PATIENT CARE MANAGEMENT

Emergency Medical Treatment & Labor Act EMTALA
All pts entitled to a medical screening exam (MSE), to determine if they have an emergency medical condition (EMC).

This includes pregnant women who are having contractions.

If an EMC exists, the ED is obligated to provide treatment until pt is stable or to stabilize & transfer.

MSE or treatment can't be delayed to determine insurance coverage.

What is "Stable"?
No material deterioration of the patient's condition is likely to result from the transfer or is likely to occur during the transfer.

Pt in active labor - the infant and the placenta have been delivered.

Transfer Guidelines Include:
Written consent prior to transfer
Risks & benefits
Copies of the medical record
Name of any on-call MD who has refused/failed to appear
Coordination by direct communication between referring physician and receiving physician
The receiving facility should have available bed space
Always document receiving physician & phone number
Must be transferred w/ experienced personnel & necessary equipment

Transfer Summary Includes:
Physician certification
Patient ID, address, and next of kin with phone numbers
History of injury or present illness
Condition on admission
VS during all phases of care
Any treatments or medications given
Copies of labs and x-rays
Fluids received while in ED and volume
Name, address, and phone #s of referring & receiving MDs and hospital

NOTES

Patient Transport Considerations
Care requirements
Space limitations
Transport time (air vs. ground)
Personnel qualifications
Weather & terrain conditions
Family members needing transport
Stabilize patient

Other Considerations
Family members
Never let family leave before patient.
Provide maps/directions and phone #s for family.

Ground
Consider BLS vs ALS needs/availability

Air
Rotary vs fixed wing
Availability risks/benefits/time

Special Considerations for Air Transport
NGTube placement
Foley catheter insertion
Decrease cuff pressure on ETT
Do Not use airsplints
Position to decrease ICP
Pneumothorax: be sure to decompress (consider Heimlich valve)

HIPAA
Health Insurance Portability and Accountability Act
Implemented under CMS
(Centers for Medicare and Medicaid Services), Statutory law
Protects health insurance coverage for workers.
Health care providers & plans must implement privacy procedures to protect patient privacy.
Regulates the disclosure of protected health information (PHI).
"Covered entities" MAY disclose PHI to facilitate patient care.

Consent
No law exists requiring written consent from patient.
Written documentation should be obtained after initial medical screening exam (MSE).
Informed consent requires that the patient understands the nature of the procedure or treatment.
If patient is unable to sign, two witnesses are required.

NOTES

Types of consent
Express Consent
Voluntary consent of a pt requesting medical treatment.
Based on the patient's competency
Example: signed consent to treat

Implied Consent
Life or limb threatening situation
Example: Critical patient, unconscious

Involuntary Consent
Individual refuses to consent to needed medical treatment.
A second professional is of the opinion that the patient receives treatment.
Example: Suicide attempt, or at risk of harm to self of others.
The ED physician can, with a psychiatrist or judge, sign a judicial consent for a specific time period.

Consent for procedure/Informed Consent:
3 Components
Explain the procedure
Explain available alternatives
Explain possible risks

Surgery performed without consent is **battery.**
Surgery performed without informed consent is **negligence.**

Negligence
"Action or inaction that does not meet the standards of care and results in injury"

4 Elements
Duty to act (relationship established)
Breach of duty/contract (care was sub-standard)
Proximate cause (breech was actual cause of injury)
Result in damage (injury caused by negligence)

Assault/Battery
Assault
Attempt or threat to touch another person or the person's possessions without his/her consent

Battery
Actual contact with a person or the person's possessions without consent
(IE: "unauthorized touching")

NOTES

Minors
States vary in the age defining a minor.
<18 = minor in most states.

Special situations
Treatment for STD or pregnancy related condition
Emancipated minor: varies by state
Pregnant minors
Behavioral/Mental health or substance issues
If a minor presents to ED without parents, reasonable effort should be made to contact.
If unable to contact parents, "minor's consent" applies to true emergencies.
Do what's in the best interest of the minor

Reportable Situations
Gunshot & Stab wounds
Injuries due to violent crimes
Communicable disease (as determined by state DOH)
Child/Elder/Spousal abuse
Any death within 48 hours of admission to the hospital
Poisonings/Overdoses (varies by state)
Fetal deaths
Dog Bites (local public health laws may dictate specifics)

Blood Alcohol Consent
Give patient opportunity to consent and document their choice.
If pt gives cosent, then proceed to draw blood.
If law enforcement has a legal warrrant or seizure order, may draw without patient's consent.
Never use physical force or intimidation.
If no warrant and patient refuses:
DO NOT DO THE BLOOD DRAW.

Critical Incident Stress Debriefing (CISD)
Confidential, not recorded
Only debrief team and employees involved
Fact finding, NOT blaming or faulting
Open talking/discussion/personal feelings are encouraged.
Possible unresolved issues or concerns addressed.
Stress reduction and communication techniques are reinforced.

Delegation and Assigning
Delegation
Technical tasks can be delegated to unlicensed personnel.
Professional activities can not be delegated.
(IE: Steps of nsg process, triage, extensive teaching, discharge)

NOTES

Assigning
The transfer of responsibility & accountability to another licensed person (within their scope of practice).
Example: RN to LPN, RN to RT

Specific state board of nursing regulations may supersede.

Forensic/Evidence Considerations
Maintain chain of custody.
Consider most reportable cases as possibly forensic .
Document behaviors & use direct patient quotes.
Preserve evidence, minimize handling when possible.
Paper bags
Don't cut thru holes (or marks) in clothing.
Hands: don't wash & consider bagging.
If possible (and safe) consider delaying cleaning the patient and/or wounds.

Restraints
Guidelines per JCAHO and CMS
Any restraint has possible risks.
Use least restrictive first, then escalate PRN.
Restraint orders must be time limited.
Policy will dictate defined assessment intervals

Consider, offer and document:
food, hydration, toileting, skin, positioning
Intermittently attempt to reduce or release restraint.
Have goals for release of restraints, include pt if possible.
Consider using a restraint flowsheet.

Procedural Sedation
AKA: "Moderate" or "Conscious" sedation
Pt can maintain their airway and protective reflexes.

Drugs: sedatives, amnesics, anxiolytics, analgesics

Reversal agents should be at hand.
Follow policy/procedure for flowsheet.
Physician consent for BOTH procedure & sedation.
Resuscitation equipment readily available.
One nurse solely dedicated to monitoring the pt and NOT involved in ANY other task, including assisting with the procedure.
Continuously monitor patient until recovered.

NOTES

Patient/Family Education
Cognitive: Thinking and Reasoning
Example: information about disease process, discharge instructions
Affective: Change in attitude or values
Example: educating to change health behaviors; importance of immunizations
Psychomotor: Motor skills
Example: crutch walking training, use of peak flow meter & inhalers

Teaching Methods
Discussion
Two way communication, open ended
Question & Answer
Assesses knowledge, stimulates thinking
Visual Aids
Adds meaning to new information
Lecture/didactic
Often faster, but not the best way

Teaching Process
Identify the needs of the patient
Identify readiness, capabilities, motivation, and barriers
Establish goals
Evaluate the effectiveness of teaching
Document
Return Demonstration

Documentation
Generate a medical record for every patient.
Rapidly occurring interventions
Use a designated recorder
Critical patients
Documented frequent, repeat assessments of patient responses and to interventions
Resolution to any identified problems must be documented.

Documentation by exception
Focus is on variances from normal assessment
"Normal" except...

Documentation elements:
Patient assessment
Interventions to identified problems
If a problem is found, it must be addressed
Patient response to interventions
Dates & times
Nurse's full name, credential & status
Communication with MDs
Patient teaching
Content taught
Method used
Pt response

NOTES

Discharge Documentation
Patient has understanding of the instructions prior to discharge.
All patients receive written and verbal instructions.
Written material at 6th grade level.
Must have available in predominant language(s).

Disaster Preparedness
A Disaster is….
Sudden and unexpected
Demands immediate, multiple resources (public and private)
It is based upon available resources
What is a disaster in a smaller community, may be the "normal" in a larger community.

Types of Disasters
Natural
Tornadoes, hurricanes, earthquakes, blizzards, epidemics, floods
Man-made
Fires, explosions, transportation/traffic, civil unrest, nuclear incidents, terrorist attacks

Federal government response: National Disaster Medical System (NDMS)
Take over state operations for a 2 week period of recovery.
Be activated only in response to a request from the governor of the state.
Send federal personnel to the state within 8-12 hours.
Exert federal control over a hospital.
Coordinate federal and state resources.

Disaster Phases
Pre-impact:
Prevention/mitigation
Usually some time or warning pre-event (hurricaine)
Impact: disaster occurs.
Rescue/Response: review of supplies and resources as ongoing further rescue work
Post-impact: long term
Honeymoon phase: "Glad to be alive", "Could have been worse".
Rehab/Reconstruction period

NOTES

Disaster Plans
Purpose and Scope
Multiple patients
< 10 casualties
Usually single hospital response
Multiple casualty
100 or less casualties
Mass casualty
> 100 casualties
Involves responses from multiple agencies
HCF significantly overwhelmed

Disaster Triage
START (Simple, Triage And Rapid Treatment)
Color coded
Red = Emergent
Life-threatening injury: airway compromise
Yellow = Urgent
Major illness/injury: open fx
Green = Non-urgent
Walking wounded: self-treat
Black = Expectant (dead or expected to die)
Full resuscitation, massive full thickness burns

Activation Process
Defines how the disaster plan is implemented

Mobilization and staging
Normal readiness
Increased readiness
Warning
Response
Recovery

Staff Recall/Notification
"Disaster Call Tree" system in place
Patient Management Plan

Procedure for key functions of plan
Patient Care
Command Posts
Work pool
Family care
News/Media/Public Relations

How To Prepare For Disasters
Have Drills
Provides opportunities for practice
Can script "what if?" scenarios
Reduces anxiety should the actual disaster arise.
Take a practical look at the plan.
Is our response plan reasonable?
Options for alternatives for disaster response.
Plan A may not always work out.

NOTES

Evaluation
Every drill needs an evaluation (“hot wash”, after action).
Ensure any identified issues in the drill are definitively addressed and followed up on.

NOTES