EMERGENCY DEPARTMENT MANAGEMENT pdf

1: PhysicianFirst Program | Emergency Department Management

EDPMA's Member Resources on Medicare, Medicaid, Emergency Medicine, and the Affordable Care Act have been recently updated. Members can learn more here.

Avoid investigations that are better done elsewhere Can the patient can be safely discharged with further work-up as an outpatient? Exhaustive investigation does not need to take place in the ED, and is often unnecessary and inappropriate. Implement guidelines and clinical decision rules to initiate necessary testing Use standing orders for nurse-initiated clinical pathways or to assist Junior Doctors in working independently These help maximize patient flow without needless investigation or meddling by superiors Pathways need to be audited to ensure they are being used appropriately Examples include: Make sure you know who the patient is if the cubicle is crowded with family! Focused exploration of the presenting complaint Aim to solve problems, use a focused history to get the information you need to know. Give the patient a time frame always slightly over-estimate for when investigations will occur and when decision nodes will arise, and what the possible outcomes will be. Anticipate these outcomes by lining up other services in advance, e. Use patient handouts It is part of being human that people will forget what you say soon after you say it. Give them something to take home. Also, they can read it while you do other stuff, so they will be primed for your subsequent explanation and advice. Educate when appropriate and practical. Communicate with clerical staff Ensure that patient labels and notes are organized early and that clerical staff have a proactive approach to organizing admissions. Previous medical information for a patient can be sought before they are seen by a doctor, or even before they have arrived. Know how to communicate with non-ED staff We need to coordinate with a lot of other staff and services, know who they are and build relationships. Be honest, so that you can call in favours when you really need them. Make sure your consultation requests are clear, focused and appropriate Again its about building up a bank of goodwill, that can be spent when you need it most. If you think the patient has appendicitis, call the surgeons after taking your hand off the abdomen. Get the bed booked early and document time of referral. The patient comes first. Is the case-mix skewed so that one admitting team is getting hammered, which may cause a bottle-neck later on? Communicate with the charge nurse A no brainer this â€" the charge nurse runs the show! Inpatients at other hospitals must have inpatient beds waiting for them before they are transferred. Eat and go to the toilet not at the same time! Plan procedures Pick times when the right people, the right equipment and the right space is available. Procedures may have to wait until after handover. Jump-start your history by reviewing previously gathered information Some patients should not be seen without the old notes! Always know what has gone on before you see them â€" review the referral letter, the ambulance transfer sheet and the nursing notes. Use the nurses Avoid a paperwork backlog Some docs like to write as they speak to patients. Scan charts and anticipate care needs This helps identify high-risk patients and may allow you to order tests before they are seen by a doctor. Use algorithms and care maps As with implementing guidelines and decision rules, they reduce the need for micro-management by senior staff. Insist that patients are ready for you The ED doc is often the rate-limiting step in patient flow. Be assertive and insist that vital signs and visual acuity are checked, wound dressings are down or the patient is appropriately positioned before you get there. Its not about power, its about efficiency. Be flexible to maximize the use of staff Staff should be moved between areas and roles according to need. Which patients actually need guards? Who actually needs monitoring? Who actually needs an ultrasound in the ED? Who actually needs occupational therapy review prior to discharge? Use nurse-initiated protocols Delays can be markedly reduced by nurse-initiated protocols for medications e. Ottawa Ankle Rules , and referrals e. Set time-orientated objectives, and check with the delegated staff if they are on track. Match the delegated task to the skill-set of the delegee e. If a medical degree is not needed for the task, try to find someone else to do it. If you have a Discharge Coordinator â€" use them till they bleed! Doctors are bad at clerical duties, delegate tasks to clerical staff wherever possible. Know the areas of your ED and their capabilities. Develop a policy on waiting room patients Waiting room patients can be rotated to an assessment stretcher and should be periodically reassessed. Remember who you are Emergency doctors have to deal with

uncertainty and multiple problems concurrently. Our job is to identify when patients are truly sick and to make sure they get the right treatment at the right time. Strategies for managing a busy emergency department.

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2: Emergency Management

The emergency department is a busy, chaotic environment where lives are at risk and: the needs of individual patients must be met patient flow must be maintained.

The recommendations on this page are no longer in effect and will not be updated. Page Summary Who this is for: Emergency department ED staff What this is for: CDC recommends that staff members screen all patients with travel histories, exposure, or clinical symptoms that might suggest the person could have EVD. How this relates to other guidance: Given that people with a risk of exposure to Ebola virus are being closely monitored by state and local health departments and directed to designated facilities for evaluation should they become ill, it is unlikely that patients with EVD will arrive unannounced at an outpatient setting. Nonetheless, ED staff should be familiar with this guidance and prepared to implement it. Refer to additional guidance documents on personal protective equipment PPE and environmental infection prevention and control recommendations for patients under investigation PUIs for EVD. Staff members should be ready to take 3 steps: Identify, Isolate, and Inform. Ask every patient if, in the last 21 days, they traveled internationally or had contact with someone with EVD. Guidance in this document reflects lessons learned from the recent experiences of U. The risk of transmission of Ebola virus from a patient to a healthcare worker depends upon the likelihood the patient will have EVD combined with the likelihood and degree of exposure to infectious blood or body fluids. That risk depends on the severity of disease. Severe illness is strongly associated with high levels of virus production. In addition, close contact with the patient and invasive medical care can increase opportunities for transmission. In general, the majority of febrile patients presenting to the ED do not have EVD, and the risk posed by patients with early, limited symptoms is lower than that from a patient hospitalized with severe EVD. Nevertheless, because early symptoms of EVD are similar to other febrile illnesses, triage and evaluation processes in the ED should consider and systematically assess patients for the possibility of EVD. Healthcare facilities should implement administrative and environmental controls for example, designated area for further evaluation of PUIs and provide onsite management and oversight on the safe use of PPE. Best practice would include continuous safety checks through direct observation of healthcare workers during the process of putting on donning and removing doffing PPE. Because the signs and symptoms of EVD may be nonspecific and are present in other infectious and noninfectious conditions that are more frequently encountered in the United States, relevant exposure history should be first elicited to determine whether EVD should be considered further. If the patient is unable to provide history due to clinical condition or other communication barrier, history should be elicited from the next most reliable source family, friend, EMS provider. Patients who meet the exposure criteria should be further questioned regarding the presence of signs or symptoms compatible with EVD. All patients should be routinely managed using precautions to prevent any contact with blood or body fluids. If an exposure history is unavailable, clinical judgment should be used to determine whether to empirically implement the following protocol. Isolate the patient in a private room or separate enclosed area with private bathroom or covered, bedside commode and adhere to procedures and precautions designed to prevent transmission by direct or indirect contact dedicated equipment, hand hygiene, and restricted patient movement. If the patient is arriving by EMS transport, the ED should be prepared to receive the patient in a designated area away from other patients and have a process in place for safely transporting the patient on the stretcher to the isolation area with minimal contact with non-essential healthcare workers or the public. To minimize transmission risk, only essential healthcare workers with designated roles should provide patient care. If the patient requires active resuscitation, this should be done in a pre-designated area using equipment dedicated to the patient. If these signs and symptoms are not present and the patient is clinically stable, healthcare workers should at a minimum wear: All equipment used in the care of these patients should not be used for the care of other patients until appropriate evaluation and decontamination. Notify the Hospital Infection Control Program and other appropriate staff and report to the relevant local health department immediately of patients with EVD exposure history regardless of symptoms. Once appropriate PPE has been put on, continue obtaining additional history and performing physical examination and routine diagnostics and

interventions which may include placement of peripheral IV and phlebotomy. The decision to test a patient for EVD should be made in consultation with the relevant local health department. Patient evaluation should be conducted with dedicated equipment as required for patients on transmission-based precautions.

3: Emergency Department Management | Ideagen Plc

Opportunities for City employees and members of the public to learn more about emergency preparedness and response.

4: Home - NES Health

Physicians' Practice Enhancement (PPE) Emergency Medicine Program was founded in to provide Emergency Department (ED) management services. Since that time, a team of highly experienced and dedicated adult and pediatric Emergency Medicine specialists and allied healthcare professionals have comprised the PPE Emergency Medicine program.

5: Emergency Department Management of Delirium in the Elderly

We manage and prepare for everyday and not-so-everday emergencies in San Francisco. Our dispatchers answer when you call. Our planners help you prepare for disaster and manage our response and recovery.

6: Managing the Emergency Department â€¢ Life in the Fast Lane â€¢ LITFL â€¢ Medical Blog

Department of Emergency Management and Homeland Security 25 Sigourney Street 6th floor Hartford, Connecticut () () FAX.

7: Emergency Department Management | Physicians' Practice Enhancement, LLC

Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Under Investigation (PUIs) for Ebola Virus Disease (EVD) Recommend on Facebook Tweet Share Compartir The recommendations on this page are no longer in effect and will not be updated.

8: Emergency Department Practice Management Association

Follow us on Twitter to stay informed before, during, and after emergency, plus tips and information about how to be prepared. Like us on Facebook to stay informed before, during, and after emergency, plus tips and information about how to be prepared.

9: Texas Division of Emergency Management

Information for managing an emergency department is assembled in this volume. All aspects of administration and management of emergency medicine are covered, including management principles, operations, contract management, financial management issues, and practice diversification.

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