

TEMPLE UNIVERSITY
HOSPITAL
EPISCOPAL CAMPUS



ED HANDBOOK

DISCLAIMER

This handbook contains both clinical guidelines and departmental policies and procedures for use by Emergency Medicine providers* working at Temple University Hospital – Episcopal Campus. This compilation has been approved by the ED Leadership Team and is designed to help clinicians enhance quality of care and patient safety as well as facilitate Emergency Department throughput.

The clinical guidelines contained within are intended to provide a standardized, evidence-based approach to the evaluation and management of patients presenting to the Emergency Department with specific medical conditions. While these guidelines can assist with clinical decision-making, they are not considered an all-inclusive list of diagnostic modalities and/or therapeutic interventions and do not supersede the provider's clinical judgment. The Emergency Medicine provider can determine applicability of these guidelines and utilize them on a case-by-case basis.

The policies and procedures contained within have been previously approved by the Department of Emergency Medicine and/or Temple University Hospital. Updated versions of these policies and procedures may have been created after the publication of this handbook and these newer versions would supersede the information contained herein.

The use of this handbook is restricted to Emergency Medicine providers working within the Emergency Departments of Temple University Hospital-Episcopal Campus. The Temple University Health System, Temple University Hospital, and Temple University Physicians, are not responsible for the contents of this handbook nor can these entities be held liable for any adverse outcome related to information contained within this document.

Other documents already listed in the Emergency Department Handbook – Department of Emergency Medicine, Temple University Hospital are not duplicated here.

* The term “providers” includes attending EM physicians, EM residents, non-EM residents working in the ED, and physician assistants.

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PATIENT MOVEMENT GUIDE

Patient Movement between C6/Acute BH/Long term BH and EC ED

From C6

- Patient will be returning to C6
 - C6 transfers patient to the ED
 - No new account/encounter needs to be created
 - Documentation is done on original inpatient chart
 - Providers document on an addendum note
 - *Be sure to update the Date of Service to the current date/time*
 - Nursing can document in Boarder Navigator
 - ED transfers patient back to C6

- Patient needs to be admitted to TUH-MC/JC
 - Patient needs immediate higher level of care
 - C6 transfers patient to the ED
 - No new account/encounter needs to be created
 - Documentation is done on original inpatient chart
 - Providers document on an addendum note
 - *Be sure to update the Date of Service to the current date/time*
 - Nursing can document in Boarder Navigator
 - Admission order placed by ED
 - Patient does not need immediate higher level of care
 - Transfer to TUH/Jeanes directly from C6

From Acute/Long Term Behavioral Health

- Patient will return to unit
 - Unit places patient on Leave of absence
 - New account/encounter is created in the ED
 - Documentation is done on the new ED chart
 - Nursing – triage, full documentation
 - Providers document on ED note
 - ED discharges patient
 - Unit returns patient from Leave of Absence

- Patient needs to be admitted to TUH-MC/JC
 - Unit places patient on Leave of absence
 - New account/encounter is created in the ED
 - Documentation is done on the new ED chart
 - Nursing – triage, full documentation
 - Providers document on ED note
 - Unit discharges patient from Leave of Absence
 - *This must be done before admission order is placed*
 - Admission order placed by ED

Updated 1/23

JEANES CAMPUS ADMISSIONS

CRITERIA

Services available at Jeanes:

Cardiology (including Electrophysiology)	ICU	Orthopedic Surgery*
ENT	Infectious Disease	Podiatry
Gastroenterology*	Nephrology	Pulmonary
General Surgery*	Neurology*	Urology*
GYN (no OB)	Neurosurgery*	Vascular Surgery*
Heme/Onc/BMT	Ophthalmology	

*See below exclusions

Services Unavailable at Jeanes:

Cardiothoracic Surgery	OB	OMFS
Pediatrics	Psychiatry	Trauma

Exclusions:

Active GI Bleed	Surgical exclusions: <ul style="list-style-type: none">- Appendicitis (follow PACU pathway)- Those who need immediate OR- Extremity infections requiring surgical intervention (ortho)
Neurology/Neurosurgery (Critical)	
Active Transplant Problem	

C6 ADMISSIONS

Episcopal C6 Unit Admission Guidelines

Beyond absolute criteria, these are simply guidelines and are no substitute for a thorough in-person clinical review
Absolute Exclusion Criteria:

- 1) Age <18 years or Pregnant
 - 2) Any disease that will need **inpatient** subspecialty consult or cardiac intervention not available at Episcopal (need determined at the discretion of the hospitalist)
 - 3) Any patient needing hemodialysis or peritoneal dialysis expected during course of hospital stay
 - 4) Patient with acute trauma related injuries
 - 5) Patients requiring MRI or other studies not available at Episcopal
-

A. Vital sign guidelines (after treatment):

** all below vitals require CBC/BMP and should clinically show no significant or possibly progressive end organ dysfunction*

- 1) SBP <90
- 2) SBP >180 or DBP >110 AND symptoms of end organ damage (severe headache, chest pain, dyspnea, altered mental status)
- 3) HR <50 or >140 (such as in case of persistent SVT, new atrial fibrillation with RVR or ventricular arrhythmia)
- 4) Tachypnea with increased work of breathing or new hypoxia with O₂ sats <90% on 4 L/min
- 5) Temp <95 or >103

B. Diagnostic exclusion guidelines:

- 1) Hgb <7 or drop in Hgb >2 gram from baseline (within 3 months) with positive FOBT or evidence of GYN bleeding or hemolysis on LFTs
- 2) Hyperglycemia >600 mg/dl (if Hospitalist feels will require insulin drip)
- 3) Any hypercapnia with pH < 7.30
- 4) Corrected Na < 125 MEQ/L or > 155 MEQ/L
- 5) K <2.5 or >6 with EKG Δ's or cellular necrosis (e.g. ACS or other arterial occlusive process)
- 6) Elevated Troponin (can be discussed with hospitalist)
- 7) Lactate > 2 coupled with >50% rise in baseline creatinine or other evidence of end organ dysfunction
- 8) EKG abnormalities: ST segment elevation, acute T wave changes

C. Treatment exclusion guidelines:

- 1) IV drips including Insulin, anti-hypertensive or pressor agents.
- 2) New or emergent BiPAP

D. Unacceptable diagnosis guidelines:

- 1) Failure to thrive (can be discussed with hospitalist)
- 2) Sickle cell crisis
- 3) Acute trauma related injuries
- 4) Acute GI or Vaginal Bleeding (with exception of no significant hgb change or ED witnessed bleeding)
- 5) Seizures
- 6) Acute CVA
- 7) Angioedema or unstable airway
- 8) Septic Joint
- 9) Vertigo (with positive HINTS exam)

See reverse for disease specific minimally required diagnostics and exclusions

Disease-Specific Minimally Required Diagnostics and Exclusions

1. **Abdominal Pain:** CBC, BMP, (hCG in females, LFTs or Lipase as indicated)
Exclusions: Peritoneal signs, ileus or evidence of partial or complete bowel obstruction, acute surgical abdomen, concomitant sepsis (with exception of CT image-verified UTI/pyelonephritis or uncomplicated diverticulitis)
2. **Asthma:** CXR, CBC, BMP if febrile; Any COPD or asthma if age >50: CBC, Troponin, ECG, CXR, ABG if pulse ox<88% or 90% on supplemental oxygen
Exclusions: Acute Respiratory Failure, RR > 28, pH < 7.3, Peak flow <20% of predicted, requiring continuous bronchodilator therapy, BiPAP, CPAP, or NRB
3. **Cellulitis:** CBC, BMP
Exclusions: Undrained abscess, infection involving >50% of limb/torso, infection secondary to animal or human bites involving face or hand, multiple comorbidities (severe PVD in affected limb or osteomyelitis), infections involving joints (such as clinically significant limitation in ROM)
4. **Chest Pain:** CBC, BMP, Troponin, ECG, CXR
Exclusions: ST segment elevation, new LBBB, acute T wave changes, positive troponin*, severe valvular disease, positive stress test within last year without appropriate intervention
**Relative Exclusion:* If Troponin <100 and low risk syndrome, can discuss with C6 Hospitalist*
5. **Congestive Heart Failure:** CBC, BMP, Troponin, ECG, CXR
Exclusions: New onset CHF, SBP <115, accompanied with acute kidney injury (>50% rise from baseline) or acute on chronic renal insufficiency with creatinine >4mg/dl
6. **Diabetes Mellitus:** CBC, BMP
Hypoglycemia: excluded if persistent altered mental status despite normalized glucose
Hyperglycemia: excluded if DKA or Hyperosmotic Hypertonic Syndrome
7. **Pyelonephritis:** CBC, BMP
Exclusions: significant immunosuppression (such as asplenia, transplant, AIDS), obstruction or any GU structural abnormality, GFR <30
8. **Syncope/Near-Syncope:** CBC, BMP, Troponin, ECG, CXR
Exclusions: acute seizures, severe valvular disease, EF <35% with other end organ dysfunction or concern for VT, VF, or heart block (or need for AICD interrogation over weekend), acute headache (without negative CT or LP if necessary), focal neurologic findings
9. **Acute Kidney Injury:** CBC, BMP, Urinalysis
Exclusions: Possible need for hemodialysis (such as oliguria, anuria or GFR <30) or urologic intervention
10. **Altered Mental Status:** CBC, BMP, CT Head, UDS
Exclusions: Visual hallucinations (unexplained), acute headache with fever, loss of coordination, neurological findings, asterixis or clonus, otherwise unexplained fevers

Patients with diagnoses not listed above, and who do not meet any general exclusion criteria, may be discussed with the hospitalist for possible admission.

TUH MAIN CAMPUS ADMISSIONS

SUB SPECIALTY CRITERIA

General Cardiology *Call CV Hospitalist (7a-7p) or Cardiology attending (7p-7a) via T3 (2-4778)*

-As of 8/14/18, the cardiology service should be called for patients meeting the following criteria:

- Unstable angina
- NSTEMI
- Symptomatic arrhythmias

Heart Failure *Call Heart Failure attending via T3 (2-4778)*

-As of 10/3/17, the heart failure service should be called for patients meeting the following criteria:

- Heart Transplant, LVAD, or inotrope-dependent patients
- Requiring IV pulmonary vasodilators
- Young patients with new cardiomyopathies (including peri-partum)
- Sees Dr. Forfia or Dr. Vaidya in pulmonary hypertension clinic
- Heart Failure patients with reduced EF (<40%), with CHF exacerbation

Pulmonary (Med Blue, Pulm 1, Pulm 2) *Call Med Blue attending via T3 (2-0923)*

-As of 4/18/19, the pulmonary service should be called for patients meeting the following criteria:

- All established* Temple Pulmonary patients regardless of the admitting diagnosis or level of care except in those cases where another specialty service should clearly manage the patient's care
- Patients with the following diagnoses meeting inpatient level of care, whether an established patient or not:
 - Asthma or COPD exacerbation
 - Pneumonia
 - Pulmonary Embolism (initial call to PERT)
 - Hx of ILD, sarcoidosis, pulmonary vasculitis
 - Spontaneous pneumothorax
 - Severe hypoxia
 - BIPAP if meet criteria for floor

Pulmonary Transplant *Call Lung Transplant attending via T3 (2-0923)*

-As of 4/18/19, the pulmonary service should be called for patients meeting the following criteria:

- All TUH lung transplant patients

*Established means seen by pulmonary service within the past 6 months

General Nephrology *Call Chronic Renal fellow via Amion*

-As of 11/4/19, the general nephrology service should be called for patients meeting the following criteria:

-Temple Nephrology patients with the following:

- Kidney disease work-up and management (renal biopsy, nephrotic or nephritic syndrome management/therapy)
- Renal Replacement Therapy Initiation or Transition
- Patient on Home Renal Replacement Therapy (Peritoneal dialysis (Temple and non-Temple) / Home hemodialysis)
- Vascular access dysfunction/infection (unless otherwise dictated by surgical attending)
- Tunneled Catheter Infection
- Other illness where specific benefit is indicated by Primary Temple Nephrologist

Transplant Nephrology *Call Transplant Renal fellow via Amion*

-As of 11/4/19, the general nephrology service should be called for patients meeting the following criteria

- Post kidney or pancreas transplant > 1 month and < 3 years (unless otherwise dictated by AOT surgeon)
- Anti-Rejection Therapy
- Illness that threatens the health of the kidney or pancreas transplant (e.g AKI, infection)
- Other illness where specific benefit is indicated by Primary Temple Transplant Nephrologist

Hepatology

-As of 8/13/19, the hepatology service is no longer primarily accepting patients.

Advanced Endoscopy and Biliary *Call Advanced Endoscopy and Biliary fellow via Amion*

-As of 8/23/21, there is a new consult service, separate from the traditional GI consult service, for the following:

- ERCP
- bile ducts
- complications of pancreatitis (collections)
- bile leaks
- cholangitis

ADMISSIONS PROCESSES OVERVIEW

For all admissions, complete the BPE for inpatient vs observation designation

1. General Medicine Admissions

- a. Complete the Site Selection Criteria
- b. Choose “Medicine” as the admitting service
- c. Use the designated Placeholder Attending as the accepting attending

2. Subspecialty Admissions

- a. Refer to subspecialty admission guidelines
- b. Confirm acceptance with the accepting service
- c. Admit to the site at which the accepting service is/where the consult was done, under the accepting attending listed in Amion

3. ICU Admissions

- a. Confirm acceptance with the appropriate ICU service
- b. Admit to the site specific to that ICU, under the accepting ICU attending

Updated 6.14.22

ED BOARDERS

MED/SURG BOARDERS

Patients waiting over 4 hours from the time admission order placed without an assigned bed

1. **Charge Nurse:**
 - a. Contacts PPC at TUH for update/ETA, notify physician
 - b. Notify Capacity Management Team to intervene
2. **EC ED Attending:**
 - a. Re-evaluate patient
 - b. Place additional orders as needed

ICU BOARDERS ADMITTED TO TUH-MC

For TUH-MC ICU patients waiting over 2 hours from the time admission order placed without an assigned bed:

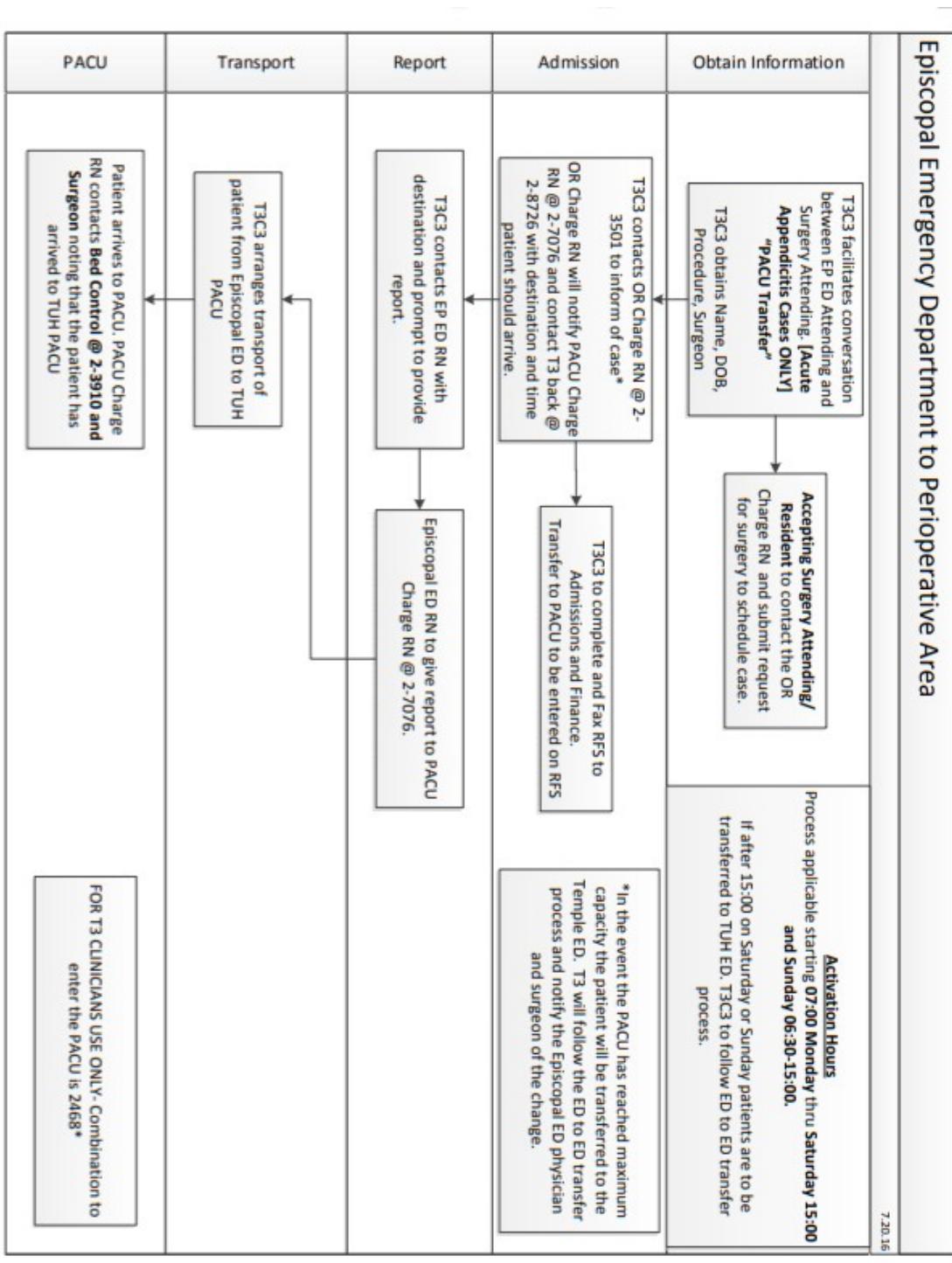
- A. Re-evaluate if the patient can be admitted to Jeanes Campus
- B. Send to TUH-MC ED:
 - a. **EC ED Attending**
 - i. Call RZ Attending to give sign out
 - ii. Transfer patient to TUH-MC ED in EPIC
 - b. **EC ED Nurse**
 - i. Call TUH-MC ED Charge Nurse to give sign out
 - ii. Transfer patient to Off The Floor bed in EPIC once patient leaves EC ED
 - c. **T3**
 - i. Facilitates transfer of patient from EC ED to TUH-MC ED
 - d. **TUH-MC ED Charge Nurse**
 - i. Accepts patient from T3 and assigns ED bed
 - ii. Calls PPC upon patient arrival to ED
 - e. **TUH-MC ED Attending**
 - i. Calls ICU attending to notify of patient arrival
 - ii. Places new admission order to ICU in EPIC
 - f. **PPC**
 - i. Assigns ICU bed

ED-ED Attending calls should be done via T3 to expedite transport

*In the event that an admitted ICU patient with an assigned bed needs emergent transport and must travel via EMS, the same process as for ICU Boarders should be followed.

ED TO PACU

ACUTE APPENDICITIS



PEDIATRIC CRC REFERRALS



ED/Physician referral procedures

- If you wish to refer a patient to the Philadelphia Children's Crisis Response Center (PCCRC), please contact the PCCRC at 215-878-2600.
- Fax the available clinical information, including any testing or interventions performed for medical clearance. Clinical information should preferably be faxed beforehand for our physician to review, or you could request to speak to the physician to determine if further information or workup is needed. Our fax numbers are 215-991-0539 or 215-581-5474.
- When you call, please have the following information available:
 - Presenting Problem
 - Patient Legal Status (i.e., Voluntary vs. 302)
 - Name and contact information of patient's legal guardian. A parent/guardian must accompany any child **under 14** unless they are being transferred on a 302. In that case, efforts made by the ED to contact the guardian prior to transfer must be documented.
 - Clinical information, including any testing or interventions performed for medical clearance.
 - Vital signs must be within normal parameters based on age and/or medical history.
- Based on clinical presentation the PCCRC physician may request further diagnostic testing, observation or medical interventions including but not limited to UDS, HCG, EKG, blood glucose, anticonvulsant and/or Lithium levels, Covid-19 test, and any other test pertinent for medical clearance.
- The PCCRC may request that further clinical information (e.g. toxicology input) or documents (e.g. 302) be faxed for review. Please do not consider patient to be accepted or transfer until the doctor officially agrees to this.
- When the PCCRC accepts the patient, the ED nurse must call a report into the PCCRC nurse.
- The referring facility must also arrange transportation.
- Assuming the PCCRC has capacity to receive new patients, we will accept any patient deemed to be medically stable for transfer by both the referring facility, and PCCRC medical staff.

CSU referrals:

- If a Psychiatric Evaluation has occurred, and the patient has been recommended for our Crisis Stabilization Unit, and a stay on the Unit has been pre-authorized by Community Behavioral Health for days on the Crisis Stabilization Unit, please follow the following procedures:
 - Call PCCRC at 215-878-2600 to make the referral.
 - Fax clinical information
 - Set up transportation upon acceptance by PCCRC physician.

FETAL DEATH GUIDELINE- EC ED

** This guideline does not apply to a live birth that expires in the ED **
Any live birth (heart beat or respiratory effort in the ED) requires its own Epic chart.

Process for disposition of remains:

* Obtain "Fetal Death Packet" from unit clerk

* Provider measures **foot length from back of heel to tip of great toe**

A. Foot Length < 18.2 mm

1. Place fetal remains in white plastic specimen container
 - a. Affix a label with mother's information to container
 - b. Order 'Pathology Fresh' in Epic and indicate "Products of Conception"
2. Transport specimen container and attached order to pathology

Do NOT complete Certificate of Fetal Death or Consent to Relinquish Remains

Do NOT use manila tags, shroud, or brown bag

B. Foot Length ≥ 18.2 mm

To be completed by physician:

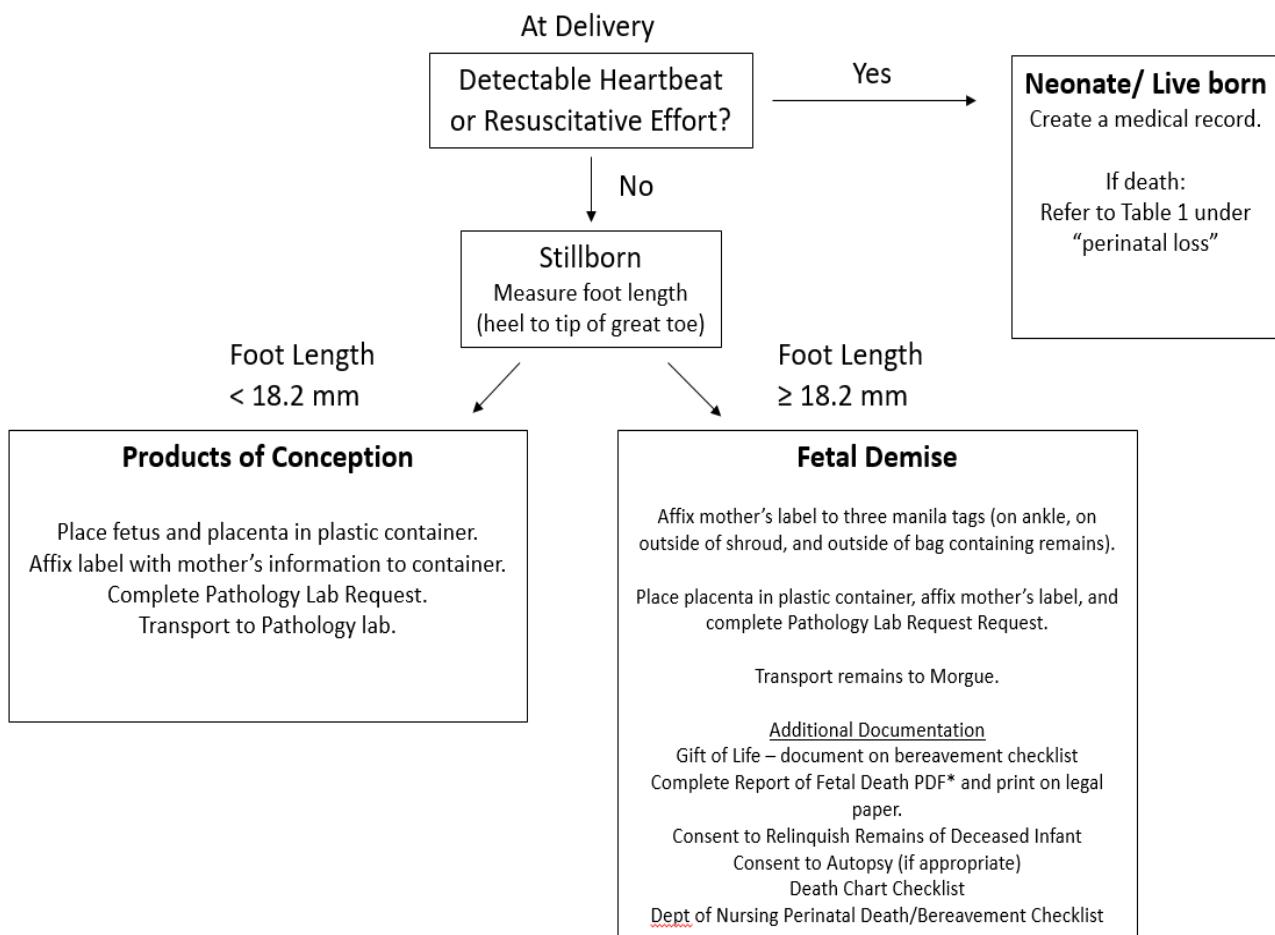
1. Complete Certificate of Fetal Death
2. Complete Consent to Relinquish Remains
3. Place placenta in white plastic specimen container
 - a. Affix label with mother's information to container
 - b. Order 'Pathology Fresh' in Epic (under Specimen Source, note "Placenta")

To be completed by nurse:

1. Complete all three (3) manila tags with the following information:
 - a. Mother's patient label
 - b. Date and time of fetal death
 - c. Foot length
 - d. Gender
2. Secure tag #1 to ankle of fetus
3. Wrap fetus in shroud
4. Secure tag #2 to outside of shroud
5. Place shroud (containing fetus) in brown bag
6. Secure tag #3 to outside of brown bag

7. Transport brown bag and completed paperwork to morgue *within two (2) hours of delivery*
8. Transport specimen container with placenta and attached order to pathology
9. Call Gift of Life to report fetal death

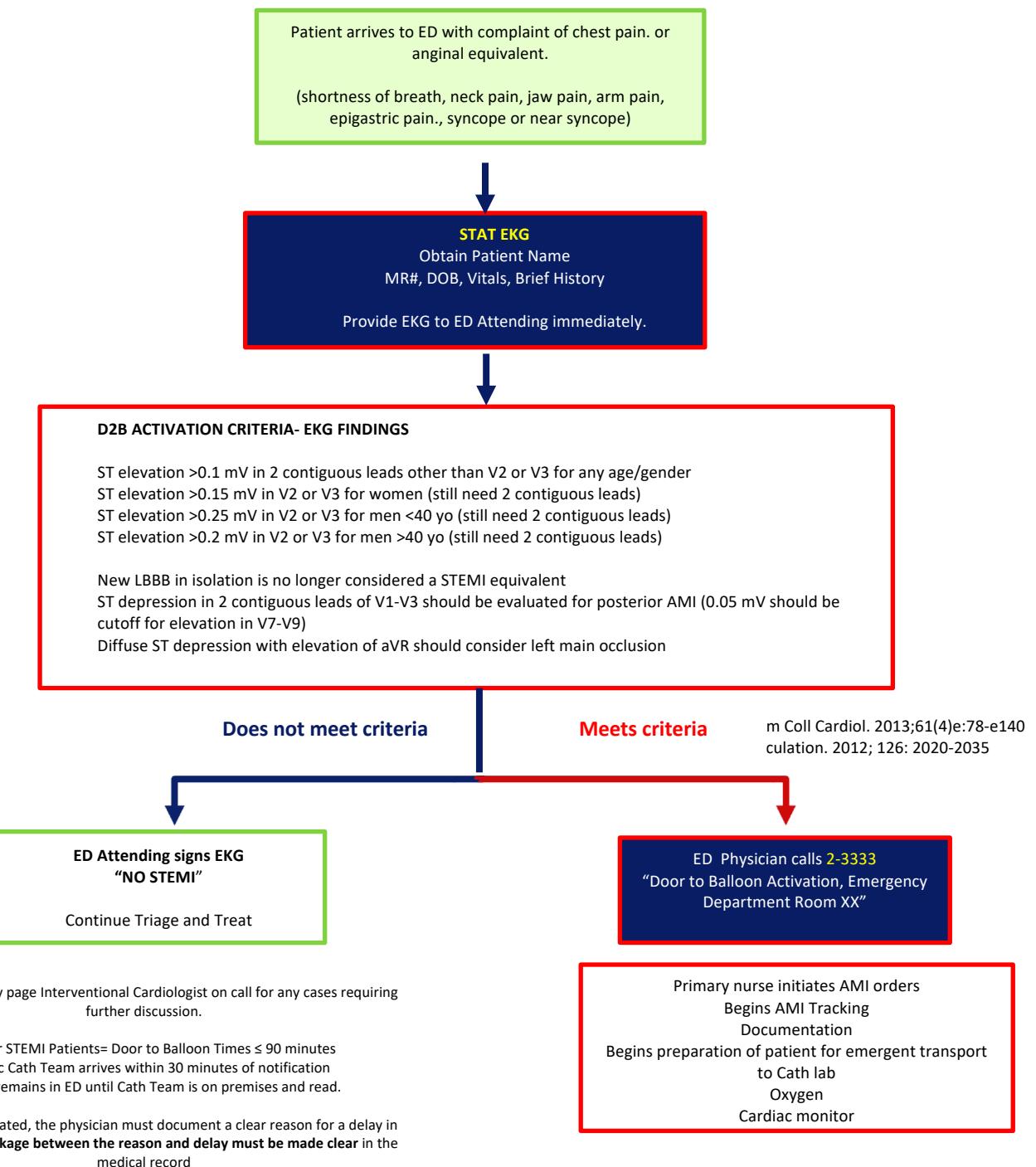
FETAL DEATH GUIDELINE- EC ED (continued)



Fetal Death Certificate:

- Report of Fetal Death PDF must be both completed and printed on the downtime computer directly behind the desk tech.
- Complete all the fields
- Change the printer to the printer in the nursing office (last 4 characters NAPC)
- Change the paper size to “Legal.”
- The certificate will print in the nursing office
 - Off hours, the nursing supervisor can open the office to obtain the certificate
- Change the printer settings back to the default settings

EPISCOPAL CAMPUS DOOR TO BALLOON ALERT



1. At same time 2-3333 is called, call T-3 to arrange emergent interfacility transport
2. Patients should be transferred ED-ED in EPIC
3. The EC attending should call the TUH-MC attending regarding the incoming transfer

EPISCOPAL DOOR TO BALLOON ALERT (cont)

For any D2B activation or patient that needs to go emergently to the TUH-MC cath lab

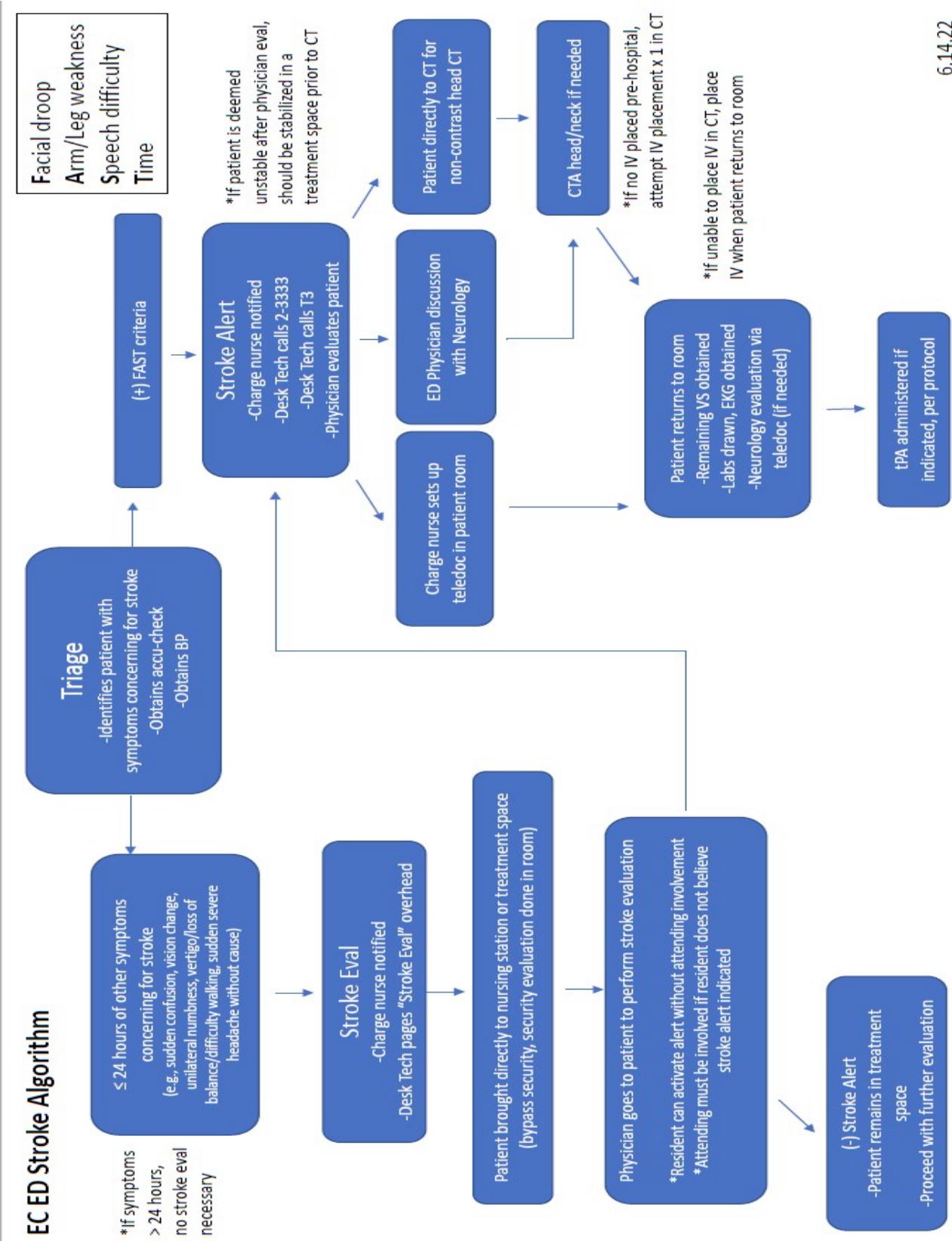
All patients requiring the cath lab must stop in the TUH-MC ED en route.

- A. Activate D2B as outlined on “Episcopal Door to Balloon” alert
- B. All patients should be transferred to the TUH-MC ED
 - a. **EC ED Attending**
 - i. Confirm acceptance of patient to cath lab by cardiology attending
 - ii. Transfer patient to TUH-MC ED in EPIC
 - iii. Call TUH-MC ED attending to alert them of incoming patient
 - b. **EH ED Nurse**
 - i. Call TUH-MC ED Charge Nurse to give sign out
 - ii. Transfer patient to Off the Floor bed in EPIC once patient leaves EC ED
 - c. **T3**
 - i. Facilitates transfer of patient from EC ED to TUH-MC ED
 - d. **TUH ED Charge Nurse**
 - i. Calls cath lab upon patient arrival to ED
 - ii. Accepts patient from T3 and assigns ED bed
 1. If patient will be moved immediately to cath lab, patient can remain in OTF bed
 2. If patient will require prolonged care in the ED, assign ED bed
 - e. **TUH ED Attending**
 - i. If patient requires prolonged care in the ED
 1. Evaluates patient
 2. Writes addendum note
 3. Places admission order to CICU in EPIC
 - f. **Cath lab**
 - i. Pulls patient to cath lab
 - ii. Cardiology places case request
 - iii. Cardiology places admission order

ED-Cath Attending call should be done via T3 to expedite transport

Updated July 2023

EPISCOPAL CAMPUS STROKE ALERT



EPISCOPAL CAMPUS TRAUMA EVALUATION GUIDELINES

If a patient has experienced a traumatic injury and describes one or more of the following, direct to the ED floor for a Trauma Evaluation:

- **Vital signs abnormality**
- **Neurologic deficit or altered mental status**
- **Penetrating Injury**
 - Head, neck, torso, groin, or extremity proximal to the elbow or knee
 - Signs of vascular compromise
- **Pregnant patient:** abdominal or pelvic trauma
- **Major amputation, degloving or mangled extremity**
- **Burns:** >20% BSA
- **Closed Head/Neck Injury:**
 - Anticoagulated
 - > 65 years old
 - > 2 episodes of vomiting after injury
 - Suspected skull fracture
 - Spinal Tenderness
- **Blunt Trauma:**
 - Concern for multiple rib fractures
 - Concern for serious intraabdominal injury or pelvic ring injury
 - Fracture of two or more proximal long bones (femur and/or humerus)
- **Bleeding disorder or patient on anti-coagulation**
- **Motor Vehicle Collision / Automobile vs. Pedestrian**
 - > 20mph, ejection from vehicle, fatality of other passenger in same collision
 - Separation from motorcycle
 - Pedestrian vs. Automobile, thrown
- **Fall >15 feet (adult) --- Child: Fall >10 feet or 3x the height of the child**

EPISCOPAL HOSPITAL TRAUMA PROTOCOL

1. Triage or charge nurse deems patient appropriate for Trauma Evaluation per Trauma Evaluation Criteria and notifies charge nurse of pending evaluation.
2. Patient is brought to ED entrance and charge nurse notifies physician of pending Trauma Evaluation
3. Physician evaluates patient and determines if patient meets trauma activation or rapid head criteria.
 - a. If there is concern for cervical spine injury, the PCT or nurse will obtain a cervical collar for the physician to apply to the patient's neck

Once Trauma or Rapid Head Protocol is initiated by attending physician:

4. Unit Secretary overhead pages "Level 1 Trauma, Emergency Room", "Level 2 Trauma to Room XX" or "Rapid Head to Room XX".
 - a. Protocolized Notifications (for all trauma activations unless otherwise noted):
 - i. CT: Clear table for incoming patient
 - ii. XR: Report immediately to ER bedside
 - iii. Lab: Expedite labs
 - b. **Inform the Unit Secretary to notify the following services if needed (Level 1 traumas)**
 - i. Blood bank (Level 1 only): Immediate need for uncrossed blood
 - ii. Respiratory (Level 1 only): Immediate need for vent
 - iii. T3 (Level 1, Level 2 per attending discretion): For transport to TUH
5. Patient is taken to an available treatment area. Bedside nurse, PCT, and registration clerk convene as a team at that location. Registration will place patient identification band.
6. If patient has not yet been screened by security, security will also report to bedside for complete screening process and apply blue bracelet
7. Nurse and PCT will remove all clothing to fully expose patient, obtain full set of vital signs, and place 2 large bore IVs.
8. Physician will complete primary and secondary trauma survey. X-rays will be completed per attending discretion.
 - a. Per ED attending discretion, if CT is to be completed in the Episcopal ED, PCT, nurse, or unit secretary will call CT to alert of incoming patient and transport the patient to and from the CT suite.
 - b. Physician will review CT images
9. If patient has severe injuries requiring further management by trauma specialists, transport to TUH will be initiated

CT SCANNER DOWNTIME

In the event of scheduled or unscheduled downtime, follow the procedure below. **Of note, we do not need to be on Divert simply due to CT downtime.** As always use your judgment in the instance where the emergency department resources are limited such that patient safety may be compromised.

The following will be notified in the event of EC CT scanner downtime:

Episcopal Medical Director

Episcopal Nurse Manager

Episcopal Emergency Department Attendings

Episcopal AOC

Temple CT Scan Manager

Chair of Radiology Department

Temple Radiologist reading CT scans

Temple ED Charge Nurse

Temple ED Red Zone Attending

CT downtime plan is as follows:

1. Patients who need truly emergent scans (CVA, etc) must be transferred to the TUH-MC ED
 - a. EC ED attending calls TUH MC ED attending via T3 to alert them of the transfer
 - b. EC ED charge nurse calls TUH MC ED charge nurse to alert them of the transfer
 - c. TUH MC ED team will disposition the patient
2. Patients for whom the CT will not change an admission disposition, admit them without the CT
3. Patients for whom the CT will determine disposition (discharge vs admission) should be transferred to TUH MC ED
 - a. EC ED attending calls TUH MC ED attending via T3 to alert them of the transfer
 - b. EC ED charge nurse calls TUH MC ED charge nurse to alert them of the transfer
 - c. TUH MC ED team will disposition the patient

STAFFING ADJUSTMENTS

OVERALL RECOMMENDATIONS		
<ul style="list-style-type: none"> Rooms should be filled per 4:1 nurse staffing ratios at a minimum. We recommend that you do not overfill the department to start a shift. This usually leads to even longer throughput times and higher stress for the entire ED team. <ul style="list-style-type: none"> If there are multiple ED boarders, consider adjusting assignments to a maximum staffing ratio of 5:1. Assignments may be modified to include more boarding patients. Ratios should not be adjusted for ICU patients. Charge nurse may care for patients who require few resources, one or two at a time, in an open treatment space. STAGING! There are guidelines for nursing placing protocol orders for most chief complaints. Staging orders can be placed on any patients waiting (in the WR or treatment space). A PCT or nurse can execute protocol orders. If staffing permits, a PCT can be placed in triage to aid with drawing protocol labs on patients in the WR, 		
RECOMMENDATIONS BASED ON CURRENT ED SITUATION		
Indications:		
<ul style="list-style-type: none"> WR with many ESI4s and ESI5s 	<ul style="list-style-type: none"> WR with many ESI3s and minimal ESI4s and ESI5s 	<ul style="list-style-type: none"> Too many providers and unable to open additional rooms
<p>1. <u>Open Minor Care:</u> If you have an available MLP, you can close one floor assignment (4 beds) and open Minor care (5 beds) and have the MLP see these ESI4s and ESI5s in minor care.</p>	<p>1. <u>Closed Minor Care:</u> If Minor Care is open with a PCT and nurse, closed minor care and move this team to the hallways. MLPs can see ESI3 patients in the hallways with attending supervision. ESI 4s and %s can be seen out of the main ED.</p>	<p>1. <u>Staging:</u> If you have an available PCT <ul style="list-style-type: none"> - MLP to evaluate and stage patients in triage - PCT to collect labs - Radiology may take patients from WR to complete imaging and return patients to the WR </p> <p>2. <u>No MLP assigned to minor care:</u> <ul style="list-style-type: none"> - If there is a minor care nurse but no MLP, MDs should consider seeing patients in minor care space </p> <p>3. <u>Vertical Bedding:</u> <ul style="list-style-type: none"> - MLP or MD can see vertical ESI 4s and 5s in Rm5 if open. If a critical patient comes in, the patient who was in Rm5 can be moved to a chair outside X-ray room (Hwy 14). </p>
<p>Each day's scenario is a little different. We attempted to cover the most common situations above. However, if you have any questions or would like further guidance regarding a real-time situation, please call ED leadership.</p>		

Updated 2.28.23

SURGE PLAN

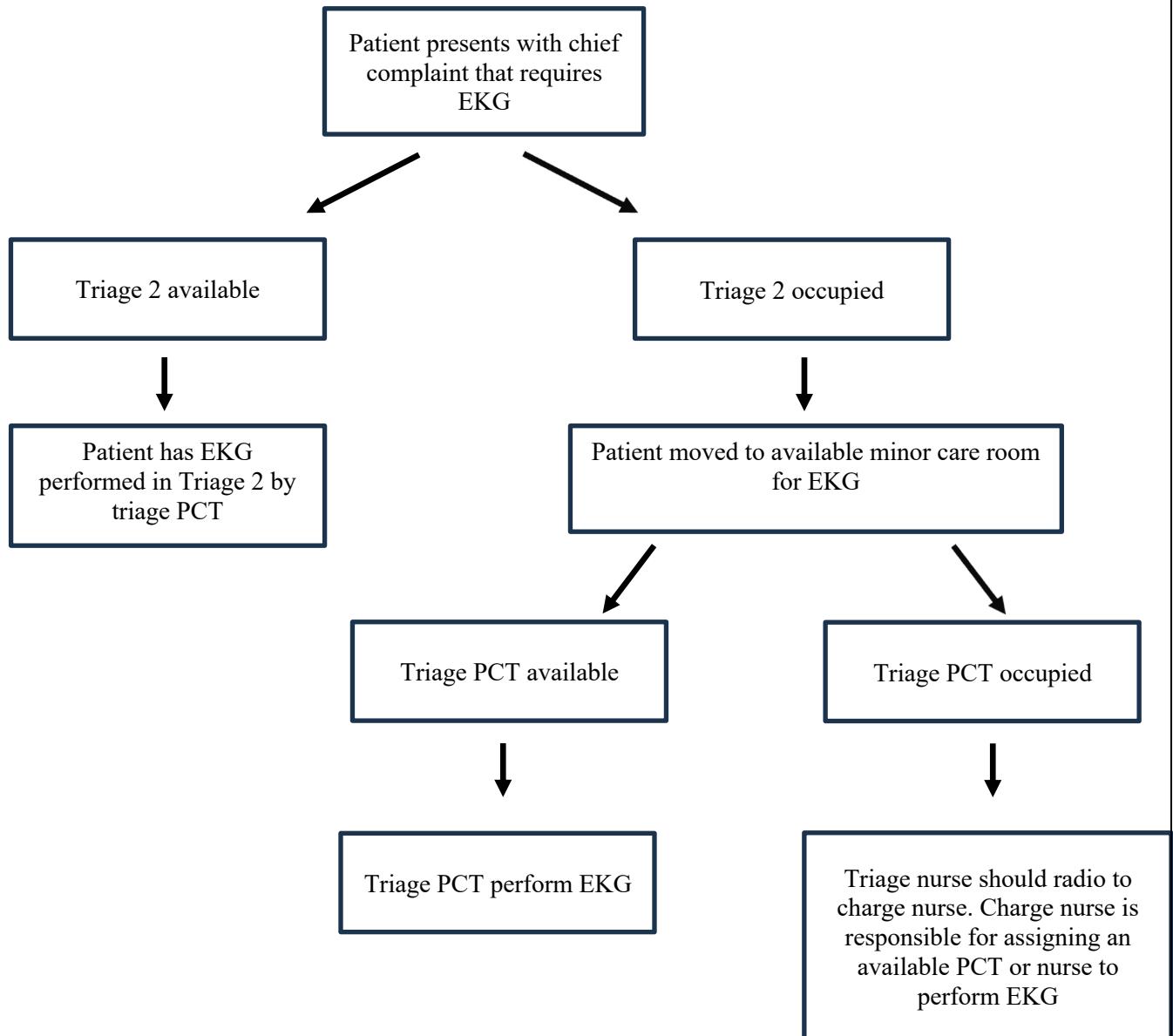
NORMAL STATUS (GREEN)		
Charge Nurse:	ED Staff Nurses:	ED Physicians (Attendings and Residents)
<ul style="list-style-type: none"> <input type="checkbox"/> Ensure All Treatment Spaces Open: Use Short Staffing Algorithm <input type="checkbox"/> Pull to Full (no WR pts if beds open), prioritizing ESI 2 patients <input type="checkbox"/> Follow ICU Boarders algorithm 	<ul style="list-style-type: none"> <input type="checkbox"/> Initiate protocol orders <input type="checkbox"/> Follow nurse report algorithms for TUH/Jeanes/C6 <input type="checkbox"/> Proactively call C6 if bed is not available and/or clean 30 min after admission order was placed <input type="checkbox"/> File MIDAS reports for any delays in transportation 	<ul style="list-style-type: none"> <input type="checkbox"/> Respond promptly to push notifications of results <input type="checkbox"/> Run your list with charge nurse after prolonged resuscitations for next steps/dispositions <input type="checkbox"/> Update Next Steps and escalate delays <input type="checkbox"/> Use Telemedicine consults

ESCALATION STATUS (YELLOW)		
<i>All ED spaces full AND WR ≥ 7 ESI2/3, or ≥ 2 critical care patients without transport, or WR ≥ 12 ESI4/5</i>		
Charge RN/ED Attending huddle when criteria met:		If Yellow criteria are still met, follow additional steps below for respective escalation indication:
<ul style="list-style-type: none"> <input type="checkbox"/> Ensure all steps in Green Status have been taken <input type="checkbox"/> Call T3 to escalate admission and/or transport delays <input type="checkbox"/> Review admitted patient needs – Can anyone discontinue telemetry or isolation? <input type="checkbox"/> Can anyone be admitted to C6 that was previously admitted to TUH/Jeanes? <input type="checkbox"/> Can any ICU admits be admitted to another campus, if beds are available? <input type="checkbox"/> Can anyone be discharged with follow-up call? <input type="checkbox"/> Call Radiology/Lab for expedited reads/results 		
Critical Care Boarding ≥ 2 critical care patients with no transport	High/Moderate Acuity Volume WR ≥ 7 ESI2/3	Low Acuity Volume WR ≥ 12 ESI4/5
Attending Physician	Charge Nurse <ul style="list-style-type: none"> <input type="checkbox"/> Call ICU for assistance with management 	Nurse Manager <ol style="list-style-type: none"> 1. Convert minor care waiting room to results waiting area

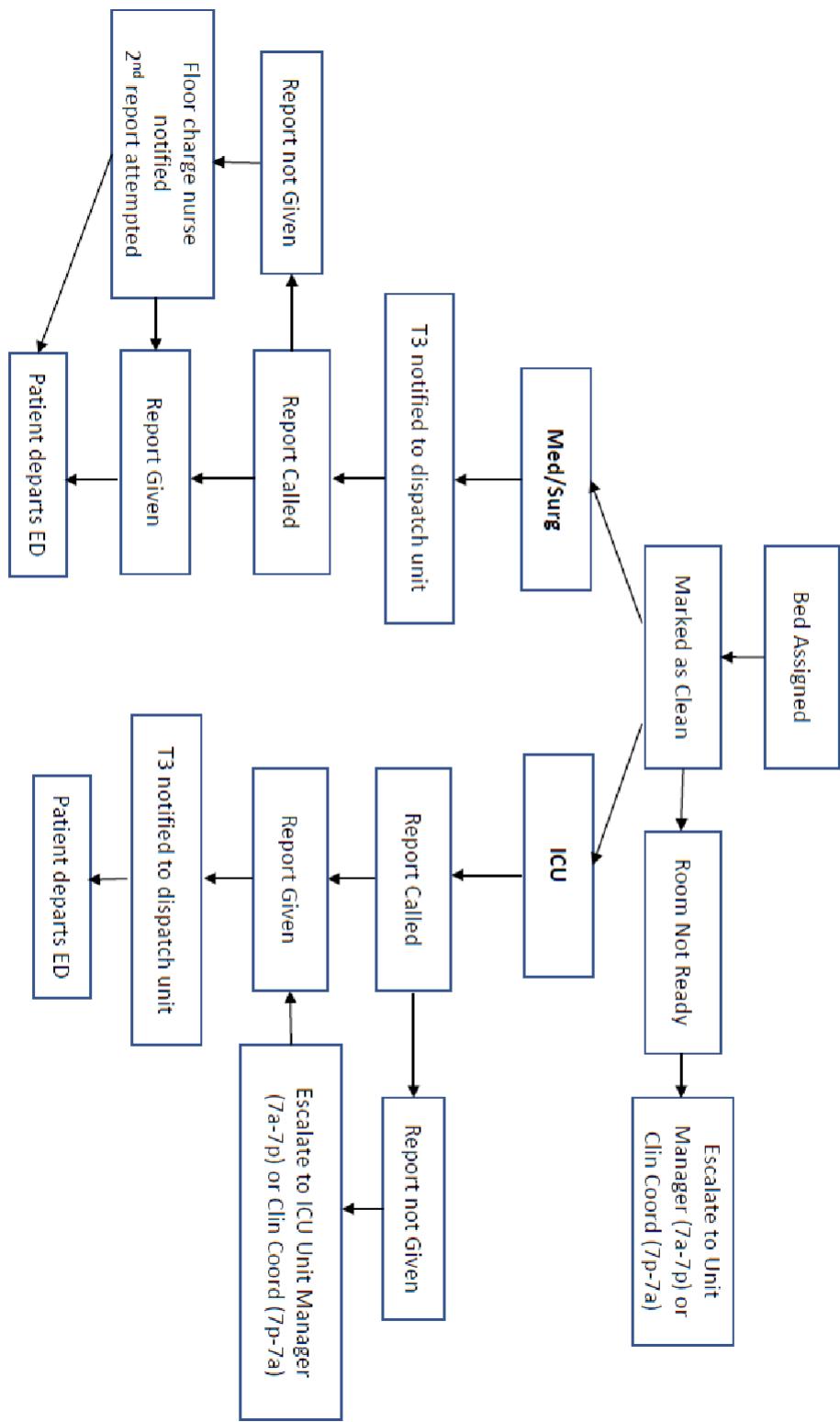
CRITICAL STATUS (RED)		
<i>All ED spaces full AND WR ≥15, or ≥4ESI2 in WR >30 mins, or ≥8 Admissions without Beds Assigned, or 3 critical care patients without available transport in next 2 hours</i>		
Charge RN/ED Attending huddle when criteria met.		If Red criteria are still met, notify Operations Team (Nurse Manager and Medical Director) 2. Place ED on Divert per ED attending discretion
<ul style="list-style-type: none"> <input type="checkbox"/> Ensure all steps in Green and Yellow Status have been taken and all ED spaces are full <input type="checkbox"/> Review admitted patient needs – Can anyone discontinue telemetry or isolation? <input type="checkbox"/> Call T3 to escalate admission and/or transport delays 		
3. Notify Capacity Management Team	Capacity Management Team <ol style="list-style-type: none"> 4. Ensure all available inpatient spaces are being used (OVR, 7W double rooms, NICU, BICU, 3W/E, Boyer PACU) 5. Assist with movement to Jeanes/C6 6. Call EVS and transport supervisors for additional staff to expedite inpatient bed turnover 7. Call NRO for additional staff for surge spaces 	
Escalate any delays per ED Escalation Algorithm:	Charge nurse → ANM/NM → CMT	Attending → MD/AMD → CMT

EPISCOPAL ED ATTENDING DIVERT PROTOCOL SUMMARY	
INDICATIONS FOR DIVERT:	
All ED spaces full (including hallway beds), as possible per staffing, <i>AND 1 of the following:</i>	
<ul style="list-style-type: none"> <input type="checkbox"/> WR ≥15 <input type="checkbox"/> ≥ 4 ESI2 in WR >30 mins <input type="checkbox"/> ≥8 Admissions without Beds Assigned <input type="checkbox"/> 3 critical care patients with no transport available in next 2 hours 	
PROCEDURES:	
1. Complete Critical Status (Red) Charge RN/ED Attending huddle per Surge Plan guidelines 2. Place ED on EMS Divert if criteria still met despite interventions 3. Notify Nurse Manager and Medical Director	
IN SHORT STAFFING SITUATIONS:	
<ul style="list-style-type: none"> <input type="checkbox"/> Follow short staffing algorithm 	

TRIAGE EKG ALGORITHM



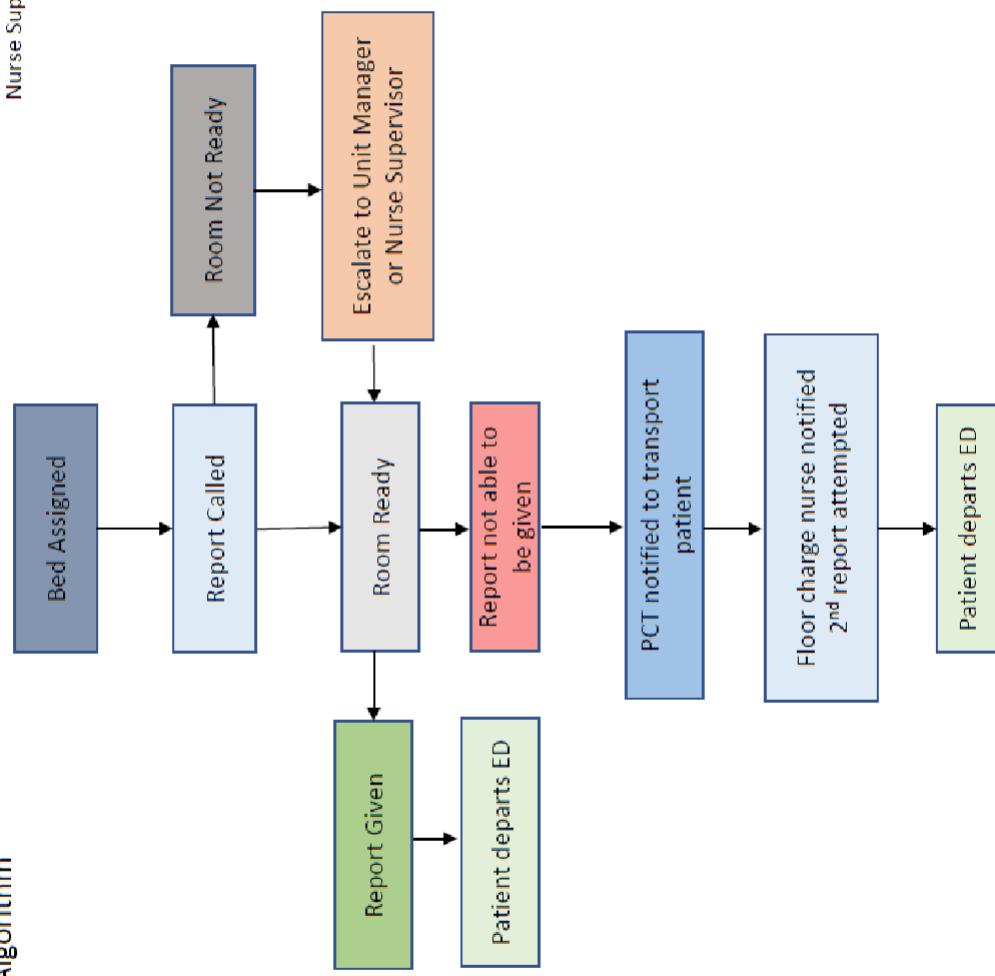
EC ED TO TUH/Jeanes
Nursing Admission Algorithm



EC ED TO C6
Nursing Admission Algorithm

C6 Charge Phone # (445) 444-6769
C6 Nurse Manager # (215) 707-0550
Nurse Supervisor Phone # (267) 788-0680

NURSE REPORT ALGORITHM
C6



Updated 9/22/21

EMERGENT BLOOD TRANSFUSION PROTOCOL **FOR UNCROSSMATCHED BLOOD**

The following protocol, outlined by roles, and adapted from Blood Product Transfusion Procedure TUH_Admin 950.2038, must be followed for the lab to release blood in an emergent situation.

1. PCT
 - a. Call the lab with the patient's name and MRN before going to the lab to pick up the blood
 - i. If the patient is not identified, use the Med/Male or Med/Female name and associated MRN
 - b. Take the Emergent Blood release form to the lab with the patient's name and MRN on the form. Include birthdate if known.
 - c. Sign the form when picking up the blood product
2. Nurse
 - a. Document in EPIC under transfusion narrator
 - i. If unable to document in EPIC, use downtime form
3. Provider
 - a. Place transfusion order in EPIC
 - i. If unable to place order in EPIC, use downtime order form

MINOR CARE

ESI III CHIEF COMPLAINT EXCLUSION CRITERIA

Abdominal Pain: fever, age >50 years

Allergic Reaction: more than local skin reaction

Asthma: peak flow <300

Back Pain: fever, hx IVDA, hx ESRD, abnormal bowel or bladder function

Chest Pain: age <19, >30; abnormal EKG

Headache: sudden onset, “worst headache of life”, fever

Hyper/Hypoglycemia: IDDM, oral agents other than Metformin, clinical concern for DKA

Pain: requiring IV analgesics, cannot sit comfortably in a chair

Pregnancy: No documented IUP

Shortness of Breath: anything but asthma

Syncope: age >40, any associated complaint

Trauma: fall > 6ft, major MVC (rollover, vehicle fatality)

Vaginal Bleeding: symptoms of anemia; heavy bleeding

BATHROOM ALARM

ED Main Waiting Room Bathroom Alarm

Beginning April 23rd, we will begin to use the new bathroom alarm system for one of the bathrooms in the main waiting room. This is a trial in one bathroom at this time.

How it works:

- The bathroom door must be left open when not in use.
- When a patient enters and closes the door, the censor is activated. The censor will activate an alarm if the patient does not move for a specific period of time.
 - An audible alarm is sounded in the department.
 - A visual light flashes at the bathroom door, triage 2, and on the wall facing the nurse desk at asthma chairs.

Who must respond?

- The following staff responds to the bathroom to assess the scene, rescue or activate a RRT as appropriate;
 - Charge Nurse
 - Triage Nurse
 - MD

How to silence the alarm:

- The alarm must be turned off at the bathroom alarm box with a key.
 - Key to the alarm and a key to the bathroom door will be located;
 - Charge nurse computer drawer
 - Triage computer drawer
 - Unit clerk computer drawer
 - Security will have keys
 - Working on getting an emergency spare set placed in Pyxis

CODE BLUE

EPISCOPAL ED CODE BLUE PROTOCOL 2023

During an OHS confirmed Code Blue, please follow the process below for managing homeless patients seeking shelter who are ultimately deemed stable for discharge

- All patients presenting for shelter during a Code Blue need a medical screening exam
- Contact social work to facilitate placement during daytime hours
- No swab is necessary for placement
- Patients wait in the ED waiting room or CRC waiting room
- When the OHS Code Blue expires, patients should leave the campus

M-F 9-5, Send Patients:

- Roosevelt Darby Center
215-407-3044
802 N Broad St,
Philadelphia, PA 19130
- Appletree
215-686-7150
1430 Cherry St,
Philadelphia, PA 19102

M-F after 5P and Saturday and Sunday

- Men- Mike Hinson Resource Center
215-496-9610
1211 Chestnut St,
Philadelphia, PA 19107
- Women- Gaudenzia- House of Passage
215-849-7200
111 N 49th St,
Philadelphia, PA 19139
- Family- Red Shield
215-787-2887
715 N Broad St,
Philadelphia, PA 19123

CRC RESTRAINTS

For patients that present to EC to go directly to the CRC who require restraints to facilitate transport through the ED, the temporary restraint order on the back portion of the CRC form must be completed by an ED attending.

TEMPLE HEALTH EPISCOPAL CAMPUS EMERGENCY DEPARTMENT CRISIS RESPONSE CENTER INITIAL SCREENING/SAFETY SEARCH CHECKLIST	PATIENT LABEL
---	---------------

TRANSPORT RESTRAINT ORDER TO CRC

- Restraints required for assaultive or aggressive behavior towards staff or self, or risk of elopement
- Alternatives to restraints unable to be attempted due to patient's behavior
- No medical or physical barriers to restraints

Restraint Type: Four-point restraints

Other: _____

CRC physician to determine need for continued restraint.

The Restraint Order will not exceed one hour.

Ordering MD (Print): _____

Signature: _____

Date: _____ Time: _____

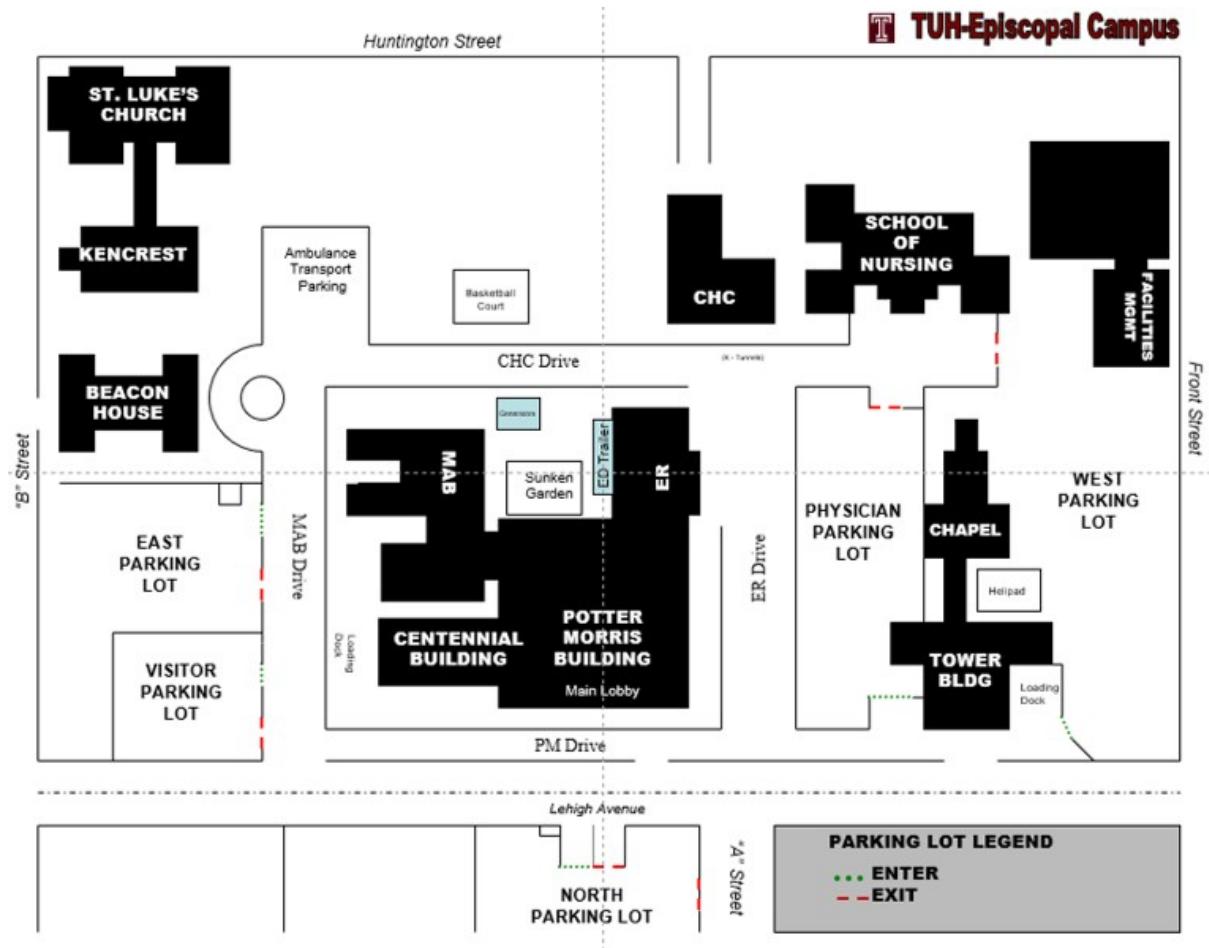
ED-920005 (10-18) PAGE 2 of 2

These patients do not have to be fully registered in the ED, unless they require medications in addition to restraints.

The restraint order will be continued electronically by the CRC physician once the patient arrives in the CRC.

RAPID RESPONSES

MAP



RAPID RESPONSES

DIRECTIONS

MAB

Directions: Go past the main lobby, away from the ED. You'll see a sign for the MAB on the right.
Lower Level: outpatient dialysis
1st Floor: EKG, Heart Station, Outpatient Psychiatry, Employee/Occupational Health (room 110)
2nd Floor: Tus Ojos, Dr. ~~Bakhshi~~, administrative and executive offices
3rd Floor: Financial Services, IT Training Lab, administrative Psychiatry offices

Centennial Building

Directions: take the elevators that are just past the security desk, on the left
C3 – connects to PM3
C4 Unit
C5 Unit
C6 Unit, radiology and PFT lab

Potter Morris Building

Directions: take the elevators that are in the ED, next to the ~~x-ray~~ room.
2nd Floor: OMFS clinic, medical records office, Special Smiles
3rd Floor: CRC
4th Floor: PM4 Unit, long-term behavioral health patients
5th Floor: PM5 Unit
6th Floor: PM6 Unit, long-term behavioral unit, can also get to C6

CHC

Directions: go out main ED doors and turn left
1st Floor: Internal Medicine, Pediatric Medicine clinics
2nd Floor: OB/GYN clinic
3rd Floor: Progressive Vision, Physical Therapy
to take a wheelchair/stretcher, you have to go through the basement

Tower Building

Directions: go out the main ED doors and across the street
1st Floor: wound clinic down the steps on the right

Code Cart Locations

PM-6
Cent. 6th floor
C-5 Link
C-4
Radiology 3rd floor
ED – pediatric and adult
Minor Care
CT Scan
Nuclear Medicine
Wound Care
CHC 1st floor
CHC 2nd floor
Dialysis
Central Supply

ED COVERAGE OF C6

ED Guide

Sign out

The EC ED attending scheduled for the 3p-11p shift will take sign out from the C6 provider at 6:45p daily.

A written sign out, including a patient list and any active issues, will be posted in the ED by the C6 hospitalist. The sign out will be inclusive of all patients on C6 including Long Length Of Stay (LLOS) and acute patients. A brief verbal sign out may accompany the written sign out for acute patients.

The C6 attending will call into the ED at 6:45a daily to get any updates on existing patients and/or overnight admissions.

Detailed week to week signouts will be done hospitalist-hospitalist, and the ED will not be involved.

EPIC guide: Setting up your C6 Access

EPIC Guide: Access and print C6 patient list

Existing C6 patients

The ED will be responsible for orders, assessments, and documentation, as needed, on C6 patients from 7p-7a daily. New LLOS patients are not the responsibility of the ED.

C6 nursing will escalate concerns in a tiered manner based on the type of response required:

Routine care (prn orders) and non-time-sensitive evaluation requests will be called to the ED

Patients who require an urgent in-person evaluation, but do not yet meet criteria for an RRT will be called to the ED as a “critical eval”.

Patients meeting criteria for an RRT will trigger an RRT on C6

EPIC guide: Documentation on C6 patients

EPIC guide: Orders on C6 Patients

New C6 patients (EC ED to C6 admissions)

The attending admitting a patient from the EC ED to C6 will be responsible for completing initial admission orders and a medication reconciliation on any new admissions from EC ED to C6 between 7p and 7a. The full H+P will be done by the hospitalist the following day.

EPIC guide: C6 Admissions

Dispositioning patients from C6 should be extremely rare. Discharges should all be deferred to the hospitalist the following day. Any patient who leaves overnight from C6 should be an AMA. Any patient who requires a higher level of care should be an RRT and moved to the ED, as per protocol.

EPIC guide: Dispositioning a Patient from C6

ED Attending Responsibilities

During the times when the ED is covering C6, the following should generally occur, with the exception of a critical patient mandating attending presence in the ED:

The non-C6 attending (2p-10p, 10p-6a) will cover RRTs outside of C6.

The C6 attending (3p-11p, 11p-7a) will cover RRTs on C6.

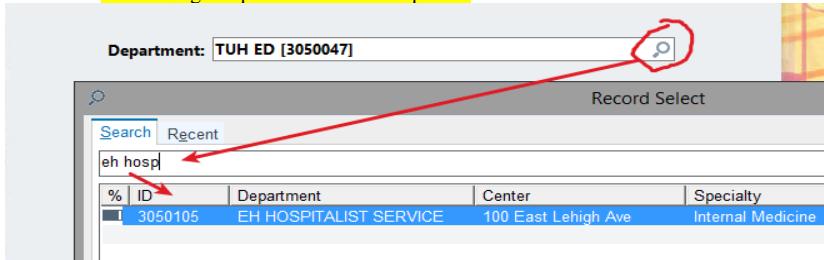
The non-C6 attending will accompany T3 on any rides.

*If the C6 attending wishes to accompany T3, they must sign out the C6 patients to the other attending, who will then cover C6 in their absence

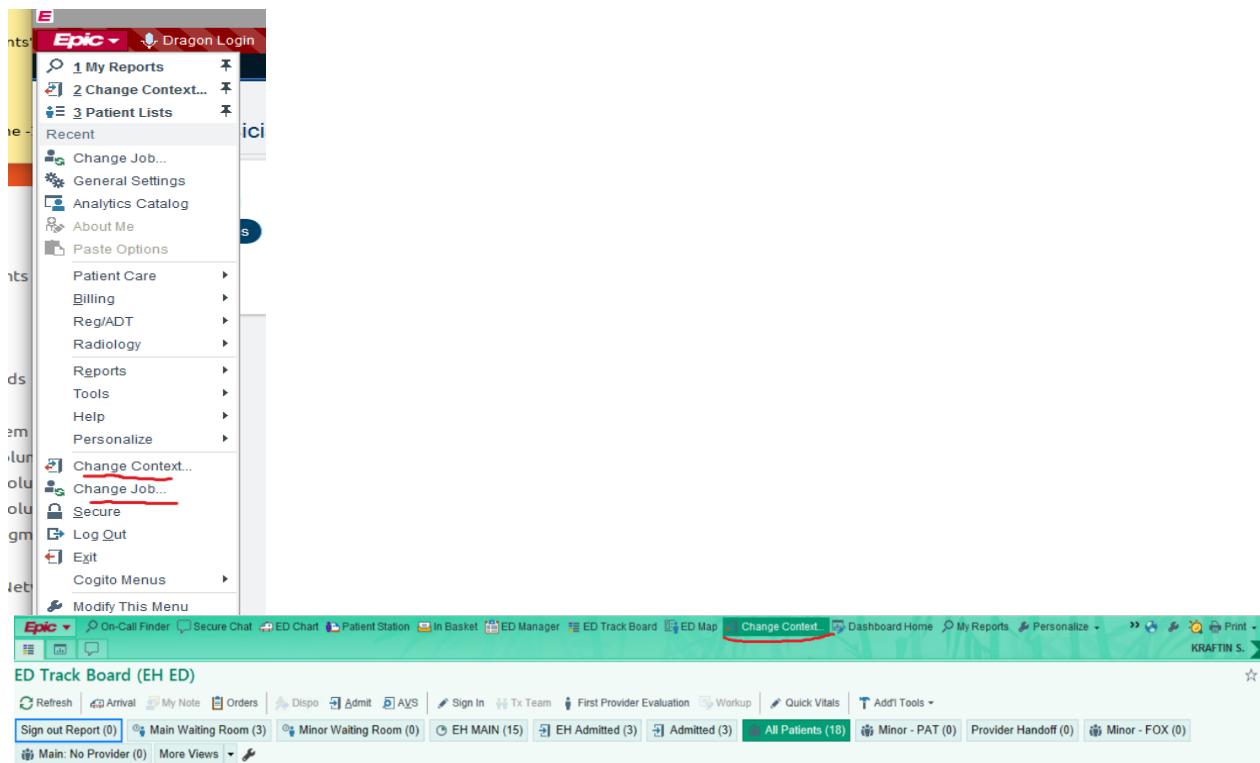
EPIC Setting up your C6 Access

Setting up your C6 Access/Patient List/Orders

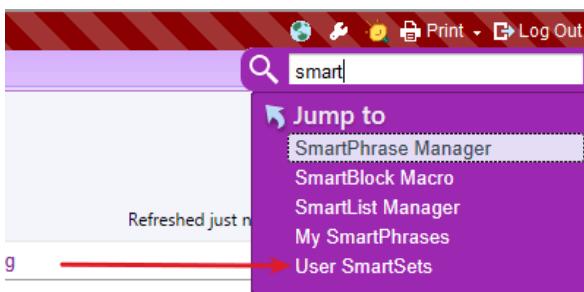
1. Log on as usual
2. Then change Department to EH Hospitalist



*note – you can also change job and context after you log in, from the EPIC drop down menu or from the menus above the trackboards :

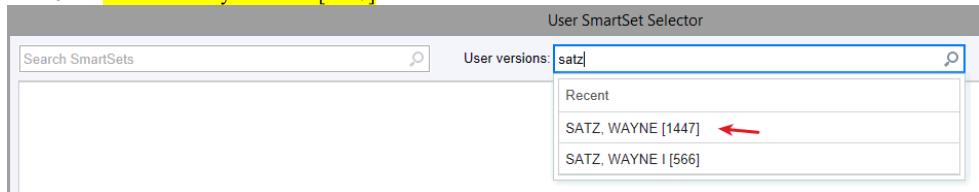


3. Then on top right magnifying glass, enter "smart"



4. Then the User SmartSet Selector opens.

5. Choose Schreyer or Satz [1447]



6. Then click on the Favorites stars for each order set and click Copy Version

Search Results

3040000174 TUH IP CAR ACUTE CORONARY SYNDROME ADMISSION (Wayne Satz, MD - M... Acute Coronary Syndrome Admission / Chest Pain (Wayne Satz, MD - My CAD) <input type="button"/>
3040000380 TUH IP GEN ASTHMA/COPD ADMISSION (Wayne Satz, MD - My ASM) Asthma and COPD Admission (Wayne Satz, MD - My ASM) <input type="button"/>
3040000223 TUH IP GEN COMMUNITY ACQUIRED PNEUMONIA ADMISSION (Wayne Satz, M... Community Acquired Pneumonia Admission (Wayne Satz, MD - My PNA) <input type="button"/>
3040000226 TUH IP GEN GENERAL ADMISSION (Wayne Satz, MD - My Adm) General Admission (Wayne Satz, MD - My Adm) <input type="button"/>
3040000410 TUH IP GEN BLOOD GLUCOSE MANAGEMENT (Wayne Satz, MD - Glucose Mgmt) Glucose Management (Diabetes Orders) (Wayne Satz, MD - Glucose Mgmt) <input type="button"/>
3040000496 TUH IP GEN HEALTHCARE ACQUIRED PNEUMONIA ADMISSION (Wayne Satz,... Healthcare Acquired Pneumonia Admission (Wayne Satz, MD - HCAP) <input type="button"/>
3040000186 TUH IP GEN CONGESTIVE HEART FAILURE ADMISSION (Wayne Satz, MD - My... Heart Failure Admission (Wayne Satz, MD - My CHF) <input type="button"/>
408090004 TUH RX IP OPIOID DEPENDENCE ORDER SET (Wayne Satz, MD - OUD) Opioid Dependence Order Set (Wayne Satz, MD - OUD) <input type="button"/>
3040000180 TUH IP GEN SYNCOPIC ADMISSION (Wayne Satz, MD - My Syncope) Syncope Admission (Wayne Satz, MD - My Syncope) <input type="button"/>

Delete Version + New Version Copy Version Edit Version Cancel

7. Go to patient lists, Available Lists, Episcopal Campus, Units

The screenshot shows the 'Patient Lists' interface. On the left, the 'Available Lists' sidebar is expanded, displaying various patient lists under the 'Episcopal Campus' category. Red arrows point to the 'EH ED' and 'EH P6' items. The main area shows a grid titled 'My Patients' with 0 Patients, with columns for Unit, Room/Bed, and Patient Name.

- Right click on EH ED, and EH P6 to add to Favorites. They will then show up above under 'My Lists' (up top on the left-hand column)

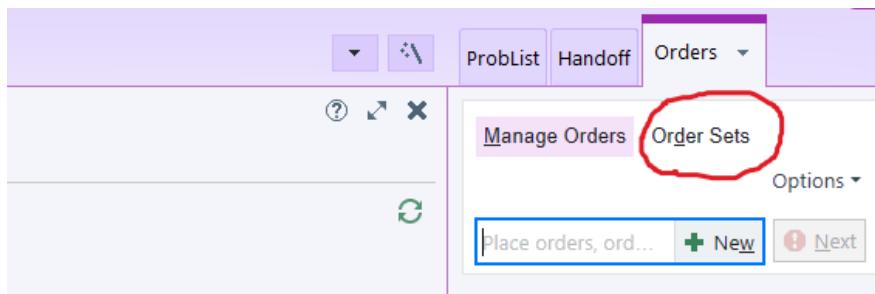
The screenshot shows the 'My Lists' screen. The 'My Favorite Lists' section is highlighted with a blue border, containing entries for 'EH ED' and 'EH P6'.

- Then select any patient row (just single click on the patient) and then click on the quick button 'orders'

The screenshot shows a patient detail screen for 'EH ED'. At the bottom, there is a row of quick buttons: 'Problem List', 'Orders' (which has a red arrow pointing to it), 'Notes', and 'Allergies/Contraindications'. The patient name 'EH ED' and ID 'EE11' are displayed at the bottom.

(This is actually the 'managed orders' item not the 'orders' tab we use in the ED if you need to find from other screens, workflows, search for 'managed orders')

- In the far right, Click on Order Sets



Voilà. Now you'll see the Order sets you set as Favorites

A screenshot of the 'Order Sets' page. At the top left, there is a 'Favorites' section with a small triangle icon. Below it is a list of favorite order sets, each preceded by a checkbox. The list includes: Acute Coronary Syndrome Admission / Chest Pain (Wayne Satz, MD - My CAD), Asthma and COPD Admission (Wayne Satz, MD - My ASM), Community Acquired Pneumonia Admission (Wayne Satz, MD - My PNA), General Admission (Wayne Satz, MD - My Adm), Glucose Management (Diabetes Orders) (Wayne Satz, MD - Glucose Mgmt), Healthcare Acquired Pneumonia Admission (Wayne Satz, MD - HCAP), Heart Failure Admission (Wayne Satz, MD - My CHF), Opioid Dependence Order Set (Wayne Satz, MD - OUD), and Syncope Admission (Wayne Satz, MD - My Syncope). To the left of the favorites list, there is a 'Order Sets' section with a triangle icon. Below the favorites list, there is a 'Recent Order Sets' section with a triangle icon. At the bottom of the page, there is a 'Recent Order Sets' section with a triangle icon.

EPIC ACCESS AND PRINT C6 PATIENT LIST

1. Go to C6 Patient List

Patient Lists

Edit List | Write Handoff |

My Lists

- Consults
- My Patients
- My Favorite Lists
 - 4 Day Discharged
 - EH ED
 - EH P6

Shared Patient Lists

2. Click Print → Patient List

Hyperspace - EH HOSPITALIST SERVICE - Epic PRD | 1 Incidental and Abnormal Fi... | 17 | Hospital Chart Completion | 7 | Log Out | KRAFTIN S. | EpicCare |

Patient Lists

Edit List | Write Handoff | Patient Msg | Create Progress Note | Orders | Treatment Team | Sign In | Sign Out | Reports | **Print** |

My Lists

- Consults
- My Patients
- My Favorite Lists
 - 4 Day Discharged
 - EH ED
 - EH P6**

Shared Patient Lists

Print Rounding List | Print Handoff | **Print Patient List**

Unit	Bed	Patient Name	Age	Attending	Exp Disch Date	MLOS
EH P6	S11A					
EH P6	S06A				05/17/...	3.8
EH P6	S02A					
EH P6	S04A					
EH P6	S12A					
EH P6	S09A					

Recent Searches

- All Admitted Patients
- EH Discharged Patien...
- Episcopal Campus
- Fox Chase Campus
- Fox Chase Discharge...
- HOD
- Jeanes Campus
- JH Discharged Patien...
- Preadmitted Patients

66°F Mostly cloudy | Search | 1:38 PM | 6/28/2023

EPIC DOCUMENTATION ON C6 PATIENTS

1. Go to P6 Patient List
2. Select patient row of patient you want to write a note on
3. Click 'Notes' (can double click and go to notes also)

The screenshot shows the EPIC Patient List interface. At the top, there are tabs for 'Problem List', 'Orders', and 'Notes'. A red arrow points to the 'Notes' tab. Below the tabs is a list of patients with their names, room numbers, and status. The first patient listed is 'EH P6 S00A Radiant, Rvcthree Epic'. On the left side, there is a sidebar titled 'Available Lists' with various patient categories like 'Recent Searches', 'All Admitted Patients', 'Chestnut Hill Campus', etc. A red arrow points to the 'EH P6' entry in this list.

4. Click New Note

The screenshot shows the 'Notes' section of EPIC. At the top, there are buttons for 'Summary', 'Chart Review', 'Results Review', 'Problem List', 'Hospital Course', 'Notes' (which has a red arrow pointing to it), and 'Discharge Summary'. Below these are buttons for 'New Note' (circled in red), 'Create in NoteWriter', 'Filter', 'Load All', 'Show My Notes', and 'Show Notes by ...'. A red line also highlights the 'Notes' tab in the top navigation bar. At the bottom, there are tabs for 'All Notes' (highlighted in blue), 'Progress', 'Consults', 'Procedures', 'H&P', 'Discharge Summary', and 'ED Notes'.

5. Then put in a "1" for note type of Progress Notes, so that it gets filed in the correct spot in Chart Review

Date of Service: 6/14/2023 11:17 AM

Type: 1

Title	Number
Progress Notes	1

EPIC ORDERS ON C6 PATIENTS

1. Go to P6 Patient List
2. Select patient row of patient you want to place an order on
3. Click 'Orders' (can double click and go to orders also)

Unit	Bed	Patient Name	Age/Gender	Isolation
EH P6	S11A	[REDACTED]	57 y.o. / M	Contact
EH P6	S06A	[REDACTED]	87 y.o. / F	—
EH P6	S02A	[REDACTED]	46 y.o. / M	—
EH P6	S04A	[REDACTED]	67 y.o. / M	—
EH P6	S12A	[REDACTED]	56 y.o. / F	—

4. Click on 'Manage Orders' or 'Order Sets' to add new orders.
 - a. Existing orders can also be modified from the Orders tab under 'Active'

EPIC C6 ADMISSIONS

1. Select new admitted patient from C6 list
2. Under Orders Tab, go to Order Sets on far right

The screenshot shows the EPIC C6 interface. The top navigation bar includes 'Chart Review', 'Summary', 'Synopsis', 'Intake/Output', 'Problems', 'History', 'Notes', 'Medications', 'Flowsheets', 'Results', 'Allergies', 'Direct Admit', 'Orders', and a dropdown menu. Below this is a secondary navigation bar with tabs for 'Active', 'Signed & Held', 'Home Meds', 'Cosign', and 'Order History'. A message at the top states, '(?) Pathways can now be added in the orders cart alongside other orders and order sets.' On the right, a floating window titled 'Orders' shows 'Manage Orders' and 'Order Sets' with a circled 'Order Sets' button and a red arrow pointing to it. The main content area displays 'Other Procedures' for 'Admit to Inpatient Services' with details like 'Service: Hospitalist, Level of care: Acute', 'Admission diagnosis: Soft corn', 'Accepting attending: PANKRATOVA, TATYANA', 'Bed request needed? Yes', and 'Bed type: Routine'. Buttons for 'Modify' and 'Discontinue' are visible.

3. Select General Admission (or other relevant order set)

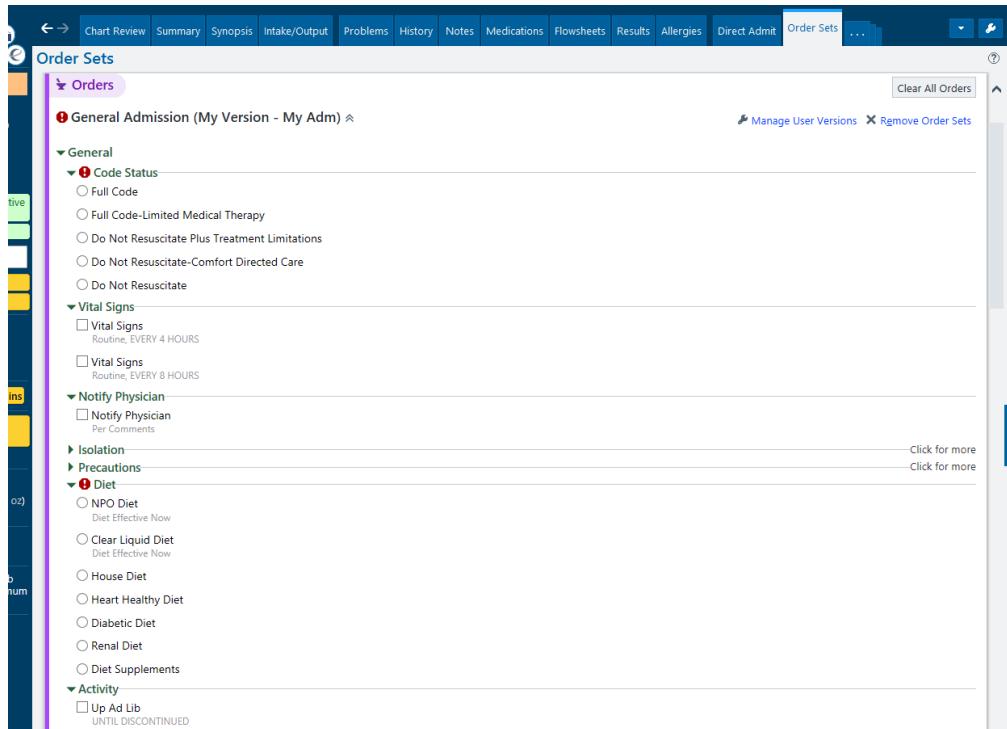
The screenshot shows the 'Order Sets' screen. The top navigation bar includes 'Chart Review', 'Summary', 'Synopsis', 'Intake/Output', 'Problems', 'History', 'Notes', 'Medications', 'Flowsheets', 'Results', 'Allergies', 'Direct Admit', 'Order Sets', and a dropdown menu. The main content area has a sidebar with 'Order Sets and Pathways' and 'Favorites' sections. Under 'Favorites', there is a list of order sets with checkboxes: 'Acute Coronary Syndrome Admission / Chest Pain (My Version - My CAD)', 'Asthma and COPD Admission (My Version - My ASM)', 'Community Acquired Pneumonia Admission (My Version - My PNA)', 'General Admission (My Version - My Adm)' (which is checked), and 'Glucose Management (Diabetes Orders) (My Version - Glucose Mgmt)'. To the right, there is a list of additional order sets: 'Healthcare Acquired Pneumonia Admission (My Version - HCAP)', 'Heart Failure Admission (My Version - My CHF)', 'Opioid Dependence Order Set (My Version - OUD)', and 'Syncope Admission (My Version - My Syncope)'. At the bottom right are buttons for 'Open Order Sets' (with a green checkmark) and 'Clear'.

4. The General Admission Order Set will open.

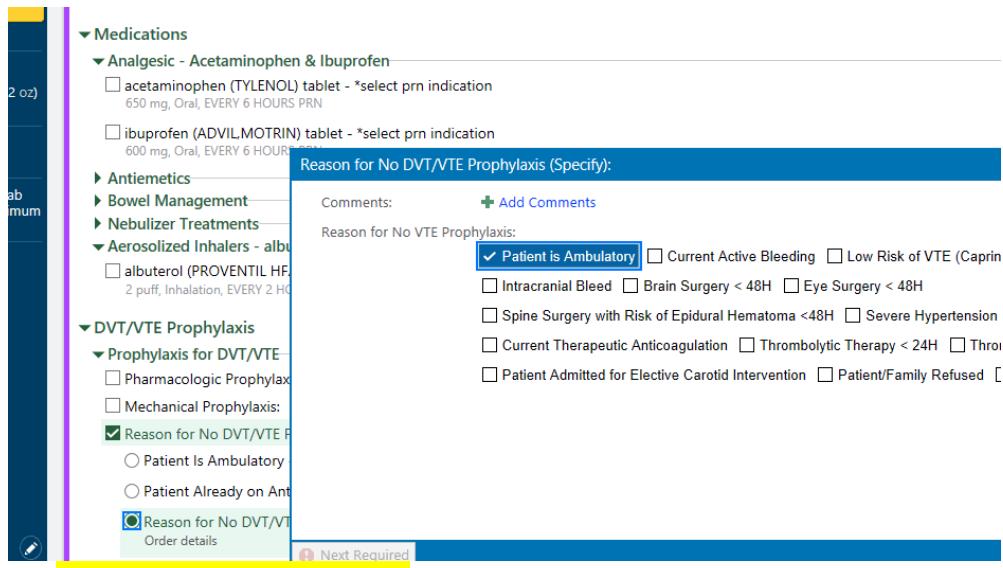
- a. There are a few mandatory fields (code status, diet, DVT prophylaxis).

You can also click through other common orders like vital signs (q8 is most common) and medications.

- a. Note, tele orders are not included and would have to be ordered separately if needed.



5. DVT prophylaxis will open further and prompt you to choose the correct option.



6. Go to the Admission Tab



7. Review the problem list. Add any new diagnoses if needed. Then click Admission Orders:

Admission

OUTSIDE RECORDS

Care Everywhere
Rec Outside Info

HISTORY

Medical
Surgical
Family
Social
Sexuality & Gender
Immunizations
Allergies
Outside Meds
PDMP in Epic
PTA Meds

ORDERS AND BPA

Problem List

Admission Orders

BestPractice

HISTORY & PHYSICAL

Expected Discha...
H & P Notes
Progress Notes

8. First, reconcile outside medications. Edit as needed.

Admission

1. Reconcile Outside Medications 2. Review Home Medications 3. Review Current Orders 4. Reconcile Home Medications Restart from Previous Admission 5. Order Sets

Dispense Report Medication Rx

9. You can add (plus sign) or delete (trash can) as needed

Reconcile Outside Information

Allergies Medications Problems

Medication	Sig	Start Date	End
DESOGESTREL-ETHINYL ESTRADIOL			
desogestrel-ethinyl estradiol 0.15-30 MG-MCG dosepak New Add as: desogestrel-ethinyl estradiol (APRI) 0.15-0.03 mg per tablet	Dose: 1 tablet	Take 1 tablet by mouth daily.	
ABACAVIR/DOLUTEGRAVIR/LAMIVUDI			
abacavir-dolutegravir-lamivud (TRIUMEQ) 600-50-300 mg Tablet On chart		Take by mouth daily.	
abacavir-dolutegravir-lamivudine (TRIUMEQ) 600-50-300 mg tablet Similar Add as: abacavir-dolutegravir-lamivud (TRIUMEQ) 600-50-300 mg Tablet tablet		Take by mouth .	

[Dispense Information Disclaimer](#)

Medication

Medication
DESOGESTREL-ETHINYL ESTRADIOL
desogestrel-ethinyl estradiol 0.15-30 MG-MCG dosepak New Add as: desogestrel-ethinyl estradiol (APRI) 0.15-0.03 mg per tablet
ABACAVIR/DOLUTEGRAVIR/LAMIVUDI
abacavir-dolutegravir-lamivud (TRIUMEQ) 600-50-300 mg Tablet On chart
abacavir-dolutegravir-lamivudine (TRIUMEQ) 600-50-300 mg tablet Add as: abacavir-dolutegravir-lamivud (TRIUMEQ) 600-50-300 mg Tablet tablet

[Dispense Information Disclaimer](#)

Certain dispense information may not be available or accurate in this list, including items that have been discontinued or removed from the system.

10. Then, go to order sets and open the general admission order set (or whichever applies to your admission)

Admission

1. Reconcile Outside Medications 2. Review Home Medications 3. Review Current Orders 4. Reconcile Home Medications Restart from Previous Admission **5. Order Sets**

Orders from Order Sets

Order Sets and Pathways

Favorites

Acute Coronary Syndrome Admission / Chest Pain (Wayne Satz, MD - My CAD)
 Asthma and COPD Admission (Wayne Satz, MD - My ASM)
 Community Acquired Pneumonia Admission (Wayne Satz, MD - My PNA)
 General Admission (Wayne Satz, MD - My Adm)

Glucose Management (Diabetes Orders) (Wayne Satz, MD - Glucose Mgmt)
 Healthcare Acquired Pneumonia Admission (Wayne Satz, MD - HCAP)
 Heart Failure Admission (Wayne Satz, MD - My CHF)
 Opioid Dependence Order Set (Wayne Satz, MD - OUD)

Open Order Sets Clear Selection

Previous Next

11. Complete the order set. Please note Diet and DVT prophylaxis are required fields.

Orders from Order Sets

Order Sets and Pathways

Orders

General Admission (Wayne Satz, MD - My Adm) ☰

Clear All Orders

Manage User Versions Remove Order Sets

General

Code Status

Vital Signs

Vital Signs
Routine, EVERY 4 HOURS

Vital Signs
Routine, EVERY 8 HOURS

Notify Physician

Notify Physician
Per Comments

Isolation

Precautions

Diet

NPO Diet
Diet Effective Now

Click for more

Click for more

12. You can then order any additional items needed. See EPIC_Orders on C6 Patients for more information on how to do that.

EPIC DISPOSITIONING A PATIENT FROM C6

*Only used for AMA. All discharges should be left to AM attending. Anyone needing a transfer should come through the ED as an RRT.

1. Open patient from C6 list

2. Go to Discharge Tab

The screenshot shows the EPIC Orders interface. At the top, there are tabs for Summary, Chart Rev..., Results, Proble..., Hospit..., Notes, Orders, Admission, and a dropdown menu. The Orders tab is highlighted with a pink border. A red arrow points to the 'Discharge' option in the dropdown menu, which is also highlighted with a pink border. Below the tabs, there are buttons for Active, Signed & Held, Home Meds, Cosign, Manage Labs/Reprint, and Order History. A status bar at the bottom says, "Pathways can now be added in the orders cart alongside other orders and order sets." A 'Dismiss' button is also visible.

3. Go to Discharge Orders

The screenshot shows the EPIC Discharge Orders interface. At the top, there are tabs for Summary, Chart Review, Results Review, Problem List, Hospital Course, Notes, Orders, Admission, Transfer, Discharge, Procedure, and Discharge. The Discharge tab is highlighted with a pink border. On the left, a sidebar lists various discharge-related options, with 'Discharge Orders' highlighted with a red box. The main area shows sections for BestPractice Advisories (No advisories to address), Discharge Instructions (Additional Diet Instructions, Additional Activity Instructions), and Discharge Readmit/Deceased options.

4. Go to Order Sets and select 'General Discharge'

The screenshot shows the EPIC Order Sets interface. At the top, there are tabs for Summary, Chart Review, Results Review, Problem List, Hospital Course, Notes, Orders, Admission, Transfer, Discharge, Procedure, and Discharge. The Discharge tab is highlighted with a pink border. On the left, a sidebar shows 'Orders Needing Cosign' and 'Place New Orders'. Under 'Place New Orders', 'Order Sets and Pathways' is expanded, showing 'General Discharge' selected. A red box highlights the 'General Discharge' link. The main area shows a list of order sets, with 'General Discharge' circled in red. To the right, a detailed view of the 'General Discharge' order set is shown, listing items like 'Take 20 mg by mouth daily', 'paroxetine (PAXIL) 40 mg tablet', and 'senna (ENOKOT) 8.6 mg tablet'.

- Click 'Open Order Set'

Discharge

Review Home Medications Meds to Beds Opt-In 1. Reconcile Orders for Discharge 2. Order Sets

Orders Needing Cosign

General Discharge

Opioid Dependence Order Set (Wayne Satz, MD - OUD)

Open Order Sets Clear Selection

2. Under 'Discharge Patient' click 'Order details' and choose 'Left Against Medical Advice'

Discharge

Review Home Medications Meds to Beds Opt-In 1. Reconcile Orders for Discharge 2. Order Sets

Orders Needing Cosign

General Discharge

Discharge patient

Discharge Patient Order details

General

Diet

Discharge Diet: Return to Clinic
 Discharge Diet with Restriction
 Discharge Diet with Fluids
 Discharge Diet -Enteral

Nursing Instructions

Discontinue Telemetry Monitor Routine ONE TIME today

Discharge Patient

Disposition: Left Against Medical Advice Court/Law Enforcement Hospice/Home Hospice/Medical Facility Trans to LTAC Hospital Trans to Psych Trans to SNF/Ext Care Transfer to Rehab Discharge to HH related to Admission

Discharge Date & Time: Today Tomorrow

Morning Midday Afternoon Evening

Who is responsible for completing the discharge summary for this patient?

3. Then complete remaining required fields. The patient will need a discharge summary – just write a quick note about the AMA.

- If the patient was admitted that same shift, the H+P (found under the admission tab) will also be required – just copy and paste the ED MDM.
- On the treatment team, update the attending to you