CSMC ED Orientation

Parking

* ED doctors lot
* main doctors lot (code- 125).

Physical layout

* Breakroom
* Cafeteria/Drs cafeteria
* Eye room (puff tonometer and tonopen)
* Fast track
* Suture carts (12345)- in FT and between room 19/20
* Physician areas
* Dictation room

Cisco phones

Codes

* ER - 6:30a/6p doctor
* Inpt - 8a/7:30p doctor
  + Leave a note in the chart.
  + Fill out chart on computer(cardio/pulm arrest)
  + get copy of face sheet and code sheet from floor and place in basket in break room with a billing sheet (blank ones in the basket). If the code sheet hasn't been filled out, you can ask them to bring it to you in ED to sign.
  + On the back of the code sheet is a place to write in a debriefing comment for process improvement.
* Glide scope is available in ER and can be taken to floor, just ask nurse or medic if you need assistance.

STEMI

* Tell charge nurse
* Tell unit coordinator (secretary) to call interventional cardiologist
* Enter orders including EMR notify stat interventional cardiology and, if you want, there is an EMR STEMI care set
* Ask cardiologist which hospital pt is going to, BG or BHN.
* Ask cardiologist what meds they want given (plavix, heparin, etc.)
* Sign transfer paperwork.

Brain attack

* 10 min to see pt (usually seen by doctor in triage)
* Tell charge nurse
* Enter EMR brain attack orders (if <8 hrs and score >6 order)
* D/W neurologist – iPad (telemedicine) to eval pt (nurse will set up if needed)
* If needed, the neurointerventionalist on call can be consulted (transfer to BHN).
* Charge nurse will give you a brain attack sheet to fill out and return.

In-patient Brain attacks

* We respond, take the ipad.
* If you arrive and feel that it truly is a brain attack, run as you would in the ED with EMR brain attack order in the computer and neuro telemedicine.
* If the primary is present and wants to assume control, they can. Make sure they have an ipad, if not leave the ER ipad and make sure a tech stays or the charge nurse is aware so it can be retrieved.

Trauma

* Consult trauma doctor on call at BHN. Transfer if necessary.

Psyc

* Baker act – tell charge nurse and unit coordinator (they will print baker act form and transfer papers for you).
* Order appropriate labs: CBC, Chem, UA, Upreg, Utox, Stox, CPK
* When labs back, enter EMR dispo psyc and transfer into computer.

Sepsis

* LA, cultures (when in doubt, just order both), 3hr bundle, 30ml/kg for shock, reassess, etc
* Reassessment for LA > 4 and persistent hypotension after bolus necessitating pressors
  + See power point slides for reassessment drop down box

Consults

* If you need an on-call consultant to come in, make sure you tell them, "I need you to come in and evaluate the patient". They have 30min to respond to this by hospital bylaws.
* If you have any issues, have charge nurse bump this up the chain of command to the nursing supervisor.
* If consultant is not returning a call, also tell charge nurse to bump up to nursing supervisor.
* If you are admitting a surgical emergency/urgency to medicine, make sure that a call is placed to the surgeon while the patient is in the ER. You can ask the admitting doctor which surgeon they would like, or if truly emergent, call the on-call.
* SCP prefers the Shintre, Zaragoza, Shachner group for general surgery.

HTN

* PQRS 317 – add verbiage to d/c instructions for any BP > 120/80 (either as d/c instruction or saved as a macro)
  + We documented your blood pressure to be greater than 120/80mmHg. Blood pressure measurement in the Emergency Room is often abnormal. This can be due to many conditions, including pain and stress. We strongly recommend you follow up regarding your blood pressure reading with your primary care physician for further evaluation as we discussed. (or something like this)

Airway

* Glidescope
* Flexible videoscope (intubating endoscope)
* Both are in the code room.

Zika

* We are not testing in hospital, have patient f/u with their OB or department of health

Triage

* You may be called to see patients in triage if waiting times are backing up.

Prescriptions

* The preferred route of delivery is e-prescribe.
* Pharmacy info should be entered by registration. If not, you can enter it yourself, or ask registration to enter it.
* There is an outpatient pharmacy in the hospital during normal weekday business hours and overnight on a case by case basis.
* The case workers can authorize some prescriptions to be filled for free by the hospital if they are tax assisted (case by case basis).
* There is a pharmacist (Michael) in the ER that can answer pharm questions during the day.
* Publix gives some free prescriptions. Walmart and Target both have a $4 list.

Radiology

* Utilize IV contrast only CT when appropriate.
* CT ready column (\* for priority CT)
* If xray or ct is not getting read, ask charge nurse to investigate or call the tech.
* If you have a question, call the file room and ask to speak with the radiologist. They are always very helpful.
  + Day time call CS, after 5pm call NB or BG, after 11pm call BG.
  + Phone numbers on phone list

MLP

* Primarily run FT. If there are no FT patients or FT is closed, they can pick up regular patients in the main ED or help triage patients.
* Charts are sent to your inbox (message center tab) within 24 hours for cosign with an appropriate addendum.

Labs

* Once labs are sent, new orders can generally be changed to "Specimen in lab" under the collection priority.

Meetings

* Every 2nd Wednesday at 10am.
* Power point usually sent out morning of, call in number provided.

Metrics

* 90 min d/c
* 120 min admit

Charts

* Must be completed w/in 24 hours.

Computer issues

* Call HELP desk or ask unit coordinator or CN to call.

Downtime

* There are hand written T-sheets available in the rack (or you can wait until computers come back up and enter notes in computer). If you hand write, keep copies for your records, they have been known to go missing.
* Pts are hand written by CN on white board and downtime triage charts are placed on desk between doctors for new patients waiting to be seen.
* Sign up on white board when going to see new patient.
* Orders are hand written and given to clerks for entry.
* Results arrive by fax.

Pain medication

* We do not routinely give dilaudid in the ER. You may tell patients that this is the hospital policy. Of course, if the patient warrants it, you can give it.

Hurricane policy

* If you're here, you stuck! (until your relief can make it in) - As of right now (may change in the future).

Concussion clinic

* Place order for "Physical therapy OP Concussion" in the computer
* Save as d/c favorite "concussion clinic rehab services (954)344-3108.

Wound care OP

* Refer pt to Dr. Montejo or Bravo

Pregnant

* >20weeks with pregnancy related complication – straight to L&D, if already in a room, you can call and let the private OB or on call OB know your sending them up.

EKG's

* Triage EKG – sign and leave on middle of desk if nonemergent.
* Admit EKG's – give to clerk before pt leaves ER
* D/C EKG – place in basket behind case management

Case management

* Usually in ER 10-10 – place order in computer and let them know.
* If not in ER, they are often available in house. Have nurse or clerk page.

Uninsured follow up

* Refer to Pompano clinic (adult or prenatal) or central scheduling
* On d/c instructions click Organization/Clinic Search and then dropdown menu below

Reconcile

* Reconcile meds prior to d/c
* Tab on the top of the order screen.
* Meds can be renewed on reconcile screen by clicking the middle column.

US

* Kept in storage room. Code 125 or ask nurse.
* Long IV's and midlines available on machine.
* If ordering a US breast, make sure to tell the tech, it does not populate on their list. Can only be ordered in ED to r/o abscess.

Storage rooms

* Code 125

Sign out

* If everything complete and just waiting for admission, complete and sign the chart.
* If pt is definite d/c waiting for result, complete and sign chart and enter d/c instructions and scripts.
* If waiting for results that may impact care of patient, write on chart "signed out to …"
* If receiving a patient for simple admit or d/c, no further notation is needed, place star as warranted (can place under other drs. Name by right clicking on order)
* If receiving a pt "signed out to you" complete a new note under "Encounter Pathway" then type "addendum".
* Out going physician usually will move into dictation room to complete charts.
* 6:30-5:30 doc signs out to the 8-7:30 doc.
* 12:30-9:30 signs out to 7:30 –6:30 doc unless it’s a lot of patient, then they should be split up.
* Late doc overnight should sign up and try and place orders on pts they aren't going to see at the end of their shift (this improves our metrics and patient care). They may remove their name before leaving.

Needle sticks

* Employee – use employee health folder. HIV/hep are NOT ordered in computer – use preprinted lab slip.
* Nonemployee – no hard and fast rules, may refer to employee folder for guidance.

MIPS

* Female abd pain preg test
* PE – anticoagulant and document reason for CTA
* CT for blunt head trauma – document reason
* Health counseling
* Sepsis
* Foley – document reason
* ED median time

Foleys

* We are trying to avoid all foley in the ED as per new hospital protocols.

Splint

* Order "splint" and fill in
  + Side
  + Type
  + Apply to

Transfers

* Let charge nurse and clerk know, there are 2 sheets that need to be filled out.
* Common transfers:
  + STEMI – NB or BG
  + Trauma - NB
  + Psyc – charge nurse or case manager
  + Ophtho – if not on call
  + Burn – to Jackson usually
  + Complex Hand cases – Try plastics, then ortho, if no then transfer to NB or BG
  + Aortic dissection – To BG
  + Neuro intervention - NB or BG