burn chart.

   F. The R.N. obtains cotton swab samples of all contaminated areas under the direction of the Health Physicist and stores them under his/her direction.

3. Physical Decontamination of Radioactive Areas

   A. Contaminated open wounds:

      1. Irrigate thoroughly with normal saline for three minutes.
      2. Debride devitalized areas as necessary.
      3. Monitor and repeat irrigation as needed.
      4. If contamination persists, wash with three percent hydrogen peroxide.
      5. When wounds are decontaminated or debrided, save all products of surgical debridement and label as above.

   B. Contaminated eyes:

      1. Rinse with water, stream should flow from bridge of nose-to-temple, away from medial canthus.
      2. Monitor and repeat step 1 as needed.

C. Contaminated ear canals:

1. Rinse gently with small amount of water; suction frequently.
2. Monitor and repeat step 1 as needed.

D. Contaminated nares (nostrils) or mouth

1. Turn head to side or down, as the patient's medical condition permits.
2. Rinse gently with small amounts of water, suctioning frequently.
3. Prevent water from entering mouth in so far as possible.
3. Insert nasogastric tube into stomach; suction and monitor contents. If contents are contaminated, lavage with small amounts of normal saline until contents are returned free of contamination.

E. Contaminated intact skin:

1. Wash with surgical soap and scrub brush, gently scrubbing with the soft side of the brush for three minutes.
2. Monitor and repeat set up as necessary, using care not to irritate skin with harsh scrubbing.
3. If contamination persists, use lava soap.
3. If previous washing procedures fail to remove contamination, use Clorox either full strength for small areas or diluted for large areas.

F. Contaminated hair:

1. Shampoo with mild soap for three minutes and rinse.
2. Monitor and repeat step as needed.
3. If contamination persists, clip hair (do not shave scalp).

G. Grossly Contaminated Patients

1. At the discretion of the Health Physicist, the shower room located at the ambulance entrance, can be utilized to assist with decontamination.

NOTE: Any radioactive liquids generated from the above decontamination procedures must be collected for proper disposal, and not released to the sanitary sewer.

REMOVAL OF PATIENT FROM DECONTAMINATION AREA

l. Dry patient thoroughly treating all towels as contaminated.

2. Re-swab all previously contaminated areas:

A. Label swabs with site, time and "post-decontamination".

B. Health Physicist collects all specimens for later survey and monitoring.
C. Health Physicist then monitors patient's entire body.
D. New covering is placed on floor from exit of decontamination area to the patient and, if required, from clean stretcher outside decontamination area.
E. A fresh stretcher is then brought in and the patient is transferred to the stretcher by patient attendants not previously involved in the decontamination area but appropriately gowned with discardable protective clothing. The Health Physicist then monitors the stretcher and the wheels as it leaves the decontamination area over the clean floor covering.

EXIT OF DECONTAMINATION TEAM

1. Each team member goes to clean line at exit from decontamination area and removes protective clothing, placing all of it in a plastic bag marked contaminated and follows the procedure below:

A. Remove outer gloves first, turning them inside out as they are pulled off.
B. Give reading of dosimeter to Health Physicist.
C. Remove all tape at trouser cuffs and sleeves.
D. Remove outer surgical gown, turning it inside out; avoid shaking.
E. Remove surgical shirt
F. Remove hood
G. Pull surgical trousers off over shoe covers.
H. Remove shoe cover from one foot and let Health Physicist monitor shoe; if shoe is clean, step over clean line, then remove other shoe cover and have shoe monitored.
I. Take off inner gloves.

2. Have feet and hands monitored for final time.

3. Take shower. (Located in the staff bathroom)

NECESSARY MATERIALS LIST

1. Heavy polyethylene sheeting in rolls
2. Radiation warning tape
3. Survey meter (Cute pie and Geiger-Mueller tube)
4. Large sturdy bags (plain)
5. Surgical gowns, gloves, scrub suits, hoods and masks
6. Badges to be provided by Health Physicist
7. Dosimeters to be provided by Health Physicist
8. Wipe-test equipment including containers, swabs and appropriate charting and tables
9. Five-gallon, wide-mouth jugs labeled radioactive
10. Blood drawing and sampling equipment