MSH Emergency Department

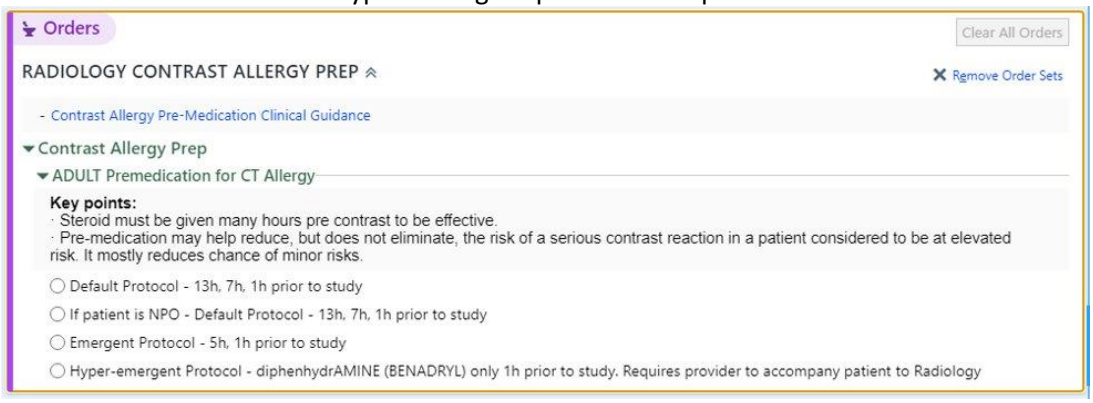
EM Operations and Quality Updates

Date: 1/13/2025

Clinical Care

Radiology Updates

- Contrast Allergy Order Set
  - Please use the new Contrast Allergy Order Set, shown below, for patients requiring pre-medication for iodinated contrast allergies
  - The top of the order set contains a link to clinical guidance that helps determine which protocol to use. For the majority of ED studies for patients requiring urgent studies with a history of mild or moderate reactions, please use the 5-hour protocol.
  - For patients who have a history of a severe allergic reaction or anaphylaxis, please consider performing a non-contrast study or use an alternative modality. If the decision is made to proceed with a contrast study in this population, a provider must accompany the patient and document their reasoning in a progress note. This is also true for instances when the hyper-emergent protocol is required.

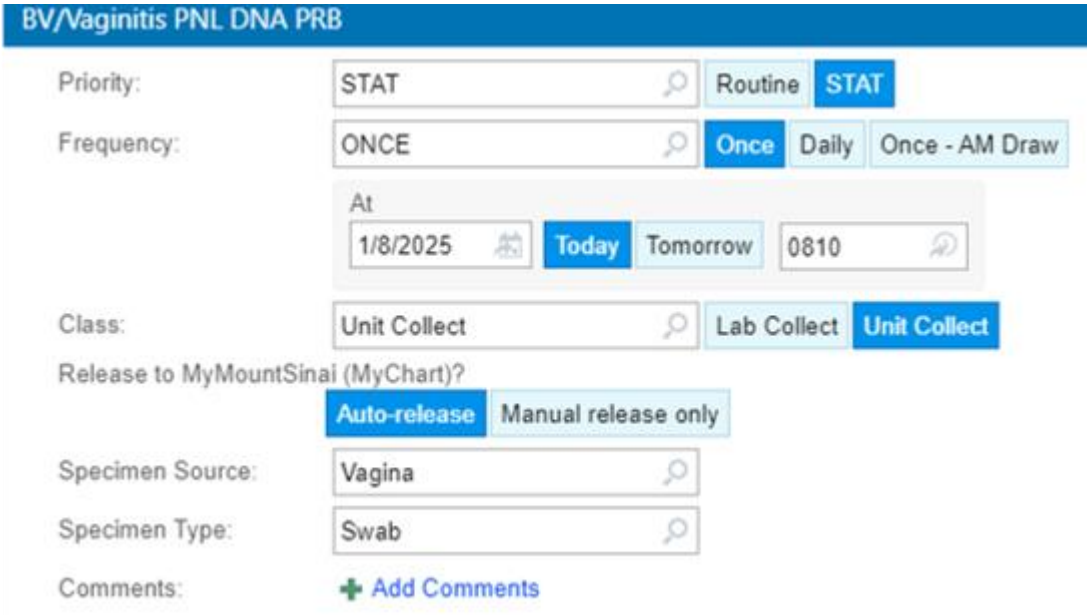


- Push model for Non-Contrast CT
  - Please continue to order transport for stable patients pending non-contrast imaging. This is the only type of imaging we can put in transport for and will help ensure these studies get done in a timely manner. *Please do not order transport for patients to go to x-ray.*
- Resus Chat
  - The daily Resus Radiology Chat is being started by Yadira who is the day-time expediter. Please ensure the chat includes all members of your Resus team (Attending, Resident, Resus Flex Senior, Resus Shadow Intern, Resus Lead RN). You should add the on-coming provider at sign out to ensure continuity of each day's chat. Ideally, the chat should also include the Charge RN, ANM, and AOC.
- MRI Weekend Staffing

    - There is no weekend night MRI availability (Saturday/Sunday 11:59 PM-8 AM) except for emergent studies. To get an emergency study (e.g. cord compression) performed, please call the radiology reading room and have the resident call in the on-call tech. If there are issues getting the resident or on-call tech, please escalate to the AOC in real time. This should also be factored in when accepting transfers for emergent MRI.
- Non IV Contrast Administration
    - Please review the policy on Non-IV Contrast Administration, which is now available on Epic Documents. This policy delineates who is expected to inject contrast for each type of study. For urethral and rectal contrast, Urology and Surgery are the preferred injectors but are not required to inject and at times if they are unavailable, the ED provider would be expected to inject contrast.

Update on STI Testing

- The blue endocervical/urethral swabs have been removed from the ED. All gonorrhea and chlamydia testing should be performed using the orange swabs that can be used for vaginal, rectal, and oropharyngeal testing.
- When ordering STI testing, please use the STI order set to place the order and select the correct swab to ensure the order is not cancelled by the lab. Please also ensure the correct label is placed on the correct swab. The order set also includes guidance on proper co-testing and treatment. Free texting the test will likely result in ordering the incorrect one and result in cancellation.
- BV/Vaginitis Swabs are now stocked in the supply rooms and can be used to test for BV and Candida. Please follow the directions on the bags to appropriately collect the specimen. The test order name is “BV/Vaginitis PNL DNA PRB”, specimen source is “Vagina”, and specimen type is “Swab”.



PIT Overnight Weekend Staffing

- There will no longer be a PIT provider scheduled for Friday, Saturday, and Sunday overnights. PIT will start to close at 10:30 PM each night.
- The PIT provider should huddle with the EMS and Walk In RNs to determine the final few patients to go through PIT to ensure no patients pending when they leave at 11 PM.
- Please monitor the track board on weekend overnights to ensure patients triaged to your area have orders placed in a timely manner if evaluation is delayed.

Guidelines for Managing Adult ICU Patients in the ED

- As a result of a few safety events surrounding ICU patients boarding in Resus, ED and ICCM leadership have established new guidelines and workflows for the management of these patients
- Please read through the entire guidelines prior to your next Resus shift as they include screenshots of important workflow changes. They can be found under Epic Documents: Critical Care > "Guideline for Managing Adult ICU Patients in the ED"
- Key takeaways:
    - Patients accepted to any ICU will be admitted using the regular admission order but handoff note is written when patient is ready for transport to the ICU. This will keep the handoff icon red on the trackboard to make it obvious at signout that these patients are still active ED patients.
    - An admitted ICU patient in the Adult ED remains under the care of the ED team until the patient goes upstairs HOWEVER there is to be a check in between ED and ICU team every 4 hours after the initial consult if patient remains downstairs to follow up on any outstanding tasks and/or help troubleshoot delays
    - Prior to transfer to the ICU:
        - Vitals should be updated to within 15 minutes of departure time
        - Any concerning status change should be communicated to ICU team by phone
        - ED team will complete "ED ICU Handoff" note using .EDADMITICU smart phrase which will automatically pull in latest vitals and drip rates
        - Once handoff note is signed, handoff icon on track board will display green check mark notifying nursing that transport can safely be arranged

Cardiology Admissions

- Cardiology patients can ONLY be admitted to telemetry (ADS or Teaching) or to the CCU (requires discussion with CCU fellow).
- If you are told by a specialty service (e.g., EP) to admit to Cardiology Stepdown, please inform the consultant that this is not an option from the ED and ask if they think the patient is stable for a medicine telemetry bed or needs the CCU. If they need CCU, they *and* you should communicate with the CCU fellow and request a formal CCU consult.
- This is reflected in Epic Documents under "ED to Cardiology Admission Workflow"

Send to OR Disposition

- Patients going directly to the OR require a "Send To" order placed prior to them being moved to the operating room. If a patient's work up is not complete, please do not disposition them to the OR, and please notify OR staff if they contact you about moving a patient that the patient is not cleared to move to the OR. The disposition to OR must be discussed with the ED attending and the Send to OR order must include the surgical attending booking the case.

Death Workflow

- In an effort to streamline the workflow for expired patients, we now have a new system workflow that will display with other links in the disposition tab when "Expired" is selected as the patient's Disposition.
- For All Deaths
    - Call Social Work
    - Notify NOK
    - Determine if ME Case (Review Reportable Death Criteria) and complete OCME Worksheet if the case is accepted or you have not heard back from the ME by the end of your shift.
    - Complete and sign your ED Provider Note
    - Ask NOK about Autopsy and complete the consent form if they agree (even if ME decision is pending)
    - Complete Deceased Patient Disposition Order
    - Start Death Certificate in eVital and sign if not an ME case

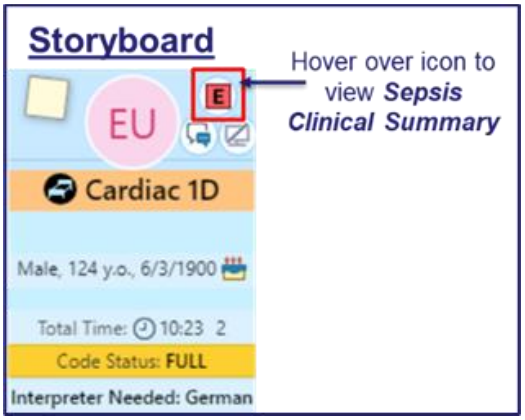
Sepsis Storyboard

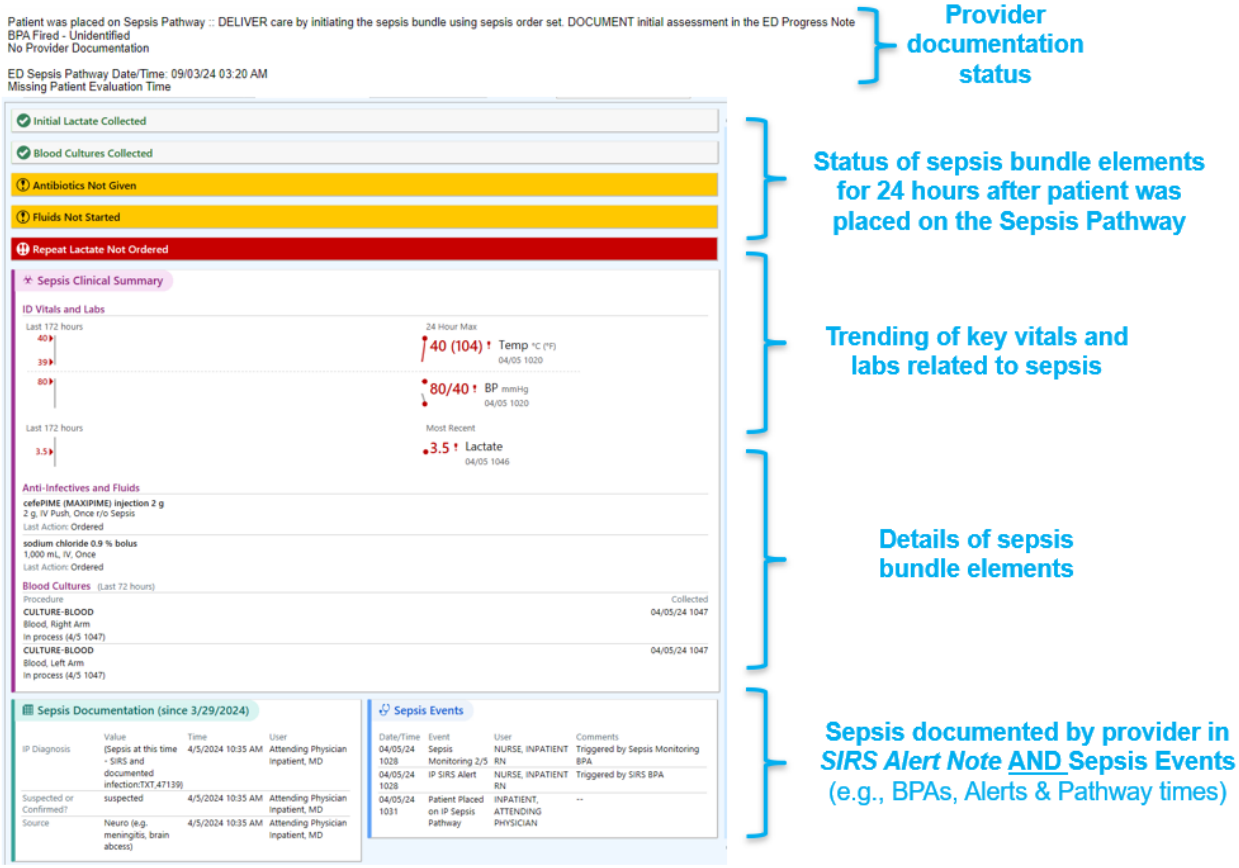
- The screenshots below show the new Sepsis Storyboard icon, which when clicked shows a detailed view of the patient's sepsis care. The hope is that this can be utilized by teams to understand what parts of the sepsis bundle have been completed.
- Please ensure that sepsis flags are addressed in a timely manner and all pending sepsis tasks are included explicitly in sign out. *If you are receiving sign out on a patient and they have an unaddressed sepsis flag, please ask the team to address it prior to signing out.*
- Over the next month our team will be hoping to implement workflows to improve the door to antibiotics times for severe sepsis and septic shock patients. These patients require *broad-spectrum* antibiotics within 1 hour of identification of potential sepsis.

CMS Definitions	
Sepsis	≥2 SIRS criteria + known or suspected infection

Severe Sepsis	Sepsis AND
	At least 1 sign of organ dysfunction:
	• Sepsis-induced hypotension
	  • SBP <90
	  • MAP <65
	  • ↓ SBP >40 from normal baseline
	• Cr >2.0 or urine output <0.5 mL/kg/hr x2 hours
	• Bilirubin >2.0 mg/dL
	• Platelet count <100,000/mm^3
	• INR >1.5 or PTT >60 sec
	• Lactate >2 mmol/L

Septic Shock	Severe sepsis AND • Persistent hypotension after 30 mL/kg crystalloid • Lactate ≥4 mmol/L





Chest Tubes

- Chest tube placement trays have been stocked in the far-right cabinet in resus. You can use these kits with the chest tubes stocked in the middle cabinet. The kits include the following supplies:

AMPULE BREAKER	NEEDLE 22G
ANTISEPTIC APPLICATOR	NEEDLE 25G
CSR WRAP	NEEDLE HOLDER
FOAM POUCH	OR TOWEL
FOAM SHEET	PETROLATUM DRESSING
FORCEP	SCALPEL NO.11
FORCEP	SCISSORS
GAUZE 4X4	SUTURE O SILK
LIDOCAINE 1% 5ML	TRAY
NEEDLE 18G	

Quality & Safety

Cardiac Monitoring

- When high risk patients are put on telemetry, it's important to know how to review the monitor to see if any dangerous arrhythmias have been captured. You can find a step-by-step process here: How to Review Cardiac Monitoring.pdf
- While we know that beeping monitors can be frustrating, DO NOT unplug the monitors. If the beeping is incessant or bothersome, please address any concerning alarms with the nurses caring for the patients and if persisting, please escalate to the ANM or call the Physician AOC to help troubleshoot. ***Under no circumstances should monitors be unplugged as this is a huge safety issue.***

HIPPA violations in Zone C

- Understanding that space is an issue, please take extra steps to protect private patient information in Zone C (Mid-Fast). We should not be interviewing or providing discharge instructions to patients in the lounge when other patients are within ear shot. Patients should be escorted to a bay or room for an interview and exam and once complete, moved back to the waiting area so other providers can use the space.

Psych Consult for Capacity Evaluation

- As discussed in faculty meetings, we consistently review safety nets, and part of our response is clinical pathways. This is one example of more to come.

Psych to ED

- Acute 2/PIC or Pediatric Attending may receive a call/secure chat for patients in the Psych ED with medical concerns requiring ED evaluation.
- If you can evaluate the patient in the Psych ED in <30 minutes, please proceed.
- If not, the patient should be accepted and transported to Acute 2/Peds ED.
    - Accepting attending calls ED Charge RN (917-841-2823) in anticipation of patient transfer.
    - Psychiatry attending will write or co-sign a note with recommendations.
- Accepting ED RN will call Attending to huddle using a checklist.

Find more information here: Psych ED to Med ED Transfer Pathway.pdf (mountsinai.org)

Initiation of OCPs from the ED

- It is now possible to initiate OCPs from the ED, please find recommended clinical pathway in Epic ED Documents.

Find more information here: 10.09.2024 Provider Education_ Initiation of OCPs from the ED.pptx

New Blood Transfusion Consent Form

- A new system wide Blood Transfusion consent form has been rolled out and updated on Epic Documents. It has been noted that the new form makes it less obvious to obtain a witness however ALL consents require a witness. We are working with the system to update the form to make it more obvious but in the meantime, please make sure you are having a witness sign the consent form.