

<b>Hospital Name</b>	
<b>Section:</b> Emergency Department	<b>Policy Description:</b> Initiation of Treatment Protocols in the Emergency Department
<b>Pages:</b>	<b>Revised:</b>
<b>Approved Date:</b>	<b>Reviewed:</b>
<b>Effective Date:</b>	<b>Reference Number:</b>

**Purpose:**

To provide guidelines for initiation of treatment protocols in the emergency department.

**Scope:** Emergency Department Triage Area

**Responsibility:** All Staff

**Policy:**

All patients presenting to the emergency department with an emergency medical condition will be provided care and treatment in a timely manner. The goal is to expedite care as soon as acuity can be determined when a physician or licensed independent practitioner (LIP) cannot immediately physically initiate the medical screening exam for the patient. In addition, conditions of volume and patient flow in the emergency department may dictate that the physician/LIP initiating the order may not be the physician/LIP of record for a particular patient visit.

In order to initiate diagnostics and treatment when necessary in the triage area or department the following processes must be in place:

- A mechanism to alert charge nurses and physicians that patients categorized as “Emergent” are in the triage area or department.
- A process to correctly initiate Emergent Orders in the triage area.
- A process to request intervention for patients categorized as “Non-Emergent”: *Urgent; Semi-Urgent ; Non-Urgent.*
- Previously approved Treatment Order Sets based on chief complaint and symptomology

**Procedure:**

To initiate Emergent order sets in the triage area, the triage nurse must:

- Determine that the patient is a Triage Acuity 2 (Emergent)
- Notify charge nurse and physician/practitioner that an emergent patient has presented.
- Initiate appropriate Treatment Order Set with no deviation. Contra-indications to any order need to be documented (i.e., med allergies)

- Keep patient in triage area and facilitate movement to an appropriate emergency department bed as soon as possible

To initiate Non-Emergent order sets in the triage area, the triage nurse must:

- Determine that the patient is non-emergent (Triage Acuity 3, 4 or 5)
- Notify the physician or practitioner of the need for diagnostic or therapeutic intervention.
- Notify physician/practitioner of the need to initiate a medical screening exam.
- Take verbal order for requested order set and specific interventions if no MSE can be performed immediately and waiting will be required.
- Execute orders according to department and facility policy as directed by the physician/LIP.
- Assure results of diagnostic tests are brought to the attention of the physician/practitioner.
- Assure correct Evaluation agreement is signed by the patient

### **Documentation Elements:**

All order sets must be appropriately documented upon and signed by both the RN carrying out the orders and the physician/practitioner responsible for initiating the order. Order set documentation is a part of the permanent patient medical record.

In addition, patient evaluation agreement (either addressing order set initiation prior to MSE or following initiation of MSE) must address the patient's mental status and be signed by both the patient and provider for inclusion in the patient's medical record.

Facility must also outline a discrepancy follow-up process to address issues such as (but not limited to) those listed below and document such on each patient that leaves after care is initiated but is not necessarily completed:

- Lab results initiated that come back positive or abnormal or Critical Values
- An escalation process commensurate with the level of urgency of the information that is communicated to the patient
- A process to ensure all follow up steps and any escalation is connected to the medical records.
- Create a call back system to patients that leave without conclusion of their visit even when results are negative.
- Ensure the Non-Emergent patients waiting are fully/actively registered in a timely mechanism.