I. RUNNING THE ROOM

1) Make sure everyone in the ED is seen expediently

a) Screen patients ---eyeball and make sure orders have been ordered/sent for
- Middle of the Room (MOR) patients—within 20 minutes
- BBN or beds 1-3-- ASAP
- Beds 4-13 or RUSH within about 15 minutes, if possible
- Otherwise within 30-45 minutes
- Possible critical complaints you should also eyeball ASAP: low BP, CP, LN

b) Assigning patients
- if it's been >30min, see the pt yourself OR assign the pt to a co-worker
- DO NOT try to see everyone yourself
- Don't get stuck in long procedures/hallways
- **BE AWARE of all the Tiers and assign someone. Nurses may not tell you directly. Keep your eye on the board and listen for the pager/radio.
- Any trauma patient in Peds needs a senior to intubate (still should be R3s?); assign someone.

d) Be wary of the intern/med student who has not presented in 1 hour+
- Good tip: assign a student/intern to and I&D/lac/easy dispo you eyeballed

2) Opening up beds

a) One bed in bed 1-3 should be opened at all times

b) After you get your list of "follows" try to eyeball all your admitted patients as this will help you decide if they can be downgraded (confirm this with admitting team)
- Tele for r/o ACS patients who have stable vitals, one neg enzyme
- neg AFBs x 3 can get off ISO

c) At night **Ward Call** is in charge of all **boarded ED patients**

d) Write holding orders for Fam Med/Med (not hospitalists), for WARD immediately, for PCU w/in 30 minutes

3) Triaging patients that are BLS runs

a) Do a quick H&P/exam, can get BS, hemoccue

b) Normal vitals, normal MS, non-worrisome complaint, can walk/sit in chair, not heavily intoxicated, not suicidal, not active vomiting, can go to triage
- if in doubt, ask an attending

c) Tier-0s
- Feel their belly, check MS and extremities, ask if they were knocked out-
- If anything is "off" you can make it a delayed Tier-1
- Try to clear c-spine, or at least get them off the backboard

e) Try not to get bullied by the charge nurse to send patients out. You know better!

f) "Clear to Psych with no medical complaint" needs a quick note on a 254 (the same the medicine residents use) explaining that you have cleared them
- ETOH < 0.2 (use the breathlyzer)
- no history of overdose, and same guidelines as above

g) In general, we aren't supposed to send out any (MLK) transfers to triage, but in severely overcrowded cases, it's been done, just run it by the attending

II. PHONE CALLS

1) Abnormal lab callbacks

a) Try to locate patient, check if patient is still in the ED or MSE, or admitted
b) If admitted, tell the tech/rads that they need to call the admitting doctor
c) If not, check out what was done for the patients, i.e. EDM
- if not yet in EDM, to find out who saw the pt and DISCHARGE DIAGNOSIS
- on Affinity, go to the Results scroll down for i.e. "chemistry " select / click on "***ED Log***", a new window should give you the resident / their diagnosis
-- or go to the “back room” and look for the last week’s paper charts

d) If pt was sent home and they need to be recontacted look up pt contact info
- Ask clerk to print out demographic info
- Also can look up with the newer " clinic work station” app, under section "Administrative data"
- Call patient or send them a telegram if they are hard to reach
- Can call police in an emergent situation

2) ED Discrepancy Folder (over reads)

a) Check folder every shift, and clear 2-3 over-reads
b) Open synapse and go to -->Conferences--->ED discrepancy
c) If the patient is admitted, then write that pt is admitted in the note section
d) if not, then it's the same process for pt with abnl labs for tracking them down

3) Outside clinics, MLK, Hubert-Humphrey transfers

a) We generally don't refuse any transfers
b) However, if the pt is unstable, they should call 911 and go to the nearest hospital
c) Inform the charge nurse that esp if they need open a monitored bed

4) Harbor Clinic patients

a) Again, generally cannot refuse patients
b) if they do not need to be monitored bed, they can go to Urgent Care instead
c) if they are being admitted, and are otherwise stable (do not need monitor) then they should bypass the ED and go through pt flow coordinator
d) When Urgent care closes, pt is sent to the ED, they will sign out to you 11pm-mn
e) FYI the charge nurse about all incoming patients

5) MAC transfer requests

a) Often for "higher level of care"
b) Must route through the patient flow facilitator (PFF) first. PFF contacts the subspecialist for approval. PFF then calls us for approval.
c) Make sure you run the patient by the specialist and admitting team, e.g. multi-trauma pt who needs NSG needs to be accepted by neurosurgery AND trauma

6) If NEDOCS is super high—we can close to MLK transfers- also MAC lateral transfers (ER-ER, non EMTALA) etc.. look at NEDOCs for what to do

Last updated: 4.2.2010