

## 1: High acuity patients in Minor Care and low ER staffing | allnurses

*High acuity patients needs lots and lots of care. Most nurses say the system works badly. An intensive care nurse wrote that a high acuity patient on the ICU mean one that without constant intensive care would die.*

Macones, MD; Christian M. Pettker, MD; Maria A. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Emergency departments typically have structured triage guidelines for health care providers encountering the diverse cases that may present to their units. Such guidelines aid in determining which patients must be evaluated promptly and which may wait safely, and aid in determining anticipated use of resources. Although labor and delivery units frequently serve as emergency units for pregnant women, the appropriate structure, location, timing, and timeliness for hospital-based triage evaluations of obstetric patients are not always clear. Hospital-based obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women. Recently developed, validated obstetric triage acuity tools may improve quality and efficiency of care and guide resource use, and they could serve as a template for use in individual hospital obstetric units.

**Recommendations** Hospital-based obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women.

**Introduction** This Committee Opinion focuses on hospital-based triage of obstetric patients and attempts to offer approaches and frameworks for triage that are applicable to any center providing obstetric care. The concept of triage comes from the military, where workers in field hospitals use systematic principles to evaluate and prioritize how quickly wounded soldiers are fully evaluated and treated. Triage in hospitals typically is associated with emergency departments that aim to categorize and prioritize patients who present for emergent or urgent care before detailed evaluation and management. In a study of one large center, up to one third of evaluated women did not give birth at that time and were sent home or to another unit at the completion of their evaluation and management 2. Pregnant women most commonly present for evaluation for labor at term. However, preterm labor, signs and symptoms of preeclampsia, decreased fetal movement, preterm premature rupture of membranes, vaginal bleeding, and acute abdominal pain also are reported frequently. Acute and critical conditions, such as motor vehicle collision injury, large abruptio placentae, or seizure, are less common, but they demand immediate attention and management. Pregnant patients could present for care to any institution providing urgent or emergent care. However, obstetric patients are best served if local emergency services develop protocols whereby pregnant patients are taken to the most appropriate facility, which may be a designated obstetric care center, with pregnancy status, level of acuity, and distance travelled all being important factors 3. Guidelines from local and national regulatory organizations eg, state Department of Public Health, the Joint Commission should be followed. The federal Emergency Medical Treatment and Labor Act EMTALA requires an initial medical screening examination to determine if a true medical emergency exists; in the case of a pregnant woman, this includes evaluation of the woman and the fetus. The medical condition of a woman having contractions is not considered an emergency if there is adequate time for her safe transfer before delivery or if the transfer will not pose a threat to the health or safety of the woman or the fetus 4. An individual or individuals determined qualified as designated by hospital policy must perform an appropriate medical screening examination to determine whether the patient has an emergency medical condition. This determination should take into account the health of the woman and the fetus. If an emergency medical condition is determined to exist, stabilize the patient or transfer her if the obstetric care provider certifies that the benefits of transfer outweigh the risks. In the case of the latter, a written certification is required. When necessary, arrange for transfer to another appropriate facility if the patient is stabilized or if the benefits of transfer outweigh the risks. Transfer should be carried out by qualified personnel and transportation equipment. Patients can decline transfer after being informed of the risks and benefits of transfer. Appropriate medical screening cannot be delayed to

inquire about payment method or insurance status. In the situation of preterm labor or preterm premature rupture of membranes, transport of the woman in labor is recommended if time allows 4. Antenatal transfer is associated with improved neonatal outcomes compared with neonatal transfer. Typical triage protocols involve an initial assessment and decision about the priority level for evaluation. In the case of the pregnant patient, this assessment may be conducted by a registered nurse, certified nurse-midwife or certified midwife, nurse practitioner, physician assistant, or physician as designated by hospital policy. Triage is followed by the complete evaluation of the woman and the fetus by a health care provider with skills and training appropriate to evaluate the issues identified during triage. These elements will vary based on the issue at hand, and a full review or listing is beyond the scope of this document. Although a separate triage area and standing orders may facilitate care for obstetric triage patients, having an available health care provider appears to best optimize patient flow and reduce length of stay 6. The use of certified nurse-midwives or certified midwives who provide obstetric emergency care triage services, for example, may improve efficiency, reduce length of stay, and improve screening and evaluation 7. For a given center, the obstetrics department, in conjunction with the other appropriate departments, should establish written guidelines defining the appropriate unit to evaluate obstetric patients based upon criteria such as gestational age and delivery status, symptoms, medical condition, and available medical staff. For instance, some nonobstetric conditions eg, highly transmissible infectious diseases like influenza or varicella, critical traumas, and acute chest pain may be better treated in another area of the hospital, regardless of gestational age. Conversely, many postpartum conditions may be best addressed by labor and delivery staff. Disaster preparedness plans should include care of pregnant women 3. For all of these reasons, coordination and communication between obstetric and emergency departments, as well as hospital ancillary services, is critical 3. Emergency departments should consider early consultation with obstetric care providers when triaging and managing pregnant patients, especially for patients beyond the first and early second trimesters. To be considered an appropriate location to evaluate and care for pregnant patients, a unit should have the ability to perform basic ultrasonography and fetal monitoring. In cases that involve a woman with a viable pregnancy who is evaluated outside of an obstetric unit, it may be necessary to bring these resources from the obstetric unit to the location of the patient. Triage algorithms for obstetric acuity to assess and assign priority to obstetric patients may be useful. Women should be cared for according to triage acuity rather than by time of arrival. The Emergency Severity Index was designed by the Agency for Healthcare Research and Quality to triage nonpregnant adults and has been adopted by many emergency departments 8. Several obstetric triage acuity tools have been developed based on this model. Several of these tools have been tested for content validity 10 and interrater reliability 11 , 12 and may be used to improve quality and efficiency of care and guide allocation of resources. Hospital obstetric units are encouraged to develop triage protocols based on local conditions but informed by evidence-based decision making. Examples are trauma from motor vehicle accidents, falls, and intimate partner violence. The MFTI is designed to guide clinical decision-making but does not replace clinical judgment. Vital signs in the MFTI are suggested values. Values appropriate for the population and geographic region should be determined by each clinical team, taking into account variables such as altitude. Content validity testing of the maternal fetal triage index. J Obstet Gynecol Neonatal Nurs ; For More Information The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at [www.](http://www.) These resources are for information only and are not meant to be comprehensive. The resources may change without notice. Guidelines for professional registered nurse staffing for perinatal units executive summary. Toward a concept of triage for labor and delivery: J Perinat Neonatal Nurs ;4: American College of Obstetricians and Gynecologists. Guidelines for perinatal care. Elk Grove Village IL: American College of Obstetricians and Gynecologists; J Midwifery Womens Health ; A systems analysis of obstetric triage. J Perinat Neonatal Nurs ; The utilization of nurse-midwives as providers of obstetric triage services. Results of a national survey. J Nurse Midwifery ; Implementation handbook, edition. Agency for Healthcare Research and Quality; Retrieved March 14, Interrater reliability testing of the Maternal Fetal Triage Index. Implementing an obstetric triage acuity scale: Am J Obst Gyn ; No part of this publication may be reproduced, stored in a

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### 2: Rapid response team (medicine) - Wikipedia

*Anecdotally, high-acuity, high-volume emergency departments will admit 20% to 25% of cases to the hospital. Compared with the outpatient setting, a greater number of emergency department patient encounters require a diagnostic workup.*

Army Retired , and health care consultant; e-mail: These requirements, or patient acuity, could then be used to manage nursing personnel resources, costs, and quality. Paramount among these are a validity and reliability are infrequently monitored; 4 , 5 b the tools are often complex and require considerable time to complete; 4 c they lack credibility among staff nurses and administrators; 5 , 6 d they are not designed to detect census variability throughout the day from patient movement due to admissions, discharges, transfers, and short-stays; 7 , 8 and e their focus on tasks shortchanges the cognitive work and knowledge inherent to expert nursing care and sophisticated surveillance. Patients were said to be sicker and leaving health care facilities more quickly. Concerns about rising patient acuity continue into the new millennium because of the relentless change that is now common in health care. Moreover, acuity is one of many elements that comprise the often used but not yet well specified concept of workload. First, most of the research reports are about developing or comparing instruments to measure patient acuity. Unlike early PCSs that were designed for medical-surgical patients in acute care facilities, these instruments are tapping into other care settings such as long-term care, 13â€™17 home care, 18 , 19 emergency departments EDs , 20â€™28 and neurological rehabilitation centers, 29â€™33 to name but a few. There is little evidence, however, regarding the extent to which these tools are being used. Second, most reports simply mention that patient acuity is increasing without supporting data. Only four studies actually examined trends in patient acuity to empirically substantiate perceptions that acuity is rising. Interestingly, these investigations were all conducted outside the United States. PCS scores were compared over 3 months in and the same period in for critical care patients in one Australian hospital. Although the PCS scores followed similar patterns in and , the PCS scores were higher for all shifts in Monthly PCS data from 17 units in a Swedish hospital indicated that average scores in each of four acuity categories increased from to However, they also demonstrated discrepancies between actual and required staff, with the actual staff consistently lower than required. This gap has also been observed in U. The least complex patients declined by 24 percent, and the most complex patients increased by percent, representing an overall increase of percent for the most complex patients. The fourth study examined care needs for long-term-care LTC residents in Alberta, Canada, between and Finally, studies were rarely designed to assess patient acuity in relation to patient outcomes. Of those shown in Table 1 , three evaluated heterogeneous groupings of patients in acute care settings. One study focused exclusively on critical care patients, 41 and another considered only obstetrical care for teenagers. Although three studies showed a positive association between acuity and adult mortality, 38 , 40 , 41 findings were more equivocal for the relationship between acuity and neonatal mortality rates. The investigators who studied critical care patients concluded that variations in mortality might be partially explained by excess workload. As expected, the two studies using the same dataset 38 , 40 both showed similar resultsâ€™ a positive relationship between acuity and adverse outcomes such as infections and decubiti, but not medication errors and falls. The third study was conducted on 32 units in a different hospital. Rather, acuity was a significant predictor of various self-care measures such as symptom management. The ED study assessed patient satisfaction as the outcome measure. However, when perceived throughput time was controlled, acuity did not predict satisfaction with ED care. The importance of patient perceptions was clearly in effect in determining satisfaction. Research Implications At present, very little is known about the relationship between acuity and outcomes. The lack of a standardized approach to measuring acuity has broad research implications. For investigations using PCSs, reports need to include information about the psychometric properties of the tools. It would also be helpful to examine the relationship of PCS acuity to clinical outcomes using more homogeneous patient groupings. Perhaps the most important research issues concern greater clarity about the larger conceptâ€™ workload. There is an urgent need to develop a conceptual model illustrating the relationships of the various elements comprising workload as

well as a standardized definition of workload. Empirical testing of the model might then better elucidate how acuity, as one aspect of workload, relates to patient safety. It would also be very helpful if U. It would be most beneficial if these studies looked not just at acuity in the aggregate, but also at acuity for homogeneous patient populations. This could help clarify whether acuity for medical-surgical patients has escalated. Finally, it would be useful to have a sense of acuity in the outpatient setting, given how patient care has shifted. Although outpatient acuity is particularly difficult to capture, it remains a research challenge for the future.

**Conclusion** Patient acuity is a concept that is very important to patient safety. Presumably, as acuity rises, more nursing resources are needed to provide safe care. Very little research has actually been conducted, however, to verify this premise. Moreover, findings from the research that has been conducted are largely inconsistent. Design issues account for these differences. In addition, it is possible that factors other than patient acuity may contribute more to patient outcomes. It remains important to derive a much better grasp of the relationship between patient acuity, outcomes, and patient safety. At present, little can be said with confidence about this association. A reference librarian assisted in choosing the search terms. The abstracts for all citations were reviewed. Of these, were considered to be potential candidates for use in this review. The references that were excluded from this assessment included a wide array of topics that were irrelevant to patient acuity. The diversity of these articles is too great to provide a complete view of them, but a few examples include quality of life, menstrual cycle abnormalities, blood pressure variability, and fever management for children. After reading the candidate articles in their entirety, an additional 72 papers were omitted from the remainder of the analysis. Papers were excluded because they were more tangentially related to patient acuity e. As a result, this review was based on findings from 32 research reports. They conducted the database searches and assisted in acquiring numerous papers considered in this review. Abdellah FG, Levine E. Work-sampling applied to the study of nursing personnel. Malloch K, Conovaloff A. Patient classification systems, part 1: Using patient acuity data to manage patient care outcomes and patient care costs. Patient classification system evaluation, part I: Can you depend on your patient classification system? Improving the ability to detect the impact of labor on patient outcomes. Analyzing fluctuating unit census for timely staffing intervention. Intensive Crit Care Nurs. Patient requirements for nursing care: The development of an instrument. Can J Nurs Adm. Alternatives for minimum nurse-to-patient ratios. Clocking care hours with workload measurement tools. Prevalence and characteristics of nursing homes residents requiring light-care. What would VA nursing home care cost? Methods for estimating private sector payments. Is it adequate for nurse staffing? Reliability and validity of a new preadmission acuity tool for long-term care. A preliminary casemix classification system for home and community care clients in Western Australia. The development, validity and reliability of the hospital in the home dependency scale HDS. Aust J Adv Nurs. The Emergency Severity Index triage algorithm. Version 2 is reliable and valid. A system for grouping presenting complaints: The pediatric emergency reason for visit clusters. Maldonado T, Avner JR. Triage of the pediatric patient in the emergency department: Are we all in agreement? Reliability and validity of scores on the Emergency Severity Index Version 3. Refining Emergency Severity Index triage criteria. Reliability and validity of the Toowoomba adult trauma triage tool: Implementation and refinement of the Emergency Severity Index. Measuring nursing needs of stroke patients in clinical rehabilitations: Critical care dependency tool: Levenstam AK, Bergsbom I. Coding response to a case-mix measurement system based on multiple diagnoses. PMC ] [ PubMed: Concerns identified by population and care trends.

### 3: Emergency and acute medical care in over 16s | Guidance and guidelines | NICE

*WHO's Emergency, Trauma and Acute Care programme is dedicated to strengthening the emergency care systems that serve as the first point of contact with the health system for so much of the world, and to supporting the development of quality, timely emergency care accessible to all.*

Throughout medical school, you will encounter patients in many clinical arenas: Although medicine at its core involves taking care of patients, the approach and sequence of steps involved in caring for patients will be different depending on the health care setting in which they are encountered. When evaluating a patient, the health care provider nurse, medical student, resident, or attending needs to develop an approach tailored to the specific health care setting and available resources. Think of the ambulatory care and hospital outpatient clinic setting. In this clinical venue, unexpected emergencies occur; however, they are few and far between. Some patients will require diagnostic studies laboratory tests or diagnostic imaging. Fortunately in this setting, the majority of these are routine, and most are obtained electively. Many patients requiring diagnostic studies will need to be referred to an off-site laboratory, diagnostic imaging center, or hospital to undergo testing. Therefore, the results of many of these diagnostic studies are not available to the ordering physician for days. Although many private offices and outpatient clinics have a system in place allowing unscheduled walk-in visits, the overwhelming majority of patient visits are scheduled, and patients are cared for on a first-come-first-served basis. When patients are sick, or when the office is closed, patients are referred to the emergency department. In addition, the majority of patients seeking medical care in an ambulatory care or outpatient clinic setting are established patients compared with the emergency department, where the overwhelming number of physician-patient encounters are new visits.

**Case Study** Consider the patient with an elevated blood pressure measurement who is referred to the emergency department for evaluation from a local health clinic. The patient is asymptomatic, without complaints of headache, chest pain, or shortness of breath. The goal is not necessarily to establish baseline laboratory values, to obtain diagnostic studies for future comparison or even to necessarily normalize the blood pressure at this time. Traditionally, approximately half of all outpatient encounters are made to primary care physicians, with many of these visits being for preventive care. The most common reasons for a patient to visit an outpatient clinic include progress visit, general medical examination, routine prenatal care, cough, and sore throat. By contrast, the emergency department provides care to the acutely ill or injured. In the emergency department, nursing triage guidelines are designed to ensure that more seriously ill patients are cared for first. The acuity level is also much greater than the ambulatory care or outpatient clinic setting. Compared with the outpatient setting, a greater number of emergency department patient encounters require a diagnostic workup. This may include laboratory tests or advanced imaging techniques such as CT scans and magnetic resonance imaging (MRI). The majority of diagnostic tests performed in the emergency department by design provide results to the ordering physician within minutes to hours. Although some patients will present to the emergency department with complaints that could otherwise be cared for in an ambulatory care setting, many unexpected emergencies such as trauma, myocardial infarction, stroke, pneumonia, anaphylaxis, and others come through the doors at all hours of the day and night. Some of these cases require emergency subspecialty consultation, a service that is often difficult to provide in an ambulatory care setting. In addition, the emergency department has both an ethical and legal obligation to evaluate every patient who presents for care to determine whether he or she has a medical emergency, regardless of ability to pay for health care Emergency Medical Treatment and Active Labor Act or EMTALA. These institutions serve a disproportionately high number of Medicaid and uninsured patients, a dramatically different payer mix than that of the routine ambulatory care population. In the inpatient setting, patient encounters often occur after a preliminary or definitive diagnosis has been made by another health care provider, many times by the emergency physician. Physicians caring for inpatients face legitimate challenges, some diagnostic, others therapeutic or social, such as short- or long-term placement issues. We all know that medical emergencies occur in the inpatient population; luckily they are not as common as in the emergency department. The emergency department also differs dramatically from both the

inpatient and ambulatory care setting in a few other areas. First and foremost, the emergency department never closes, and the volume of patients cared for is not limited by the number of patient care spaces. Although it is foreseeable that patients with nonurgent complaints will need to wait until an appropriate patient care area is available before they will be evaluated, the sick or unexpected emergencies are at times cared for in less-than-optimal patient care areas, such as a hallway. In the emergency department, the spectrum of patients ranges from the young to the very old, representing disease states of the newborn to the various complications seen in the elderly nursing home resident. The clinical scenarios encountered are also unique to this setting and can range from routine medical and surgical pathology to environmental emergencies, toxic exposures, substance abuse, trauma, psychiatric emergencies, and more. It is also necessary to realize that patient-specific goals are different in the emergency department from other health care settings. This can directly translate into a better understanding of the specialty-specific approach to a particular clinical scenario or chief complaint. Understanding how emergency physicians approach particular clinical problems will allow students to better place the educational and patient care objectives of their rotation in perspective. See the case study shown in this chapter as an example. Focusing on the problem at hand is key to managing most cases in the emergency department. Remember, the focus of the emergency department is different from other health care settings. Therefore, your approach to certain chief complaints or patient presentations may need to be modified to keep in line with providing optimal and efficient care in the emergency department.

#### 4: GuideWell Emergency Doctors | Urgent Care & Emergency Medicine

*Mindray's Emergency Care Solution is built around PHEIS, our Pre-Hospital Emergency Information System. PHEIS allows the clinician to be involved in the rescue right from the beginning by sharing real-time patient information between ambulance and hospital.*

#### 5: Find Locations in - Page 1 - Mount Carmel Health, Columbus, Ohio (OH)

*I work in a moderately busy emergency department in DC. I have worked in the ER for 13 years, and have worked at busy city hospitals, and as an agency nurse, and now a staff nurse. The hospital where I currently work has had a high staff turnover with 2 new managements in the past 2 years. We are.*

#### 6: Patient Acuity - Patient Safety and Quality - NCBI Bookshelf

*Services High Acuity Urgent Care For Even Severe Medical Problems And Injuries. When you need to see a doctor today and not an appointment tomorrow, Emergency Physicians Medical Center is your source for excellent medical care.*

#### 7: WHO | Emergency care

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#### 8: Should You Go to the Emergency Room or Urgent Care

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#### 9: Hospital-Based Triage of Obstetric Patients - ACOG

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