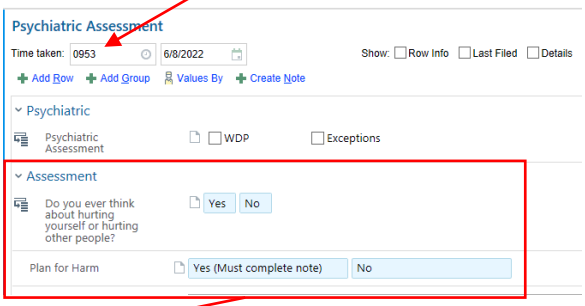
AT THE FOREFRONT UChicago Medicine

## Emergency Department

# Psychiatric Documentation Requirements

**#1 Tip** *Psychiatric Assessments in ED Narrator required every 4 hours or sooner on all psych patients*

Do not forget to adjust your time




**#2 Tip** *Suicidal and Homicidal Patients also require a Safety Assessment under the Suicide/Homicide Observation tab in the flowsheets every 4 hours*

| Safety Assessment (Must Be Completed By RN Every 4 Hours) | | | |
|---|---|---|---|
| Ask Patient: Do You Feel Safe... | | | |
| Do you ever think about hurtin... | Yes | | |
| Plan for Harm | No | | |
| RN Instructed NSA/ERT on Su... | | | |

The Psychiatric Assessment will automatically populate 2 of the 4 questions

**#3 Tip** *Violent Restraint Documentation*

*Every 15 minutes under the Restraint: Violent/Self-Destructive tab in Flowsheets except:*
*VIOLENT Order/Justification/Alternatives (Every 4 hours)*
*VIOLENT Patient Monitoring (Every 2 hours)*

| VIOLENT Order/Justification / Alternatives (Once Per Length of Order) | | | |
|---|---|---|---|
| Length of Order | 4 hours (Age 18... | | |
| Less Restrictive Alternatives | Patient Moved... | | |
| Response to Alternatives | Ineffective | | |
| Notify Family | Patient Decline... | | |
| Education | Reviewed all po... | | |
| Patient's Response to Education | Verbalized Und... | | |
| **VIOLENT Restraint Type** | | | |
| Restraint Used | Yes | Yes | |
| Locking Left Ankle | CONTINUED | CONTINUED | C |
| Locking Right Ankle | CONTINUED | CONTINUED | C |
| Locking Left Wrist | CONTINUED | CONTINUED | C |
| Locking Right Wrist | CONTINUED | CONTINUED | C |
| **VIOLENT Provider Communication** | | | |
| Physician Notified w/in 1 Hour | Yes | Yes | |
| **VIOLENT Patient Monitoring (Every 15 Minutes)** | | | |
| Location Change | Other (Pleas... | Other (Please s... | |
| 1:1 Continuous Observation | Yes | Yes | |
| Psychological Status | Alert | Alert | |
| Circulation | Peripheral puls... | Peripheral puls... | Periphe |
| Skin Integrity | No Signs of Injury | No Signs of Injury | No Sig |
| Rights, Dignity, and Comfort | WDP | WDP | |
| Ready for Discontinuation | No | No | |
| **VIOLENT Patient Monitoring (Every 2 Hours)** | | | |
| Physical Status | Agitated/Restless | Calm | |
| ROM | Declined | Declined | |
| Hygiene | Offered | Offered | |
| Hydration | Offered | Offered | |
| Nutrition | Offered | Offered | |
| Elimination | Offered | Offered | |
| **OTHER** | | | |
| BH Restraint Status | CONTINUED | CONTINUED | C |

| Non-Violent Order/ Justification / Alternatives (At Least Every 24 Hours) | |
|---|---|
| Length of Order | 24 hours |
| Less Restrictive Alternatives | Patient Moved... |
| Response to Alternatives | Ineffective |
| Family Notification | Other (Com... |
| Education | Reviewed all p... |
| Patient's Response to Education | No Evidence of... |
| **Non-Violent Restraint Types** | |
| Restraint Used | Yes |
| Soft Wrist (Left) | START |
| Soft Wrist (Right) | START |
| **Non-Violent Patient Monitoring (Every 2 Hours)** | |
| Location Change | Other (Please... |
| Physical Status | Agitated/Restless |
| Psychological Status | Confused |
| Circulation | Peripheral Puls... |
| Skin Integrity | No Signs of Injury |
| Range of Motion | Performed |
| Hygiene | Offered |
| Hydration | NPO |
| Nutrition | NPO |
| Elimination | Offered |
| Rights, Dignity, and Comfort | WDP |
| Ready for Discontinuation | No |

**#4 Tip** *Non-Violent restraints every 2 hours under the Restraint: Non-Violent/Non-Destructive tab in flowsheets except:*
*Non-Violent Order/Justification/Alternatives (Every 24 hours)*

***Remember to obtain a new order anytime a restraint is discontinued***
****Remind the ER MDs to add an order for Violent restraints every 4 hours and Non-Violent every 24 hours****

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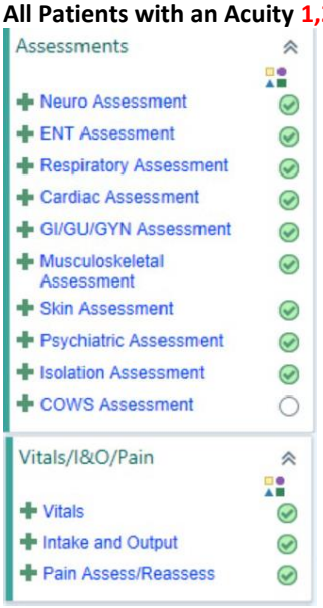
# Adult ED Documentation Standards

| | |
|---|---|
| **All Patients with an Acuity 1,2,3**<br>  | Head to Toe Assessment w/ Vitals including Pain Assessment: (refer to policy Adult ED 10.1)<br>• Airway with Cervical Spine Immobilization as needed<br>• Breathing (Respiratory)<br>• Circulation (Cardiovascular)<br>• Disability (Neurologic)<br>• ENT<br>• GI<br>• Musculoskeletal<br>• Skin<br>• Cardiac<br>• Psychiatric if presents with behavioral health complaint<br>• Reassess pain: within 30 minutes for IV/IM meds; within 60 minutes for PO/gastric tube<br>***A Head to Toe Assessment including pain by each RN at point of entry into the department, transfer of care, and beginning of each shift.*** |
| **Q 1 Hour (*or more frequent if condition warrants)*: Critical Care**<br>• *Patient meets criteria for admission to an Intensive Care Unit*<br>• *Acute cardiovascular compromise*<br>• *Acute altered mental status (GCS <15)*<br>• *Acute respiratory distress* | • Telemetry visually reviewed for changes from baseline rhythm<br>• Vital Signs w/ Pain Assessment *(in addition Level 1 & 2 Trauma patients will have vital signs every 15 minutes for the first hour)*<br>• Level of consciousness and activity level (any deviation from baseline)<br>• Intake/Output, i.e. Enteral feeds on MAR; Chest tube output<br>• Oxygen/Ventilator settings<br>• Unit/patient specific documentation (Blood Glucose, Neuro checks, pulses, etc.) |
| **Acuity 4.5** | The initial assessment will occur within 1 hour of being roomed. Initial and ongoing assessment includes the following: (refer to policy Adult ED 10.1)<br>• Airway patency<br>• Breathing effectiveness<br>• Circulation and end-organ perfusion<br>• Skin temperature and color & color of the mucous membranes<br>• Pulse rate and quality<br>• Level of consciousness and activity level (deviation from baseline)<br>• Intake and output when providing fluid for hydration<br>• Pain and discomfort with initiation of non-pharmacologic and pharmacological pain control measures, as indicated<br>• Body systems, as appropriate, based on assessment findings and desired outcome. |
| ****All Patients**** | ***VS should be obtained 60 minutes prior to departure from department*** |
| **Q 2 Hour: Critical Care and Non-Critical Care** | • Medical restraint documentation (refer to policy PC27, "Restraints and Seclusion") |
| **Q 4 Hour (*minimally*): Critical Care and Non-Critical Care** | • Ongoing Assessment |

# Adult ED Documentation Standards

| | |
|---|---|
| | ○ Note that the "no change "(NC) selection may only be used by the same RN as identified by the previous documentation.<br>○ Airway patency<br>○ Breathing effectiveness<br>○ Circulation and end-organ perfusion<br>○ Skin temperature and color & color of the mucous membranes<br>○ Pulse rate and quality<br>○ Body systems, as appropriate, based on assessment findings and desired outcome.<br>• Telemetry Documentation (refer to policy PC211E)<br>○ Rhythm, alarm review, HR parameters<br>○ "no change" when appropriate<br>• WALDO Flowsheet- IV and/or Central line assessment for placement, patency, and signs of infiltration or extravasation every 1-4 hours and PRN depending on infusate (refer to policy PC 231 "Peripheral Vascular Access Devices" and policy PC230, "Central Vascular Access Devices")<br>• Vital Signs w/ Pain Assessment (*for non-critical care patients)* |
| **Q Shift**<br>*(Of any length, a "shift" is to be considered any period of patient care)* | • Head to Toe Assessment including pain<br>• Psychological Assessment (refer to policy PC104, "Suicide Risk Screening")<br>• Fall Risk (refer to policy PC149, "Falls Prevention")<br>• WALDO Flowsheet<br>• Wound/Ostomy/Drain assessed and documented<br>• Intake & Output |

# PAIN ASSESSMENT & DOCUMENTATION

The frequency of reassessment should be based on the individual patient's pain level and report of acceptable level of pain (goal score). Minimally, this would include the following:

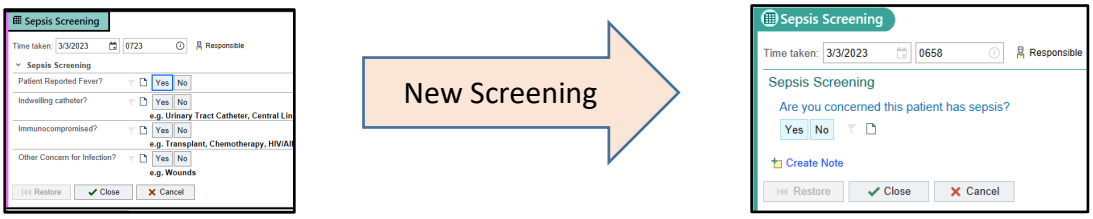
1. With each scheduled set of vital signs and more often as warranted by patient condition or acuity.
2. After each known pain-producing event
3. After each pharmacologic/non-pharmacologic intervention once sufficient time has elapsed for the treatment to reach peak effect (exception: when patients are receiving scheduled pain medications and report an acceptable pain score/are at goal score reassessment is not required)

# Emergency Department

## Improving Sepsis Screening & Activation Process

**WHAT IS CHANGING:**

The sepsis screening during the triage process is being enhanced. We are moving from a four question screen to one question. Additionally, we are creating/re-instituting a "Sepsis" activation process to make the care team aware of this concern and to bring the appropriate staff to the patient's bedside.




**WHO IS DOING IT:** Nurses in the Emergency Departments will continue to perform the sepsis screening and if concerned for sepsis, will communicate this to the team.

**PROCEDURE**

1. Sepsis Question to be asked by the nurse completing triage process in WR or in treatment space: "Are you concerned this patient has sepsis". If "yes" concerned, the Physician will receive a "static" BPA (example shown→)
    1. Inclusion: All patients will receive sepsis question
    2. Exclusion: trauma activation, "to L&D" disposition


2. WR reassessment nurse will evaluate this question and update as needed
3. When identifying concern for sepsis
    1. From WR, nurse will notify charge nurse for a room assignment. If rooms not available, will place into Resuscitation Room
    2. If EMS arrival/direct to room
    3. Charge Nurse to overhead page "Sepsis Alert, Room XYZ"
4. Responders
    1. Minimally: Primary RN, ERT, Resident
    2. Additional: Pharmacist, Attending, Others
5. Patient is placed in room
    1. Triage Nurse will communicate the concern for sepsis with responders
    2. Physician to evaluate and make decision on initial treatment


**WHAT IS SEPSIS and HOW TO TREAT IT**

**Sepsis:** A clinical syndrome of life-threatening organ dysfunction caused by a dysregulated response to infection. Diagnosis is suggested by two or more SIRS criteria plus clinical concern for infection. **Severe sepsis is defined** as sepsis plus one or more variables of organ dysfunction.

**Signs and symptoms of sepsis:** Hyperthermia, hypothermia, tachycardia, diaphoresis, tachypnea, hypotension, oliguria, delirium/confusion, alteration of mental status, multi-organ system failure (e.g. acute respiratory failure, acute renal failure, liver failure, encephalopathy).

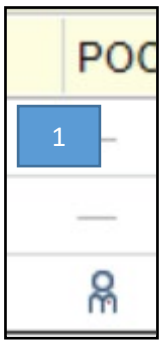
**Key words/phrases include:** systemic inflammatory response syndrome (SIRS), septicemia, urosepsis, bacteremia, bandemia, left shift (increase in neutrophils with a decrease in lymphocytes), lactic acidosis, rigors, chills.

**Treatment:**

- Perfusion restored with IV fluids; Vasopressors (e.g. norepinephrine, vasopressin, dopamine); O2 support and monitoring; Broad-spectrum IV antibiotics administered as soon as possible; Source control of underlying infection (Surgical excision of infected or necrotic tissue and drainage of pus); Supportive measures (e.g. corticosteroids, insulin)

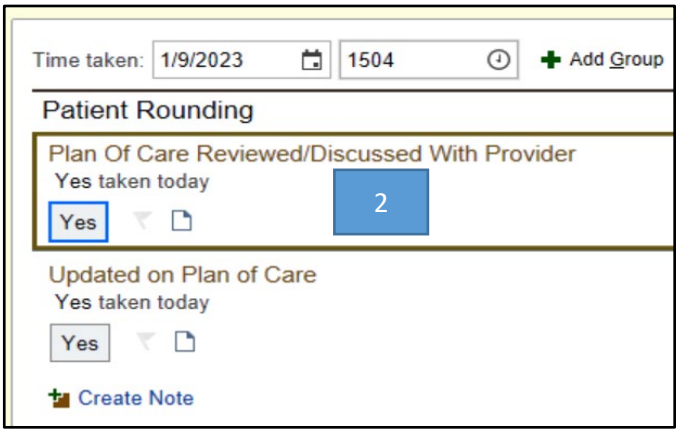
# Emergency Department
## Improving Plan of Care Process

In continuation with our process to improve the Plan of Care communication rolled out in July 2022, we have modified the documentation of the Plan of Care process. You will now notice a new column named POC (Plan of Care) with an icon in the "All Patients" and "My Patients" Epic trackboard views.

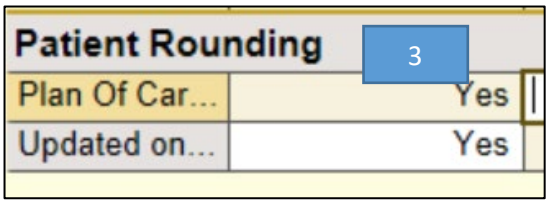



1. Trackboard column showing Plan of Care column. In the Adult ED, the icon will be visible after 3 hours from the time the patient is placed into a room, and will reoccur every 3 hours. In the Pediatric ED, the icon will be visible after 2 hours, and will reoccur every 2 hours. Example-(picture 1)

2. When clicking on the trackboard column icon, you are able to document directly into the flowsheet pop-up (picture 2). The intention of this documentation is to capture conversation with our provider colleagues related to the patient Plan of Care and that the patient is also aware of their POC.




3. Patient Rounding documentation is visible in the Pop-Up Flowsheet (picture 2) and in the Flowsheets under "Patient Rounding" (picture 3).




4. Patient Rounding documentation is also visible in the ED Narrator under the Narrator timeline, (picture 4).