

**Policy and Procedure Manual
Reviewed/Revised March, 2012**

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Reviewed/Revised March, 2012
Emergency Department
Policy and Procedure Manual
Stony Brook University Medical Center
Stony Brook, New York

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Manual Code: 1.02

Subject:
Emergency Department (ED) Classification of Capability

Effective Date:
July 1, 1989

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March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. The Emergency Department (ED) of Stony Brook University Medical Center is a Level 1 ED offering comprehensive emergency care 24 hours a day.
2. An attending physician in Emergency Medicine is on-duty in the ED 24 hours a day.
3. Attending physicians in Anesthesiology and Psychiatry are in-hospital 24 hours a day and available for consultation.
4. Senior-level resident physicians in Internal Medicine, Family Medicine, Surgery, Orthopedics, Obstetrics/Gynecology, Pediatrics, Anesthesiology and Psychiatry are in-hospital 24 hours a day and available for consultation.
5. Resident physicians, fellows and attending staff in other subspecialties are available for consultation within 30 minutes.
6. On call rosters for specialty consultation are available in the emergency department as well as being readily available via the page operator.

Subject:
Patient Assessment and Care

Effective Date:
July 1, 1989

Reviewed/Revised as of:
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POLICY:

1. All patients who come to the ED for emergency medical evaluation or treatment will receive care by qualified personnel in a timely manner consistent with the acuity of their illness.
2. Evaluation and care will be rendered to all patients regardless of age, sex, race, creed, national origin, criminal status, immigration status, type of medical illness or ability to pay for care.
3. Patients presenting to the ED will be evaluated by the ED staff under the supervision of the attending physician. The ED attending physician will be responsible for determining the appropriate treatment and disposition of the patient.
4. The assessment will include, but not be limited to, the following:
 - a. The initial assessment of the patient's physical, developmental, and psycho-social status.
 - b. The appropriate treatment setting.
 - c. The patient's desire for treatment
 - d. The patient's nutritional and functional status.
 - e. The appropriate work up and assessment of possible victims of abuse.
 - f. An appropriate discharge planning process to include medical, developmental, psychological, and functional needs of the patient.
5. All patients seen in the emergency department must be registered in the emergency department and assigned a medical record number and an emergency department encounter number. The only exceptions involve pregnant patients who may be triaged directly to the Labor and Delivery area or CPEP. (see Policy #5.03)

Subject:
Patient Assessment and Care

Effective Date:
July 1, 1989

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POLICY:

6. Patients presenting to the emergency department with hand injuries, head trauma, poisonings, and burns will be evaluated by the emergency department staff under the supervision of the attending physician. The reporting of burn injuries will be as stated in the Stony Brook University Medical Center Administrative Policies and Procedures Manual #RI:0027.

Manual Code: 1.04

Subject:
Community-based Emergency Plan

Effective Date:
July 1, 1989

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POLICY:

1. The Stony Brook University Medical Center ED staff and the attending staff in Emergency Medicine are dedicated to participating in the organization, operations and continuing education of the pre-hospital care providers and the EMS system of our community.

Manual Code: 1.05

**Subject:
Emergency Department Design**

**Effective Date:
July 1, 1989**

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March, 2013**

POLICY:

1. The ED is designed to facilitate the safe and effective care of patients.
2. The ED is on the same level as the emergency entrance.
3. The ED ambulance and pedestrian entrances are well lighted, clearly identified by signs, and protected from bad weather. Ramps are provided for patients in wheel chairs or on stretchers.
4. The ED ambulance and pedestrian entrances are wide enough to safely accommodate patients, attendants and equipment.
5. Stretchers and wheelchairs are stored in the area immediately adjacent to the ambulance entrance and do not obstruct this entry.
6. A waiting area, lavatories and telephones are provided for patients, families and individuals accompanying them.
7. Unauthorized individuals are prohibited from entering the ED treatment area (manual code 4.08). Public Safety will assist the ED staff in traffic control.
8. The Critical Care area of the ED is the receiving areas for all seriously ill or injured patients. This area also serves as the admitting area for all seriously ill or injured patients.
9. The ED design maintains patient privacy without compromising patient care.

Manual Code: 1.06

**Subject:
Initial Screening Exam**

**Effective Date:
October, 1995**

**Reviewed/Revised as of:
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POLICY:

1. The emergency department will provide, upon the request of a patient and within the capabilities of the hospital, an appropriate medical screening examination, stabilizing treatment and/or an appropriate transfer to another medical facility to any individual with an emergency medical condition, regardless of the individual's eligibility for Medicare or their ability to pay.
2. This initial screening exam will be completed under the supervision of an attending physician after the patient has been triaged.
3. If the patient is deemed to have an emergency medical condition, the emergency department will provide further examination and treatment (within the departments capabilities) to stabilize the medical condition or make an appropriate transfer in accordance with policy number 4.09 (interhospital transfers).

Manual Code: 2.01a

Subject:
Chief of Emergency Services

Effective Date:
July 1, 1989

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POLICY:

1. The ED Chairman is the Chairman of the Dept. of Emergency Medicine, SUNY-Stony Brook School of Medicine, and Chief of Emergency Services, Stony Brook University Medical Center.
 2. The Chairman is appointed by the Dean, School of Medicine, and the Chief Executive Officer, Stony Brook University Medical Center. He is a member of the medical staff in good standing.
 3. The Chief of Emergency Services has a minimum of 3 years post residency experience in either Emergency Medicine, Internal Medicine or Surgery and is Board Certified in his primary specialty.
 4. The Chief of Emergency Services has the responsibility and authority to implement all policies. He/she coordinates and implements all activities consistent with the mission of the organization and the needs of the community.
 5. The Chief of Emergency Services has the responsibility and authority to improve the organizational performance of the ED. This includes the monitoring and evaluation of clinical services and the authority to take appropriate action when indicated.
 6. The Chief of Emergency Services, Assistant Chief of Emergency Services or assigned administrative faculty in Emergency Medicine, is always available to the ED.
 7. The Chief of Emergency Services is a full-time position.
 8. The credentials files of the Chief of Emergency Services, Assistant Chief of Emergency Services and attending staff in Emergency Medicine contain biannual documentation of their qualifications consistent with their faculty appointment as well as documentation of their current competence.
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Manual Code: 2.01c

Subject:

Attending Physicians in Emergency Medicine

Effective Date:
July 1, 1989

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March, 2013

POLICY:

1. All attendings in Emergency Medicine are members of the medical staff in good standing.
2. Attendings in Emergency Medicine must have completed a residency in either Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics or Surgery or have a minimum of 4 years ED experience.
3. Attendings in Emergency Medicine must be Board Eligible or Board Certified in their primary specialty or in Emergency Medicine.
4. Attendings in Emergency Medicine report to the Chief of Emergency Services or Assistant Chief of Emergency Services.
5. Attendings in Emergency Medicine must have ACLS and ATLS certification or equivalent training such as residency training in emergency medicine or initial course training in ACLS and ATLS and board certification in Emergency Medicine.
6. Orientation
 - a. The ED physician orientation program is reviewed yearly and approved or amended by the Chief of Emergency Services or the Assistant Chief of Emergency Services.
 - b. The Chief of Emergency Services or designee is responsible for effecting an organized orientation program for all ED physicians.
 - c. The orientation program will include the following topics at a minimum:
 - disaster plan
 - interhospital transfer requests
 - location of all electronic life-support equipment
 - location of fire alarm
 - location of laryngoscopes and endotracheal tubes
 - location of thoracentesis, tube thoracostomy and thoracotomy sets
 - location of vascular cut down sets
 - medical record keeping
 - patient discharge and referral planning
 - patient transfers to another hospital
 - triage function

Manual Code: 2.01d

**Subject:
Medical Staff Coverage**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. An attending physician in Emergency Medicine is on-duty in the ED 24 hours a day.
2. The attending physician in Emergency Medicine on-duty has the authority and responsibility to oversee and coordinate all medical care in the ED.
3. Resident physicians, physician assistants, nurse practitioners, EMT's, Paramedics, and students are supervised by the attending physician in Emergency Medicine.

Subject:
Physician Assistants

Effective Date:
July 1, 1989

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March, 2012

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POLICY:

1. Physician Assistants (PA) will be providing direct patient care under the supervision of the attending physician in Emergency Medicine.
2. A PA hired to provide medical care in the ED will have post graduate experience in Emergency Medicine, Intensive Care or Surgery, and have demonstrated experience in invasive techniques, namely, suturing lacerations, endotracheal intubation and central venous catheterization.
3. The PA on duty will report to the attending in Emergency Medicine on duty.
4. Physician Assistants will adhere to and be responsible for implementing all policies.
5. Physician Assistants will be responsible to the Chief of Emergency Services and Assistant Chief of Emergency Services.
6. The PA in Emergency Medicine must have ACLS certification or equivalent training.
7. Orientation
 - a. The ED PA orientation program is reviewed yearly and approved or amended by the Chief of Emergency Services or Assistant Chief of Emergency Services.

Subject:
Physician Assistants

Effective Date:
July 1, 1989

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March, 2013

POLICY: (Continued)

- b. The orientation program will include the following topics at a minimum:
- disaster plan
 - fire safety
 - infection control
 - interhospital transfer requests
 - location and use of all electronic life-support equipment
 - location of fire alarm
 - location of laryngoscopes and endotracheal tubes
 - location of thoracentesis, tube thoracostomy and thoracotomy sets
 - location of vascular cut down sets
 - medical record keeping
 - patient discharge and referral planning
 - patient transfers to another hospital
 - triage function
8. The ED PA may perform the following invasive procedures under the supervision of the ED physician:
- arterial catheterization
 - central venous catheterization
 - cricothyroidotomy
 - endotracheal intubation
 - incision/drainage cutaneous abscess
 - nasotracheal intubation
 - phlebotomy
 - removal foreign body
 - splinting and casting
 - suturing lacerations
 - tube thoracostomy
 - vascular cutdown
 - venous catheterization

Manual Code: 2.02a

Subject:
ED Nurse Manager

Effective Date:
July 1, 1989

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Scheduled Revision:
March, 2013

POLICY:

1. The ED Nurse Manager is the Nurse-in-Charge of the ED.
2. The ED Nurse Manager has the responsibility and authority to oversee the functioning of all ED nursing staff and to implement all policies.
3. The ED Nurse Manager is a full-time position.
4. The ED Nurse Manager is readily available to the ED or has made arrangements for qualified administrative coverage.
5. The ED Nurse Manager reports to the Director and Associate Director of Nursing and to the Chief of Emergency Services and Assistant Chief of Emergency Services.

Manual Code: 2.02b

**Subject:
Nurse Practitioners**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Nurse Practitioners (NP) will provide direct patient care under the supervision of the attending physician in Emergency Medicine or practice independently with preapproved protocols for a defined subset of primary care complaints.
2. The NP will have New York State certification, Masters preparation, an ED collaborating physician, and experience in their specialty.
3. The NP will adhere to all policies.
4. The NP will be responsible to the Chief of Emergency Services and the Director of Nursing (as per Hospital Policy #MS:0006).

Manual Code: 2.02c

**Subject:
ED Nursing Staff**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. A T & R (Teaching and Research) III Registered Nurse or Relief Charge Nurse is on duty 24 hours a day and serves as the supervisor for ED nursing staff during his/her 8 hour shift.
2. Registered Nurse staffing will be in compliance with NYS Department of Health Regulations, 708.5.
3. Hospital Clinical Assistants provide assistance as directed by the registered nurses or physicians.
4. A Nursing Station Clerk is assigned to the ED nursing station 24 hours a day to provide clerical and receptionist activities as directed by the registered nurses or physicians.
5. Within one year of appointment to the ED, RN's will obtain ACLS and PALS certification.
6. If there are inadequate numbers of nurses to care for patients, the unit Nurse Manager or covering ADN is to be notified.
7. In the event that additional staff is needed, the charge nurse should utilize the Disaster Roster to call staff in from home.
8. The ED nurses practice according to the Division of Nursing Policies and Procedures.

Manual Code: 2.02d

**Subject:
ED Nursing Staff - Orientation**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
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**Scheduled Revision:
March, 2013**

POLICY:

1. The ED nurse orientation program is reviewed and approved by the ED Nurse Manager and the Chief of Emergency Services every two years.
2. The ED Nurse Manager or designee is responsible for effecting an organized orientation for all ED nurses.
3. The orientation will include the Division of Nursing Orientation conducted by nursing staff development.
4. The ED orientation includes all items listed on the Competency Check List Rating Form.
5. The length of orientation will be determined collectively by the nurse educator, clinician and orientee. Orientation should last at least 4 weeks and may be extended by the ED Nurse Manager.
6. Orientees may not function as triage officers.
7. Orientees will have a preceptor/resource person identified each shift for a minimum of 4 weeks.

Subject:
Emergency Medical Services (EMS)

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2012

POLICY:

1. The EMS Office is part of the ED and is responsible for coordinating and effecting interhospital transfers.
2. The EMS Director reports to the Associate Director, Hospital Services and takes medical and clinical direction from the Chief of Emergency Services.
3. The EMS Director will adhere, to and be responsible for, implementing all policies.
4. The EMS Director will be a member of the EMS Committee and the Disaster Committee for the hospital.
5. **EMS Staff:**

Emergency Medical Technicians (EMTs) may assist in the ED with patient care as directed by the nurse clinician, charge nurse, or the physicians on duty.

EMTs will be allowed to function in the ED up to their level of skills as performed in the prehospital setting.

An EMT can obtain and record vital signs and assist with patient transport.

An EMT-Advanced (EMT/AEMT-III) can perform as an EMT, plus can start IVs, draw venous blood samples, defibrillate/cardiovert, and monitor a patient on an EKG monitor.

An EMT/AEMT-IV (Paramedic) can perform as an AEMT, plus can perform intubation (under direct physician supervision) and administer medications under physician or nursing supervision.

Subject:
Emergency Medical Services (EMS)

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY: (Continued)

6. The ED paramedic may perform the following **invasive procedures** under the direct supervision of the ED physician:
- endotracheal intubation
 - needle cricothyroidotomy
 - needle thoracostomy
 - phlebotomy
 - peripheral venous catheterization including external jugular

7. **Orientation**

- a. The EMT orientation program is reviewed yearly and approved by the Chief of Emergency Services, the Assistant Chief of Emergency Services or the EMS Director.
- b. The EMS Director or designee is responsible for effecting an organized orientation program for all EMTs.

Subject:
Emergency Medical Services (EMS)

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY: (Continued)

- c. The orientation program will include the following topics at a minimum:
- cardiopulmonary resuscitation
 - defibrillation/cardioversion/external pacing
 - disaster plan
 - drawing venous blood samples (AEMT-III, AEMT-IV)
 - driver safety
 - endotracheal intubation (AEMT-IV)
 - fire safety
 - helicopter safety
 - impending childbirth
 - infection control
 - initial assessment and management of multiple trauma, head trauma, spine/spinal cord trauma, extremity trauma
 - local burn care
 - local wound care
 - location of fire alarm
 - location, storage and procurement of medications, blood, supplies and equipment
 - MAST suit application
 - medical record keeping
 - obtaining and interpreting a medical history
 - obtaining and interpreting an EKG (AEMT-III or AEMT-IV)
 - obtaining and interpreting vital signs
 - parenteral administration of blood/blood products (AEMT-IV)
 - parenteral administration of drugs (AEMT-IV)
 - parenteral administration of IV fluids (AEMT-III or AEMT-IV)
 - pediatric emergencies
 - psychiatric emergencies
 - psychosocial needs of patients and families
 - radio communications
 - recognition and treatment of sepsis
 - recognition and treatment of shock
 - starting IVs (AEMT-III or AEMT-IV)
 - transfer requests
 - triage function

Manual Code: 2.04

Subject:
ED Nursing Station Clerks and Clinical Assistants

Effective Date:
Nov. 21, 1991

Reviewed/Revised as of:
March, 2012

Schedule Revision:
March, 2013

POLICY:

1. Hospital Clinical Assistants provide assistance in the ED as directed by the ED registered nurses or physicians.
2. A Nursing Station Clerk is assigned to the ED 24 hours a day to provide clerical and receptionist activities as directed by the ED registered nurses or physicians.

Manual Code: 2.04a

**Subject:
ED Nursing Station Clerks - Orientation**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The ED clerk orientation program is reviewed yearly and approved by the ED Nurse Manager.
2. The ED Nurse Manager or designee is responsible for affecting an organized orientation program for all ED clerks.
3. The orientation program will include the following topics at a minimum:
 - communications, including procedure for calling for consultations
 - computer operations
 - disaster plan
 - fire safety
 - infection control
 - location of fire alarm
 - medical records, chart bursting
 - patient discharge and referral planning
 - procedure for laboratory and x-ray studies
 - procedure for patient admission
 - procedure for patient death
 - procedure for patient transfer
 - procedure for patient valuables
 - psychosocial needs of patients and families
4. The ED orientation includes all items listed on the Competency Check List Rating Form.

Manual Code: 2.04b

Subject:
ED Clinical Assistant (CA) - Orientation

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. The ED CA orientation program is reviewed yearly and approved by the ED Nurse Manager.
2. The ED Nurse Manager or designee is responsible for affecting an organized orientation program for all ED CA's.
3. The orientation program will include the following topics at a minimum:
 - UHIS Computer Operations
 - Cardiopulmonary Resuscitation
 - Fire Safety, Infection Control
 - Psychosocial needs of patients and family
 - Urine specimens
 - Observing and recording vital signs
4. The ED orientation includes all items listed on the Competency Check List Rating Form.

Manual Code: 2.05

**Subject:
ED Scribes**

**Effective Date:
June, 2002**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The ED scribes are assigned to work with an attending physician in the emergency department.
2. The scribes assist the physicians in documenting care that is rendered to the patient. This is done contemporaneously while the physician delivers medical care.
3. The scribes are non-clinical staff in that they do not have any patient care responsibilities and do not render any medical care.
4. The scribes write and submit requisitions for x-rays and retrieve x-rays when they are developed.
5. The scribe ensures that all components of the patient chart that are the responsibility of the physician are complete. Any deficiencies should be identified to the physician for correction or completion.

Manual Code: 3.02

**Subject:
Continuing Education**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The hospital administration supports continuing education activities for all ED personnel.
2. The hospital administration agrees that these educational activities may involve attendance at programs outside the hospital as needed.
3. Attendance at programs outside the department and outside the hospital are encouraged. All staff can apply to the Chief of Emergency Services, EMS Director, or the ED Nurse Manager for permission to use conference time to attend outside continuing education programs.
4. The ED Nurse Manager, EMS Director, and the Chief of Emergency Services are responsible for reviewing the appropriateness and benefit of these programs and for determining if funding is available.
5. All nursing employees (RN's, CA's, NSC's) will attend annual recertification day which will include the following topics:

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|-------------------------------|-------------------|
| Cardiopulmonary resuscitation | Infection control |
| Electrical safety | Right to know |
| Compliance training | HIPPA training |
6. Attending physicians and PA's are required to complete 20 category I CME credit hours and 30 category II CME credit hours annually.
7. All nurses should participate in continuing education activities each year.
8. Records of attendance will be kept for all continuing educational activities sponsored by the Stony Brook University Medical Center ED.
9. Continuing educational activities will include results of the ED QA program.
10. The ED staff member is responsible for submitting copies of all educational activities attended to the ED Staff Assistant, EMS Director, or the Nurse Educator.

Subject:
Disaster Plan

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. The Stony Brook University Medical Center Emergency Preparedness Manual describes 4 phases of external disasters:

Level I

Disaster Alert: ED and Administration are aware that a potential for disaster exists, but there has been no influx of patients.

Level II

Despite an influx of patients, current staffing is able to handle the load. Regardless, the administration is prepared to update the disaster level should the patient load increase.

Level III

Hospital facilities are adequate but staffing is not. Staff must be called in from home.

Level IV

Staffing and facilities have been overwhelmed. In-patients must be discharged to home or transferred to another institution and staff must be called in from home.

Notification:

2. Upon learning that a disaster situation exists, it will be the responsibility of the Emergency Medicine Attending on duty to contact the EMS Office in accordance with the Hospital Emergency Preparedness Manual.
3. In case of a Level III or Level IV disaster, the emergency department attending on duty will also notify the Chairman of Emergency Medicine.
4. In the case of a level 3 or level 4 disaster, ED staff members not currently on duty may be contacted and asked to assist

The emergency department Nurse Manager will assure that a list of all emergency department nurses, nursing assistants and nursing station clerks have up to date phone numbers. The Chairman of Emergency Medicine will assure that a list of Emergency Medicine attendings and residents has up to date beeper and phone numbers. (Generally, the Emergency Medicine phone listing will contain all this information.)

Subject:
Disaster Plan

Effective Date:
July 1, 1989

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POLICY: (Continued)

5. It is at the discretion of the ED Attending and Charge Nurse that ED rapid registration/chart processing will occur. At that time registration will activate the prefabricated numbered medical record charts. 100 of these charts are maintained in triage and 200 additional charts can be created rapidly.
6. Communication System
 - a. A radio-telephone communication system will be functional at all times in the ED to assure prehospital communications with emergency medical services personnel, police and fire department personnel.
 - b. The EMS Director for the ED has the responsibility to assure this capability.
7. The ED staff will be required to understand the hospital's Disaster Plan and this will be tested by conducting appropriate disaster drills.

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Disaster Plan

Effective Date:
July 1, 1989

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Emergency Department Emergency Preparedness Response Plan (Department Specific)

The Emergency Department Emergency Preparedness Response Plan will be activated any time the hospital wide plan is activated at a Level 3 or Level 4 response and it also may be activated at the request of the ED Charge Nurse and ED Attending physician at any other time.

General Guidelines:

- Emergency Department personnel will follow the Hospital Emergency Preparedness Plan with regards to notification to the proper individuals in the event of an emergency as well as designating appropriate treatment areas to care for patients.
- In conjunction with the Hospital Wide Incident Commander the Emergency Department Attending Physician will recommend an appropriate level of response (level 1 –4) based upon the information known at the time. This level of response will help identify the response that is required by emergency department personnel. As the incident evolves it is probable that this response level may change.
- It is probable that incidents will occur which require the activation of the Emergency Department Emergency Preparedness Plan but which do not require activation of the hospital wide emergency preparedness plan. These incidents may include cases where a small number of patients require decontamination or cases that involve a small number of critically injured patients. Any time the ED Emergency Preparedness Plan is activated the ADN will be notified. The ED charge nurse in conjunction with the ED Attending Physician will determine if they feel the ADN needs to be notified in order to activate the hospital wide plan.
- In accordance with the hospital wide emergency preparedness plan the EMS department is responsible, once they are made aware of an event, to activate the hospital wide plan. In most situations EMS will make these notifications without “permission” from the ED charge nurse or ED Attending Physician.

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- In the event of a major disaster the Emergency Department Incident Command structure will be initiated. If the charge nurse, in conjunction with the ED Attending Physician, feels that additional staff is immediately needed the charge nurse will page the hospital wide ADN and identify that the ED has a mass casualty event occurring and immediate additional staff is required. Based upon this call the ADN will immediately identify 4 critical care RN's, 4 ICR RN's, 3 Nursing Assistants and 1 Nursing Station Clerk who can respond to the ED to provide additional staffing. Simultaneous to this response will be the initiation of the Emergency Department's recall plan whereby the ED nursing station clerks begin to page and call in any emergency department staff not on duty. If additional attending physicians are required, based upon a determination by the ED attending, the clerks will also initiate a recall of all off duty ED attending physicians.
- Depending upon the scope of the incident the ED may decide to triage minor (triaged green) patients to the alternate treatment site located outside of the emergency department. If this is being done the hospital wide ADN must be notified and he/she will arrange to immediately send 2 RN's, 2 NA's, and 1 nursing station clerk to this area. The ED must contact the Department of Family Medicine to inform them of the situation as they will respond with their attendings and residents to staff this area.
- When the "Green" area is established the admitting department and the radiology department must also be notified by the ED Incident Commander. The admitting department will staff the area and will coordinate the computer assignment of patients to 05L8 which denotes patients who are being seen in the Green area. The radiology department will arrange for appropriate staffing in the Green area to provide needed radiological services.
- Critical or "Red" patients will be triaged to the Critical Care area or the observation unit (used when the critical care area is full), urgent or "Yellow" patients will be triaged to the Acute or Pediatric areas, minor or "Green" patients will be triaged to the immediate care area. If minor patients are triaged out of the emergency department the immediate care area can be used for overflow of urgent patients.

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- In the event the incident relates to the expected influx of a number of patients who require isolation these patients will be brought into the CPEP unit. When this occurs CPEP must be notified as soon as possible as they will make immediate arrangements to move any CPEP patients to an alternate treatment location. The ED will be responsible for bringing to CPEP the main ED department exchange carts to ensure appropriate medical supplies for these patients. Staffing will be provided by the ED and supplemented by in house staffing, as required, when requested through the ADN
- The Emergency Department Incident Commander will be the ED Clinician or Charge Nurse who will be relieved as soon as possible by the Administrative Director for Emergency Services or his/her designee.
- The ED Charge RN/Incident Commander will activate disaster supplies from the disaster readiness cabinet located in triage. Guidelines and resources for disaster management will be maintained in this cabinet and followed during all disaster events. An overhead announcement in the ED that “The Emergency Department disaster plan has been activated, all staff respond to your preplanned staging area” will be made.
- All personnel responding from home shall be directed to report to the EMS Transfer Center for assignment from the Incident Commander.
- The Incident Commander in consultation with the hospital COO or designee must decide if inter-facility EMS transfers should continue.
- All EMS crews shall be assigned an ambulance and report to the EMS Transfer Center to await assignment from the EMS Supervisor/Dispatcher.
- The ED Medical Officer will manage the clinical staffing including the leaders for each treatment and triage area.
- The ED Logistics Officer will secure and manage resources and equipment.
- The ED Nursing Officer will manage patient flow including patient and bed tracking.

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Decontamination:

1. At the direction of the ED Attending Physician EMS staff will assemble the decontamination tents/shower on the top deck of the ED parking garage. Tent/shower set-up shall include connection and flow of warm water. As available, one EMS staff member will remain in the immediate vicinity of the decontamination area to trouble shoot and maintain the equipment throughout the event.
2. EMS staff shall stockpile spare backboards for EMS crew replacement as needed. Backboards from the pre-hospital EMS equipment area should be utilized regardless of department designation.
3. SBUMC EMS ambulances should be relocated to make room for decontamination procedures. Crews shall then report to the area outside of the EMS.

Triage:

1. An external or an alternative triage location may be established upon the direction of the ED Operations Officer. This may include establishing an outside “perimeter” at the walk in entrance to screen patients for specific complaints, it may be the establishment of a formal exterior triage location staffed by ED nursing staff in a tent outside of the emergency department, or it may include the closing of the pediatric emergency department patient to pediatric patients and the establishment of a dedicated “event specific” triage location in the pediatric emergency department.
2. In order to avoid confusion and/or contamination of non-disaster patients, triage locations and area designation shall be made by the following chart during any external disaster operations:

| | | |
|--------------------------------|-------------------------|--|
| Ambulance Triage | Triage North | Receives patients from disaster via ambulance or walk-in if possible. |
| Walk-in Triage | Triage South | Receives walk-in patients as normal. |
| Pediatric ED Triage | Triage East | Receives walk-in patients as normal. |

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3. Every effort shall be made to determine if a patient has self-reported to the ED from an external disaster that may necessitate decontamination. If possible, such patients shall be encouraged to enter the ED at Triage North if clinically appropriate.
4. It is at the discretion of the ED Critical Care Attending and ED Nursing Officer that ED rapid registration/chart processing will occur. At that time registration will activate the prefabricated numbered medical record charts. 100 of these charts are maintained in triage and 200 additional charts can be created rapidly.
5. The Nursing Officer will assign a designee to bring the ED Disaster Log dry-erase board to ambulance triage to be used solely for patients originating from the external disaster.
6. The ED Charge RN or designee will bring all available ED stretchers to the ED ambulance bay.
7. Patients arriving via ambulance are expected to have had been initially triaged at the scene using the S.M.A.R.T. triage tag system. All ED and EMS staff shall be expected to be familiar with this triage system.
8. Pre-hospital EMS crews delivering patients from an external disaster in which there is a potential need for decontamination are restricted from entering the ED until they have undergone decontamination procedures.
9. In the event a large number of patients present to walk in triage secondary to a disaster a process whereby all “disaster” patients will be directed to the pediatric ED entrance and all non disaster patients are directed to the adult walk in entrance may be initiated.
 - a. Regardless of whether external or internal triage is established there must be a minimum of one ED staff member stationed at each entrance (walk in and ambulance) to quickly sort patients who are arriving into two distinct categories.
 - i. Those patients who are presenting as a result of the disaster
 - ii. Those patients who are presenting and are not here as a result of the disaster

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10. Hospital security should be notified as early as possible so that they can position security staff outside of the walk in entrance and the ambulance entrance. They will ensure that press, family, visitors are directed to the proper location. Only patients may enter through the ambulance entrance (family is allowed if they have physically accompanied the patient in the ambulance). Press will be directed to the main hospital entrance on level 5. Family/visitors will be directed to the emergency department walk in entrance on the South side of the hospital on level 4.

Ambulance Triage:

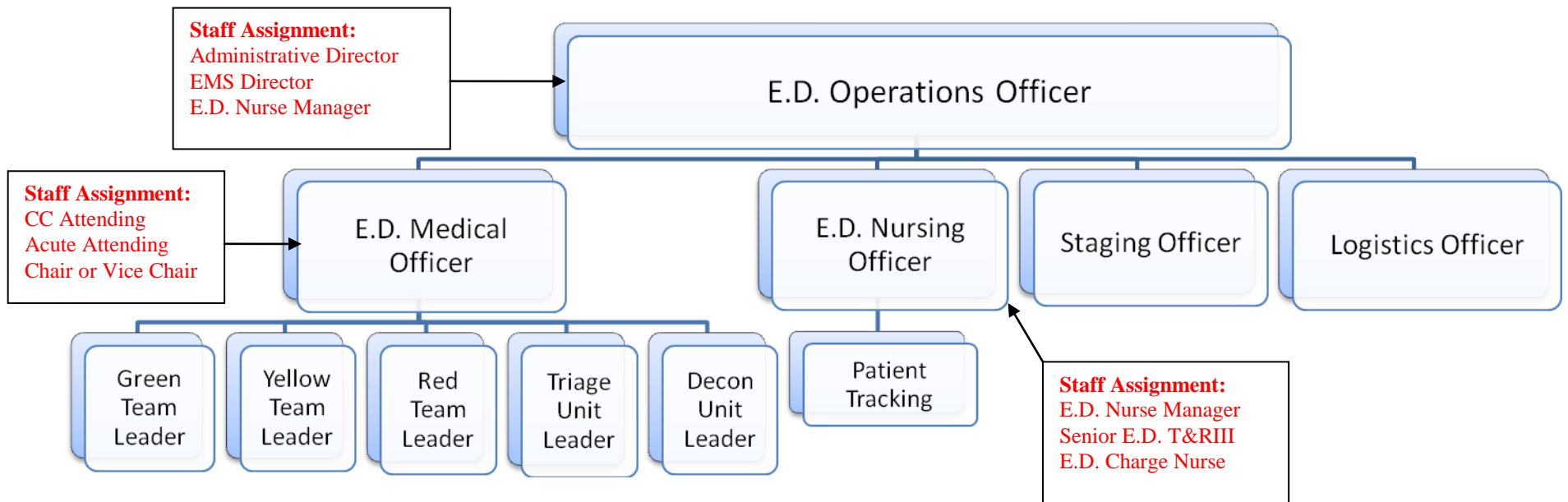
1. An ED RN will be stationed at the ambulance entrance located close to the entry doors to critical care. Any patient who is being ventilated or who is having CPR performed will be directed immediately into critical care at that entrance.
 - Staff in critical care will direct the patient to the appropriate treatment room and complete the triage process. Based upon the number of patients being treated any patient who has CPR being performed may be tagged as BLACK and no further treatment is required.
2. ED staff comprised of one physician, two nurses and one clinical assistant or EMS staff will be stationed in the ambulance hallway. Patients will be triaged and receive a wrist band and then directed to, based upon triage category of RED, YELLOW or GREEN to the appropriate treatment area. EMS crews will use the hallway between the current Acute and Critical Care areas to access the appropriate treatment area. Triage staff will maintain a tracking log for all patients triaged.
3. Based upon volume the ambulance triage staff may have ambulatory patients who present at the ambulance entrance escorted to the walk in triage location.
4. ED will arrange to have one hospital staff member positioned in the hallway near the level 4-6 elevators and another positioned in the main hallway at the intersection of the corridor that leads to the CDU. These personnel will assist ambulance crews by directing the crew to the correct ED location based upon the triage category of the patient.

Ambulance Resupply:

1. At the direction of the emergency department incident commander a “no supply” process will be initiated. This means that ambulance crews will not be resupplied with disposable equipment that they have utilized.

**Stony Brook University Medical Center
Emergency Department**

Emergency Department Casualty Care Group



**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.02

**Subject:
Flu Pandemic Plan**

**Effective Date:
July, 2009**

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March, 2013**

POLICY:

1. The triage nurse will screen all patients for influenza like illness (ILI) and document any positive symptoms in the First Net tracking system. Patients with ILI will have a mask placed on them at triage if one is not already being worn
2. It is anticipated that the emergency department can treat approximately 30 – 60 patients with ILI per day without having to modify existing procedures.
3. If the quantity of patients with ILI begins to impact on the emergency department ability to function normally then the ILI plan will be initiated.
4. With an increased volume of ILI patients the ED will convert the pediatric emergency department into an ILI treatment area at the discretion of the emergency department leadership team. Staff will be stationed outside of both the adult and the pediatric walk in entrance. Patients with an ILI will have a mask placed and then directed to enter the building through the pediatric emergency department. All patients without ILI will enter the emergency department via the adult emergency department entrance. The “green” acute area of the emergency department will be used as the alternate pediatric emergency department during this time.
5. When the ILI treatment area is opened patients will be triaged, registered and seen expeditiously by physician staff. Those patients with stable vital signs and minor complaints will be discharged quickly with appropriate discharge instructions. Those patients requiring prolonged care (estimated to be more than 60 minutes) will be moved out of the ILI treatment area to the appropriate area of the emergency department (Acute, alternate Pediatric or Critical Care Area).
6. Should the number of ILI patients exceed the capacity of the ILI treatment area the hospital wide flu pandemic plan will be initiated, at the discretion of senior emergency department and hospital leadership. This will shift the ILI treatment area out of the emergency department to either the presurgical admitting area on level four of the hospital or the ambulatory surgery building.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.03

Subject:
Blood - Location, Storage and Procurement

Effective Date:
July 1, 1989

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POLICY:

1. No blood or blood products will be stored in the ED.
2. Blood and blood products are available from the blood bank for the timely transfusion of ED patients.

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Emergency Department**

**Manual Code: 4.04
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**Subject:
Equipment and Supplies**

**Effective Date:
Nov. 21, 1991**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. The following equipment and supplies are available in the ED at all times:
 - cardiac and respiratory monitoring equipment
 - cardiac defibrillator with synchronization capability and external pacer
 - emergency obstetrical pack
 - emergency thoracotomy sets
 - end tidal CO₂ monitor
 - Foley catheters and collection system
 - Camino Monitoring System
 - laryngoscopes and endotracheal tubes
 - minor surgical instruments
 - oxygen, oxygen supplies
 - pleural and pericardial drainage set
 - splints
 - suction equipment
 - thoracentesis sets
 - tourniquets
 - tracheostomy sets
 - tube thoracostomy sets
 - vascular cutdown sets
 - ventilatory assistant equipment including airways, bag valve device and ventilator
2. The nurse assigned to each room is responsible for ensuring that all equipment required in that room (equipment list for each room will be used) is checked each shift. Deficiencies will be replaced immediately.
3. Each patient care room will be restocked daily to the par level posted in the room (attached). The par level sheet will indicate reorder levels for specific special order items. When special order items need to be reordered the ED administrator will be notified so that orders can be made. Par levels should be sufficient to allow a two week lead time to obtain special order items.
4. Exchange carts will be replaced daily by Exchange Cart. All additions or deletions to the supply carts can be made through the ED Nurse Manager.

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**Subject:
Equipment and Supplies**

**Effective Date:
Nov. 21, 1991**

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March, 2012**

**Schedule Revision:
March, 2013**

POLICY: (Continued)

5. ED property and equipment necessary for life support during transportation or transfer of patients shall be returned to the ED in a timely fashion once it may be safely removed or replaced as judged by the receiving patient care area. The nurse that transports a patient out of the ED is responsible for ensuring that all equipment is returned, cleaned, and restocked as soon as practical.
6. The receiving patient care area may substitute a similar piece of property, for example, MAST suit, for immediate return to the ED once the patient arrives at the receiving patient care area.
7. The charge nurse will assign a clinical assistant on the day shift every day to check the ED stock room. The clinical assistant will complete a par level sheet for the stock room noting how many of each item is on hand and how much need to be ordered to bring the par level up to the appropriate level. The clinical assistant, after completing this form, will send an order via computer to bulk or exchange cart for all needed items. **At no time should the quantity of supplies in the storage room exceed the maximum par levels as indicated on the check sheets.** The completed par level sheet and a duplicate of all orders placed will be kept in a par level book in the stock room. A clinical assistant will review the par level book each week on the day shift on Monday and Friday to ensure that all items that were ordered have been received (by the end of the shift). If the entire order, or individual items, are not received the charge nurse must be notified by the end of the shift.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.04a

**Subject:
Equipment Loan**

**Effective Date:
Nov. 21, 1991**

**Reviewed/Revised as of:
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**Schedule Revision:
March, 2013**

POLICY:

To ensure adequate patient care equipment is available for patient use. To provide needed equipment to inpatient areas when necessary.

1. Only the charge nurse can loan equipment.
2. All equipment must be signed out in the equipment book. All information must be completed. Completed forms will be kept in the equipment book.
3. The day ED Clinical Assistant will check the log book once per day, determine which equipment is on loan and make efforts to have it returned. Any problems will be communicated to the clinician or ED Nurse Manager.
4. When equipment is returned, the date, time, condition, and signatures will be recorded.
5. This policy applies to all BME equipment, sterile trays and reusable items.

The ED charge nurse can refuse to loan equipment to any persons/units who refuse to follow this policy; or anytime they feel that the loan of the equipment would jeopardize patient care in the ED.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.04b

**Subject:
Equipment Failure**

**Effective Date:
Nov. 21, 1991**

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March, 2013**

POLICY:

1. For medical equipment failure the ED staff will follow the Administration Policy and Procedure Manual #EC:0009.
2. For emergency maintenance service during the hours from 8:30 a.m. to 5:00 p.m. Monday through Friday, the ED staff will contact Maintenance (4-2400). Maintenance personnel will respond.
3. For emergency maintenance service on weekends, holidays, and after normal business hours, the Power Plant will be called (4-2400). The appropriate maintenance personnel will be called by the Power Plant to respond to the emergency.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.05

**Subject:
Power Failure**

**Effective Date:
July 1, 1989**

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POLICY:

1. When a major power failure occurs in the ED the Emergency Medicine attending-on-duty should contact the ED Director or Associate Director, and the on-site ED Nurse Manager or ADN.
2. Item (1) will then institute the Loss of Physical Plant Services Plan of the hospital.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.06

**Subject:
Electrical Safety**

**Effective Date:
July 1, 1989**

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POLICY:

1. All new electrical equipment will be inspected by Bio-Medical Engineering prior to use in the ED.
2. All electrical equipment shall be inspected and tagged by Bio-Medical Engineering according to customary inspection schedules. Bio-Medical Engineering keeps all preventive maintenance and repair records.
3. Extension cords are prohibited in the treatment area of the ED.
4. All exposed ends of cardiac leads or exteriorized pacemaker wires must be insulated.
5. No patient or visitor is allowed to carry an electrical appliance of any kind into the treatment area of the ED.
6. The ED staff will notify Bio-Medical Engineering concerning electrical equipment, which may be defective, damaged or malfunctioning through the computer reporting screen and a call to 4-1420 if it is an emergency.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.07

**Subject:
Fire Plan**

**Effective Date:
July 1, 1989**

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POLICY:

1. All ED staff during orientation will be instructed on fire safety.
2. ED staff discovering fire or smoke in the ED are authorized and responsible for activating the nearest fire alarm.
3. Fire or smoke in the ED will necessitate activation of the hospital's disaster plan.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.08

**Subject:
Security/Traffic Control**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. For purposes of traffic control hospital employees must refrain from entering the ED treatment area unless for a specific ED related function.
2. Hospital Security officers will assist the ED staff in traffic control and in helping to provide protective security for combative or emotionally disturbed patients.
3. Hospital Security will assist the Emergency Department staff in enforcing the visitor policy.

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Emergency Department**

**Manual Code: 4.09
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**Subject:
Interhospital Transfers**

**Effective Date:
Nov. 21, 1991**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

Stony Brook University Medical Center (SBUMC) Policies and Procedures for interhospital transfers are consistent with COBRA 42 USC Section 13955dd. (Public Law 99-272, Section 9121) and New York State Law.

PROCEDURES:

- A. Transfer requests from outside facilities to SBUMC
1. All patients to be transferred must have an identified sending and accepting attending physician, which must be documented in the medical record.
 2. If the EMS Transfer Center is contacted directly and there is yet no identified accepting attending physician, the EMS department will contact the Emergency Department (ED) attending physician. The ED attending physician will either:
 - a. accept the patient consistent with existing transfer agreements or
 - b. coordinate the communication between the sending physician and the appropriate medical service at SBUMC or
 - c. deny the request for transfer based upon lack of resources as communicated to the EMS department by the SBUMC Associate Director.
 3. If a SBUMC attending physician receives a request for transfer, it is their responsibility to ensure that appropriate space, staffing, and equipment are available to care for the patient once he or she arrives. This can be achieved by contacting the Admitting and the Emergency Medical Services (EMS) Transfer Office.

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**Subject:
Interhospital Transfers**

**Effective Date:
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PROCEDURE:

4. If any SBUMC medical service or patient care area feels that they lack the resources to appropriately manage additional patients, they must contact and discuss the situation with the SBUMC Executive Director or designee. If it is decided that such service or area is to be temporarily closed to transfers, the SBUMC Executive Director or designee will inform the EMS office. The Executive Director or designee will also inform the EMS office when that service or area is again available for transfers. It is the responsibility of the EMS department to inform and update those facilities with which SBUMC has transfer agreements.
 5. If the accepting attending physician feels that the patient requires ED evaluation then he or she must contact the ED attending physician.
 6. It is the responsibility of the ED attending (or the accepting attending physician), in coordination with the EMS department, to determine the mode of transport and ensure that appropriate staffing, equipment, and medications are available during transport.
 7. The accepting attending physician will serve as medical control for obstetrical and nontraumatic pediatric EMS transports as well as for those transports not effected by the SBUMC EMS Staff. The ED attending physician will serve as medical control for all other EMS transports.
 8. All relevant communications with the transferring hospital should be appropriately documented by the EMS office.
 9. The Chairperson of the Department of Emergency Medicine or designee will include all transfers in the departmental quality assurance program.
- B. Transfer of patients from the SBUMC ED to outside facilities**
1. No patients will be transferred on the basis of age, sex, race, creed, national origin, or the ability or inability to pay for care. The reason for transfer must be documented in the medical record.

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Emergency Department**

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**Subject:
Interhospital Transfers**

**Effective Date:
Nov. 21, 1991**

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March, 2013**

PROCEDURE:

2. All patients to be transferred must have an identified sending and accepting attending physician and facility. This must be documented in the medical record.
3. All transfers may be coordinated by the SBUMC EMS department regardless of whether they actually perform the transfer.
4. A transfer request may be initiated under the following circumstances (and require the following documentation in addition to completion of the Patient Transfer Order Form):
 - a. patient's request (also complete the patient-initiated Request for Transfer form after documentation of informed consent).
 - b. attending physician's recommendation (also complete the Physician's Certificate of Transfer Form)
5. The initial emergency care to stabilize the patient prior to transfer must be documented in the medical record.
6. An individual who has an unstabilized emergency medical condition or is in active labor may not be transferred or discharged unless:
 - a. the patient (or legally responsible person) requests the transfer, has been informed of and accepts the associated risks of transfer, and possesses the capacity to make an informed decision, or
 - b. the attending physician, based upon the reasonable risks and benefits to the patient at that time, feels that appropriate medical treatment at another facility will medically benefit the patient. If the patient (or legally responsible person) makes an informed decision to refuse the recommended transfer, this should be fully documented in the medical record (Refusal of Consent Form should be completed).

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 4.09
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**Subject:
Interhospital Transfers**

**Effective Date:
Nov. 21, 1991**

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**Schedule Revision:
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PROCEDURE:

7. Copies of all medical records (including x-rays) should be forwarded to the receiving facility.

8. The chairperson of the Department of Emergency Medicine or his or her designee will review all transfers for the purpose of quality assurance.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.10

**Subject:
Laboratory Down Time Procedure**

**Effective Date:
May 16, 1994**

**Reviewed/Revised as of:
March, 2012**

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March, 2013**

PROCEDURE:

The following procedure will be followed if the laboratory information system (LIS) or the hospital information system (HIS) are not operational.

1. Labs will be bunched in the ED at the nursing station - do not use the tube to send the specimens.
2. Every 30 minutes an ED staff person or distribution staff will bring the specimens to specimen receiving on level 3. You must announce to the person at specimen receiving that you have STAT ED specimens.
3. The specimen receiving staff will take the specimens and give them to the STAT lab technician who should process them immediately.
4. The lab will call the ED with the lab results as they are completed.
5. The ED attending in consultation with the nurse in charge will designate the staff member who will transport the specimens to the lab. This person should be assigned to the ED and should not be a hospital transporter. Staff that can transport specimens include attendings, residents, nurses, clinical assistants, nursing station clerks, and EMS staff.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.12

**Subject:
Panel Screens**

**Effective Date:
September, 1998**

**Reviewed/Revised as of:
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POLICY:

1. The emergency department has six different panel screens created in order to expedite and enhance patient care. They are:
 - a. Drug ingestion orders
 - b. Emergency cardiac orders
 - c. Major trauma orders
 - d. Code Bat (stroke)
 - e. Emergency fever
 - f. Emergency sepsis

2. The ordering practitioner will document on the patient's chart the name of the panel screen being ordered, individual components of the panel screen do not to be individually listed.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 4.13
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**Subject:
Decontamination-Possible Anthrax Exposure**

**Effective Date:
March 2007**

**Reviewed/Revised as of:
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**Scheduled Revision:
March, 2013**

POLICY:

1. Patient(s) may present to the emergency department after they may have been exposed to anthrax. The potential exposure may have occurred in any off site area but recent events have identified possible anthrax exposure as occurring in some postal facilities.

 2. The United States Postal Service (USPS) has a Biohazard Detection System (BDS) in place in many postal facilities in the New York City and Long Island region. The BDS system monitors the air in the USPS facility on an hourly basis and automatically tests the air for the presence of anthrax. The test result comes back approximately 40 minutes after the most recent air sample.
 - a. If anthrax is detected at a USPS facility all employees and customers who are at the facility will be evacuated. Decontamination and antibiotic prophylaxis will be done adjacent to the site
 - b. It is probable that some Postal Service employees or customers of the facility will have left the facility between the time an air sample was taken and the results obtained (this takes 40 minutes). In this case it is probable that some people will come to the emergency department prior to be decontaminated.

 3. Any known or suspected anthrax exposure in the New York City and Long Island Region will be communicated to hospitals in the region by the NYS DOH.

 4. In the event that we are notified of a possible anthrax exposure in our region the following protocol will be instituted:
 - a. Depending upon the suspected scope of the exposure either hospital personnel will be stationed outside of the ED entrance or a sign will be posted at the ED entrance in an attempt to identify a possibly exposed patient prior to their entering the emergency department.
-

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**Manual Code: 4.13
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**Subject:
Decontamination-Possible Anthrax Exposure**

**Effective Date:
March 2007**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

- b. Any staff treating a patient with a potential anthrax exposure should wear a gown, gloves and a properly fitting N95 respirator.
- c. Potentially contaminated patients should undress, take a shower using soap and water, and redress in “new” clothes. This decontamination procedure, if not completed at the scene can be completed here in one of the decontamination tents.
- d. Once a patient has changed their clothes and showered, staff caring for the patient does not need to take any specific isolation precautions. A N95 mask is no longer required when caring for this patient.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 4.14

**Subject:
Warmer (Fluid/Blanket)**

**Effective Date:
November 2007**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. IV fluid stored in the fluid warmer will be kept at 100 degrees Fahrenheit.
2. IV fluid in the warmer will be removed from the warmer on the 10th, 20th and the 30th of each month (the 28th in the month of February). A log sheet will be completed indicated that all IV fluids have been removed, dated and timed, and signed by the staff member who completes this task.
3. All IV fluids that are placed in the warmer will be dated with a “previously warmed, remove by” sticker. The remove by date will be the 10th, 20th, or 30th of the month, whichever date is soonest. These removed IV fluids will be brought to the medication room in the ED so that they can be used for patient care.
4. Fresh IV fluids that have not been previously placed in a warmer will be used to restock the warmer.
5. Mannitol for IV administration will be kept in a locked box in the upper compartment of the warmer in the Critical Care area. This compartment will be set for 100 degrees Fahrenheit. On the 10th, 20th and 30th of each month all Mannitol in the warmer will be discarded and replaced with new Mannitol. The log sheet will indicate when this was completed and by which staff member. The key for the locked Mannitol box will be in the Pyxis machine in the critical care area.
6. All Mannitol that is placed in the warmer will be dated with a “previously warmed, remove by” sticker. The remove by date will be the 10th, 20th, or 30th of the month, whichever date is soonest.

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**Manual Code: 5.01
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**Subject:
Consent**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

The ED will follow the hospital consent policy. (Administrative P & P RI:0014)

PROCEDURE:

A. Consent for Treatment

1. Whenever possible the patient will be requested to sign the "Authorization for Treatment" consent at the time of their initial quick registration.
2. In a life-threatening situation when item (1) is impossible to obtain, the consent for treatment is implied since the patient presented to the ED for emergency evaluation and treatment.
3. For situations as item (2) the Nurse Clinician or designee will initiate a search to notify the next-of-kin or guardian.
4. All unemancipated minors not accompanied by a parent or guardian will undergo the triage process. The charge nurse or designee will be notified and will initiate a search to notify the parent or guardian and obtain permission to treat. All triage category 1 or 2 minors will be evaluated and treated while the search is being initiated.

B. Consent for Obtaining Blood Alcohol Levels

1. The ED will comply with New York Vehicle and Traffic Law S1194 regarding drawing blood alcohol levels requested by the police.
2. Persons brought to the ED by the police for the sole purpose of obtaining a blood alcohol level will have their blood drawn by an ME office representative or, at the request of the police officer and with the patient's consent, the ED physician, physician assistant, paramedic or nurse.
3. Consent must be obtained from every coherent patient brought to the ED for the purpose of obtaining a blood alcohol level. A special kit containing vials and consent forms will be provided by the police officer.

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Emergency Department**

**Manual Code: 5.01
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**Subject:
Consent**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

PROCEDURE:

4. A blood alcohol level may be drawn on an unconscious patient or a patient unable to give consent if directed by the police, unless the patient has a bleeding disorder or is on anticoagulant drugs.
5. Samples will be preserved and handled by the police officer, as required by law.
6. The ED staff person performing venipuncture to obtain the sample will document on the medical record: date; time blood was drawn; name and title of police officer receiving the specimen; name of person drawing the blood.

C. Consent for Organ Donation

1. In accordance with Stony Brook University Medical Center Administrative Policy and Procedure Manual #RI:0029 the charge nurse will, on or before the occurrence of death, notify the New York Organ Donor Network and will then notify the Nursing Office (4-3950) with the referral number for each expiration.

D. Consent - Refusal to Consent (AMA- directly from Hospital P&P RI:0014)

Adult Patient with Capacity

1. In most cases, an adult patient with capacity may refuse treatment for himself/herself no matter how serious the medical consequences of the refusal.
2. When a patient refuses a proposed treatment, the following persons should be notified immediately:
 - a. responsible physician
 - b. unit or covering ADN
 - c. ADN, if the patient is pregnant, the single parent of a minor dependent child, or if the refusal will endanger the life or welfare of others or will cause substantial harm to the patient

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Emergency Department**

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**Subject:
Consent**

**Effective Date:
July 1, 1989**

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**Scheduled Revision:
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3. The physician or appropriately credentialed practitioner must discuss the circumstances of the refusal with the patient. The discussion must be witnessed by a nurse and/or other professional staff member and include:
 - a. the diagnosis
 - b. an explanation of the proposed treatment
 - c. the consequences of the refusal
4. The physician or appropriately credentialed practitioner must document patient's refusal and the discussion in the ED chart, including the names and titles of witnesses.
5. The "Refusal of Treatment" form (Form No. NU2C087) must be completed and filed in the patient's medical record.

Adult Patient Without Capacity

1. If a patient refuses treatment and the physician or appropriately credentialed practitioner suspects that the patient lacks capacity to make the decision, a consultation should be obtained from a psychiatrist or other appropriate physician. Both physicians must document their findings in the medical record. Consent may then be obtained from an appropriate representative of the patient.
2. A health care agent appointed by a patient may refuse medically necessary treatment for the patient when the patient loses capacity to consent (see administrative policy RI:0015 – Health Care Agent/proxy).
3. If a person who has not been appointed health care agent by the patient refuses medically necessary of behalf of a patient without capacity, the ADN and/or risk management should be contacted for advice.

Minors

1. When a parent or legal guardian refuses medically necessary treatment for a minor child and a health care provider determines that refusal creates substantial risk of physical injury which would be likely to cause death, serious and protracted disfigurement, protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, the physician must call the New York State Central Registry at 1-800-635-1522 prior to initiating treatment if the child's clinical condition permits.

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Emergency Department**

**Manual Code: 5.01
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**Subject:
Consent**

**Effective Date:
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March, 2012**

**Scheduled Revision:
March, 2013**

2. When imminent danger to a child's life or health exists as determined by a physician, treatment will be provided. The physician (two physician documentation is preferred when possible) must document the rationale for immediate treatment despite parent/legal guardian refusal and the efforts to inform the parent(s) legal guardian of the imminent need for medical treatment. The New York State Central Registry must be notified as soon as possible after treatment is initiated. This telephone communication must be documented in the medical record and include the name of the State Central Register interviewer and the case status. The most appropriate member of the treatment care team will be responsible for providing additional information to the local Child Protective Service team upon CPS request. The Social Worker will coordinate with the Medical Team in regards to status and CPS involvement.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.02

**Subject:
Confidentiality of Patient Information**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. All patients in the ED have the right to confidentiality regarding their health status.
2. The medical record will be guarded from unauthorized inspection.
3. Release of information to the communications media is the responsibility of the Public Relations Office. During normal business hours, all requests for information must be referred to that office. After hours and on weekends the ADN should be contacted.

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Emergency Department**

**Manual Code: 5.03
Page 1 of 7**

**Subject:
Triage**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. All patients presenting to the ED will undergo the process of Triage and have a triage priority documented.
2. Triage will be performed by a Registered Nurse following guidelines developed by the Chief of Emergency Services. Triage nurses must be B level competency and must be oriented to the Triage process by the Nurse Educator or a senior staff member.
3. Triage priorities are defined as follows:

| | |
|---------|--|
| Level 1 | Requires immediate life-saving intervention |
| Level 2 | High risk situation Confused/lethargic/disoriented Severe pain/distress Possible sepsis Less than 3 months old Suicidal/homicidal |
| Level 3 | Requires many resources Remember to consider dangerous vital signs for upgrade |
| Level 4 | One resource required |
| Level 5 | No resources required |
4. Triage information and priority level will be documented on the Medical Record.
5. Patients are designated to CPEP, critical care area, acute area, pediatric area, clinical decision / observation unit or immediate care area based upon their chief complaint and triage nurse evaluation. Patients with primary dental complaints will be “coded” as a dental patient.
6. Patients are evaluated in each designated area based upon their triage priority (a Level 2 patient in the acute area is evaluated prior to a Level 3 patient in the acute area).

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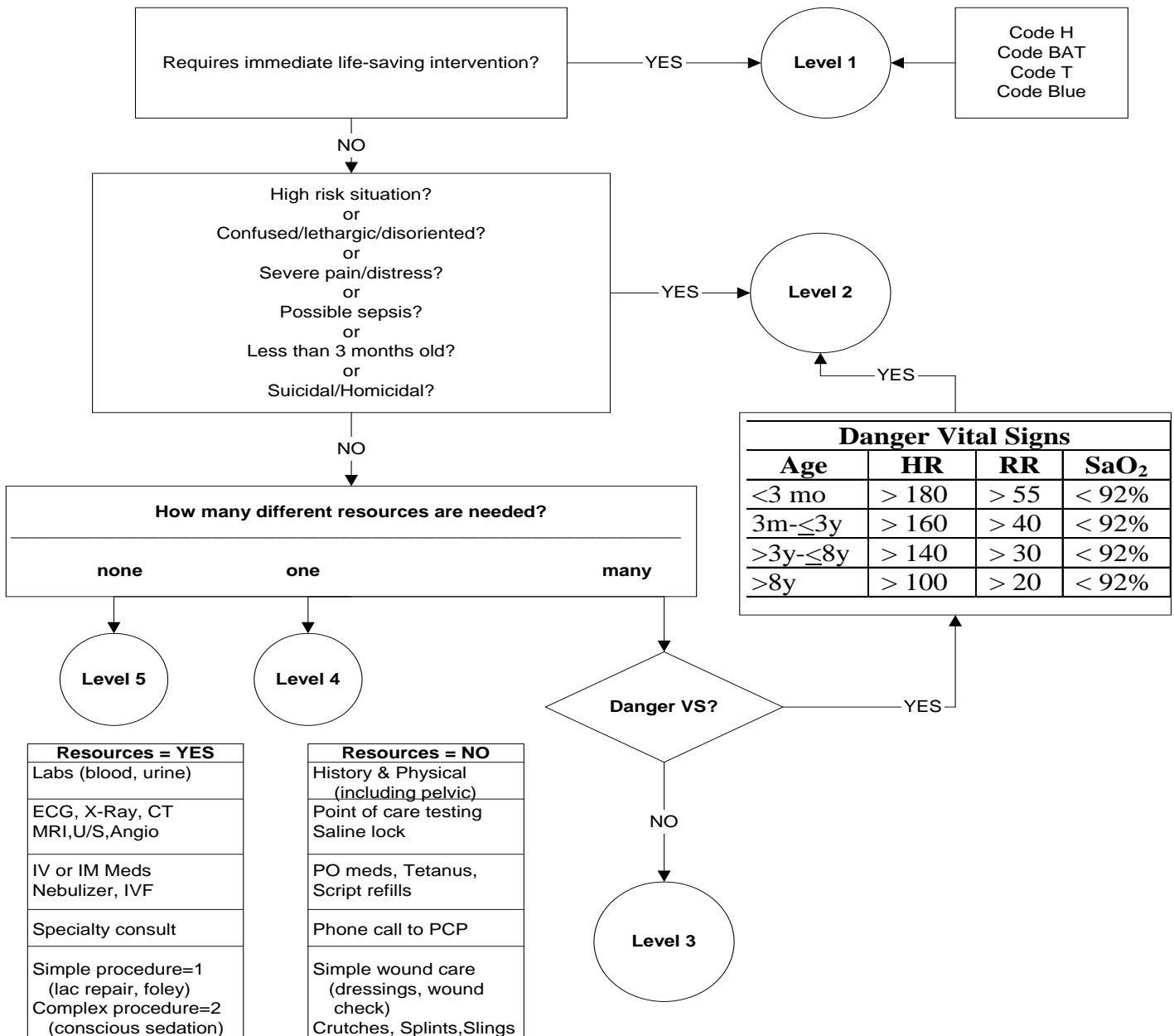
**Subject:
Triage**

**Effective Date:
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TRIAGE ALGORITHM:



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**Effective Date:
July 1, 1989**

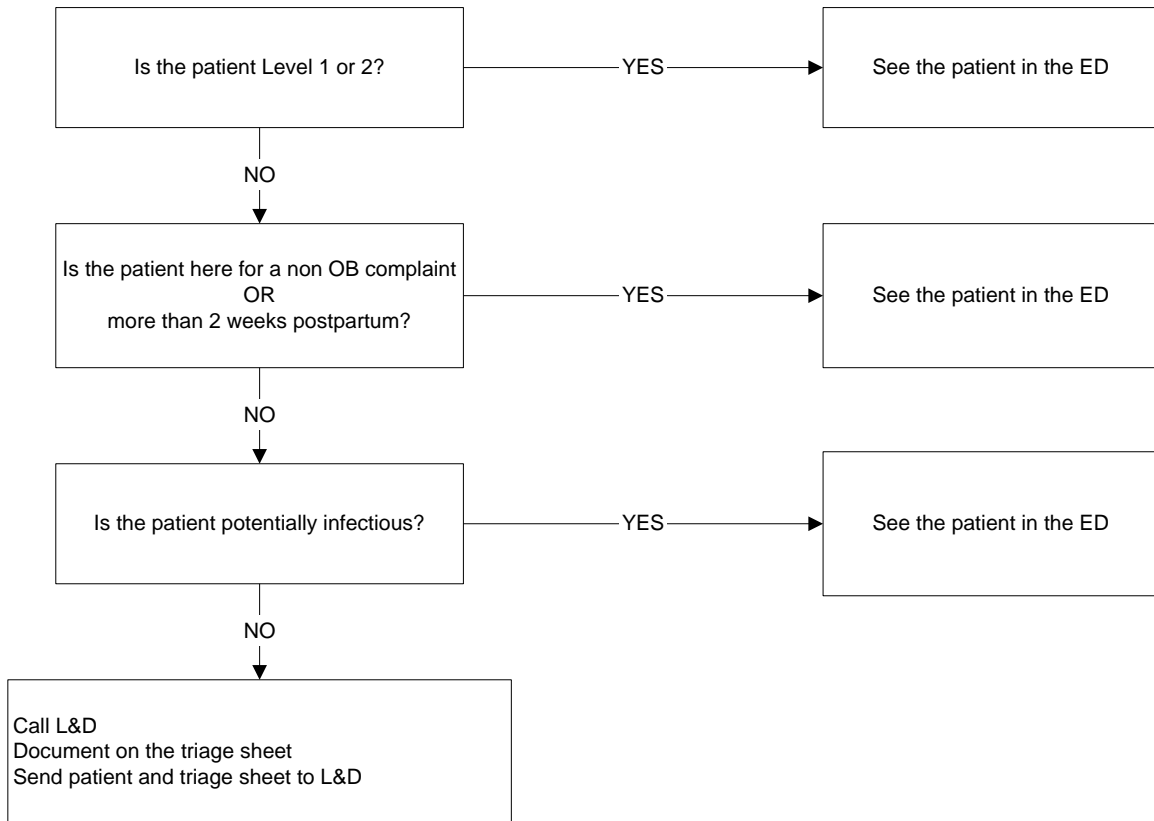
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**Schedule Revision:
March, 2013**

POLICY:

Triage of Known Pregnant Patients

7. Known pregnant patients (those with a positive pregnancy test [home test acceptable] or if a physician has told her she is pregnant) are triaged according to the following protocol:



If there is any doubt, consult with the ED attending physician.

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**Subject:
Triage**

**Effective Date:
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**Schedule Revision:
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POLICY:

8. Any patient with cough or fever and a rash will be assessed by the RN to determine if isolation is required. If the nurse determines the patient requires isolation a mask will immediately be placed on the patient and the patient will be placed in the appropriate isolation room. The triage nurse must always notify the charge nurse of the presence of patients requiring isolation.
9. Patients with behavior or thought disorders are to be triaged and evaluated according to the CPEP algorithm.
10. Any patient 18 years of age or over who presents with a chief complaint of non pleuritic chest pain and who is not triaged to the Critical Care area will have a 12 lead ECG ordered by the triage nurse. The CA assigned to triage will immediately take the patient to a treatment room and perform the 12 lead ECG. The 12 lead ECG will be brought directly to the ED attending who will read the ECG and initial the ECG.
11. Any patient with a triage level of 1, 2 or 3 has a standing order for phlebotomy and peripheral IV placement

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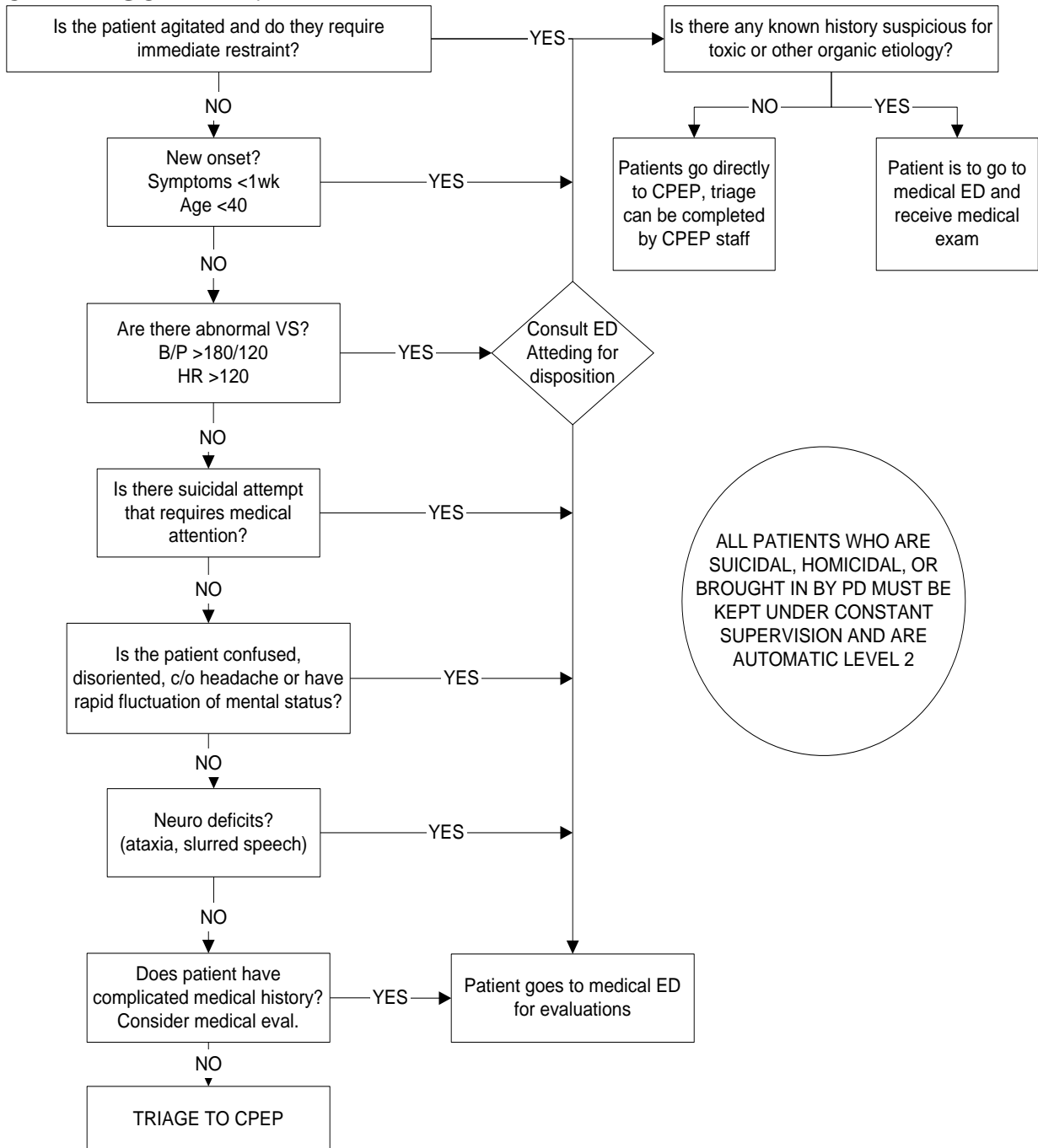
**Subject:
Triage**

**Effective Date:
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CPEP ALGORITHM:



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**Subject:
Triage**

**Effective Date:
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**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
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PROCEDURE:

1. An RN is assigned to triage at all times.
 2. If there are more than 4 patients to be triaged at any one time, the charge nurse is to be notified.
 3. The charge nurse should remain in contact with the triage nurse, to ensure patient flow.
 4. The designated negative pressure isolation rooms in the ED are Acute Care rooms 4 and 9, Critical Care room 4 and Pediatric area rooms P7 and P8, and Green Area Rooms 3 and 4. The monitor on the wall outside of these rooms identify that proper negative pressure is being maintained. The gauge should read less than negative .001 when the door is closed.
 5. Call back patients (asked by us to return for a repeat exam or test) should be expedited through the triage process and placed in the department as soon as possible. The attending should be notified that a recalled patient is here.
 6. Triage responsibilities also include:
 - radio communication with ambulances
 - notifying the charge nurse of ambulance arrivals
 - communicating with Labor & Delivery about any patients being sent there
 - communicating with CPEP, Critical Care ED, Acute Area, Pediatric Area, Immediate Care and Clinical Decision / Observation area
 - obtaining consent for treatment, or communicating with the charge nurse why consent was not obtained
 7. When triage is notified of an expected patient from a community physician, data specific to the expected patient will be recorded by the EMS Transfer Center staff. When the patient arrives the triage nurse will indicate in the patient's chart that the patient is an "expected patient".
-

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Emergency Department**

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**Subject:
Triage**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

PROCEDURE:

8. Triage should collect all pertinent medical information necessary to make a decision concerning immediacy of medical attention. (This will usually include chief complaint, past medical history, current medications, vital signs). Any incomplete triage information should be obtained and documented by the primary care team in the treatment area.

9. Patients with straightforward presenting problems, which are to be seen in immediate care or acute, are appropriate to triage directly to a treatment room. This will allow any pertinent history and vital signs to be completed by the primary care team in the treatment area.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.04

**Subject:
Private Physician (PMD) Notification**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. All patients presenting to the ED for treatment will be asked by the triage personnel the following:
 - if they have a PMD and who it is
 - if their PMD referred them to the ED

2. All private physicians have the right to notify the triage personnel or the ED physicians on duty of a patient referral and to request a feedback telephone call once the patient is evaluated by the physicians on duty. These requests should be referred to the EMS Transfer Center to be entered into the expected patient tracking system in First Net.

3. The ED attending or designee will notify the patient's personal physician or designee:
 - a. when the patient is admitted
 - b. when information is needed to care for the patient
 - c. at the request of the patient.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.05

**Subject:
Critical Care Area**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The Critical Care Area of the ED is the receiving area for all seriously ill or injured patients.
2. The ED attending on-duty is responsible for overseeing the management of all patients treated in the Critical Care Area.
3. When patients are admitted but remain in the critical care area, the ED nursing staff will follow the orders of the admitting service. Any disputes regarding patient management will be discussed between the ED physician and the admitting service.
4. The ED staff, under the supervision of the attending on-duty, is responsible for notifying the admitting service of a significant change in the patient's status.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.06

**Subject:
Patient Belongings and Valuables**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Patient property lists need to be completed on all patients with an altered mental status, all admitted patients or those who die in the emergency department. The white copy of the property list goes in the medical record (or to distribution if the property is sent to distribution), the yellow and pink copy gets attached to the patient's chart, and the gold copy is kept in the patient property book in the emergency department.
2. Valuables will be placed in a "Valuables Envelope" and sealed. If the valuable is soiled, the only appropriate container for the valuable is a zip lock bag. The envelope will be labeled with the patient's name, date, encounter number, the itemized list of valuables and the signature of employee. The envelope will be given to the registrar and the receipt attached to the Medical Record.
3. All jewelry will be described by color and shape only (i.e., yellow ring with round white stone). All cash will be counted and sorted (i.e., \$62.00, 3 \$20.00 bills and 2 \$1.00 bills).
4. Patient belongings and valuables are not to be held in the Emergency Department.
5. For any homicide or suicide patient belongings should be placed in a paper bag, labeled as above and given to the police. The police officer who takes the belongings must sign and list their badge number on the property list/valuable envelope. A chain of evidence property form must also be completed.
6. The patient's primary nurse is responsible to ensure that this policy is complied with.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.07

**Subject:
Standing Orders**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Emergency Department nurses and paramedics may initiate basic and advanced cardiac resuscitation measures in emergency situations. These measures include; initiation of intravenous therapy, oxygen therapy, and medication administration and defibrillation consistent with ACLS guidelines.

2. Emergency Department RN's, CA's, EMT's and EMT-P's may initiate basic cardiac resuscitation and first aid in emergency situations.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.08a
Page 1 of 2**

**Subject:
Laboratory Services**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Hospital
 - a. The Clinical Laboratory is on site in the hospital, and is capable and responsible for performing all routine analyses of blood, urine, and other body fluids at all times for ED patients.
 - b. These analyses include at a minimum:
 - arterial blood gas and ph determination
 - blood urea nitrogen
 - coagulation studies including PT, PTT and platelets
 - complete blood count
 - glucose level
 - gram stain, culture and sensitivity
 - serum and urine osmolality
 - serum electrolytes
 - toxicological studies
 - c. The Clinical Laboratory includes a Blood Bank, which is staffed 24 hours a day and performs typing and crossmatching procedures. The Blood Bank maintains an adequate supply of blood and blood components for ED patients.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.08a
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**Subject:
Laboratory Services**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

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POLICY: (Continued)

2. Emergency Department
 - a. The emergency department lab is used for educational purposes only.
 - b. The equipment in the emergency department lab is maintained according to Stony Brook University Medical Center Biomedical Engineering and manufacturer's standards.
 - c. All results of emergency department lab studies are reviewed by the emergency department attending.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.08b

**Subject:
Integration of Diagnostic Radiology with ED**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Diagnostic Radiology is available 24 hours a day to perform routine studies using equipment, both fixed and portable, located on site in the ED.
2. A resident physician in Radiology is available in hospital 24 hours a day to interpret all radiographs in the ED.
3. An attending physician in Radiology is available 24 hours a day for consultation.
4. The Radiology Department provides other specialty capability 24 hours a day. These specialty services are available within approximately 30 minutes of the initial request. A resident physician, fellow and attending physician in Radiology are available 24 hours a day for consultation regarding these services. These include:
 - computerized tomography
 - diagnostic and interventional angiography
 - interventional radiology, including, percutaneous drainage of abscess
 - nuclear scanning
 - ultrasonography

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.08c

**Subject:
Integration of Operating Rooms (OR) with ED**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The OR is staffed and available 24 hours a day for all surgical emergencies arising in the ED.
2. Resident physicians and an attending physician in Anesthesiology are in-house and available 24 hours a day.
3. A senior resident physician in Surgery, Pediatric Surgery and Orthopedics is in-house and available 24 hours a day.
4. Attending physicians in Surgery and all surgical subspecialties are available 24 hours a day for consultation within approximately 30 minutes.
5. The OR has the capability of the following services for any ED patient:
 - cardiopulmonary bypass pump oxygenator
 - craniotomy equipment
 - electrocardiographic monitoring with oscilloscope and defibrillator
 - endoscopes for upper endoscopy, colonoscopy and bronchoscopy
 - equipment for monitoring direct blood pressure, central venous pressure, pulmonary artery pressure, pulse rate, temperature and respirations
 - fracture table
 - mechanical ventilator capability
 - operating microscope
 - pacemaker insertion capability
 - roentgenographic equipment, including image intensifier
 - temperature control equipment for blood
 - temperature control equipment for patient

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.08d

**Subject:
Integration of Special Care Units with ED**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The ED has access to the following Special Care Units of the hospital which are staffed 24 hours a day:
 - burn unit (BU)
 - cardiovascular intensive care unit (CVICU)
 - coronary care unit (CCU)
 - labor and delivery suite (OB)
 - medical intensive care unit (MICU)
 - newborn intensive care unit (NICU)
 - pediatric intensive care unit (PICU)
 - surgical intensive care unit (SICU)
 - telemetry unit (TU)

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.09

**Subject:
Reporting of Criminal Injury**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The physician on-duty or his designee will notify University Police (x911) of all cases of suspected criminal injury caused by a gunshot wound or wounds inflicted by sharp instruments that may result in death as reported by the patient. The date and time of call, person contacted and badge number should be documented on the medical record.
2. Any weapons of suspected criminal injury, if separate from the patient or if removed from the patient in the ED, should be turned over to the University Police.
3. All bullets or foreign bodies causing suspected criminal injury which are removed from the patient in the ED are to be placed in a sealed container and handed to an officer from University Police who will complete a Chain of Evidence Form.
4. The University Police officer will notify Suffolk County Police Dept. of any criminal injuries.
5. Patients with behavior or thought disorders are to be triaged and evaluated according to the attached protocol.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.10

**Subject:
Invasive Procedures (Physicians)**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. Invasive procedures performed in the emergency department can only be performed under the supervision of a health care provider credentialed to perform such procedures.
2. The ED will not be used as an operating room.
3. Appropriate pre, intra and post operative assessments will be performed and documented for each patient.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.11
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**Subject:
Emergency Department Observation**

**Effective Date:
June, 2010**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

Definition:

Observation care is used when the initial physician evaluation does not reveal an immediate disposition and continuing treatment/work up are needed to determine the patient's disposition. If it is apparent, after initial physician evaluation that a patient is definitely going to be admitted or discharged then observation care is not appropriate. Placement of a patient on observation care is a clinical decision made by the ED physician on a case by case basis.

POLICY:

1. After initial or subsequent evaluation by the emergency department physician a patient may be placed on observation care.
2. Observation care is ordered for patients who meet observation care criteria and who will have an anticipated length of stay in the emergency department in excess of approximately three hours.
3. Patients placed on observation care must have a minimum of three physician statements which include (at a minimum)
 - a. The initial order and rationale for placing the patient on observation care
 - b. A minimum of one continuation note documenting the patient's clinical condition as well as any required continued treatments/tests while the patient remains on observation care. At a minimum, one continuation note must be completed during each attending physician shift.
 - c. An observation discharge note identifying the results of ordered tests/procedures, final patient evaluation and disposition (discharge or admit).

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Emergency Department**

**Manual Code: 5.11
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**Subject:
Emergency Department Observation**

**Effective Date:
June, 2010**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

4. As soon as a decision is made specific to patient disposition (admit or discharge) the observation order status should be completed and a note timed and dated reflecting this decision.
5. Patients who are awaiting a test/procedure while in the emergency department but do not require any clinical care and/or reevaluation during their emergency department visit are not appropriate for observation care.
6. This is a non exclusive list of patients who should, on an individual basis, be considered for observation status:
 - a. Coronary CT patients whose result will determine admission or discharge
 - b. COPD/Asthma patients requiring multiple reevaluations
 - c. Abdominal pain and/or gastrointestinal complaints requiring multiple reevaluations, IV fluids, antiemetics, pain management and/or awaiting results of a CT with contrast whose result will determine admission or discharge
 - d. Allergic reaction patients anticipated to be reevaluated over at least three hours whose reevaluation will determine admission or discharge
 - e. Pediatric croup patients requiring at least three hours in the emergency department with multiple reevaluations whose reevaluation will determine admission or discharge
 - f. Toxicology patients requiring multiple reevaluations and/or neurological checks whose reevaluation will determine admission or discharge
 - g. Acute pain patients (back pain) requiring multiple pain medications and/or MRI and/or neurology/neurosurgery consultation whose results/reevaluation will determine admission or discharge.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.11
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**Subject:
Emergency Department Observation**

**Effective Date:
June, 2010**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

7. Once an observation order has been placed it should not be cancelled unless it was entered in error. Coders will determine, base upon chart review, if it is appropriate to generate an observation charge.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.13

Subject:
Patient Transport for Radiological Procedures

Effective Date:
July 1, 1990

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

ED patients will remain safe during radiological procedures with the use of clinical alarm systems.

1. All Emergency Department patients on a cardiac monitor will be transported to the ED Cat Scan room or other radiology areas by an RN or paramedic, unless the treating physician orders transportation off telemetry. The RN or paramedic will set the cardiac monitor alarm parameters to the limits appropriate for each patient and will assure that the patient is on oxygen therapy as ordered.
2. An RN or paramedic will remain with all Critical Care area patients during Radiology Procedures unless otherwise ordered by the Critical Care area Attending.
4. Patients will continue on their current therapy (oxygen, cardiac monitoring, etc.) unless otherwise ordered by an MD.
5. Any questions should be referred to the ED Charge RN or the ED Attending Physician.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.14
Page 1 of 2**

**Subject:
Admission**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Bed Control/Admitting will be notified of all patients to be admitted to the hospital.
2. All patients admitted to the hospital will be admitted to an attending physician's service.

PROCEDURE (taken from Section 4a of the Medical Board Policies as approved 2/8/91):

1. The emergency department (ED) attending will evaluate all patients presenting to the ED, and determine the need for admission after an appropriate evaluation. The ED attending will be responsible for determining the need for consultation and more advanced evaluation to properly determine the patient's disposition.
2. The ED attending will determine the appropriate department and service for admission, and notify the appropriate attending (or his/her designee).
3. Once the patient is admitted, any further consults requested should be made directly between services.
4. If the accepting attending objects to the admission, or wishes to delay admission pending further evaluation:
 - a. The attending should present to the ED within 90 minutes to evaluate the patient. Should the attending not come to the ED, then the patient will be admitted to that service.
 - b. Should the attending disagree with the disposition of the patient, that attending will assume responsibility for the disposition of the patient, and be responsible for assuring appropriate subsequent care. The attending will be responsible for appropriate documentation of his or her evaluation and disposition. Should the attending wish consultation from other services, he or she will be responsible for contacting those services.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.14
Page 2 of 2**

**Subject:
Admission**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

- c. Should a dispute regarding patient disposition be irresolvable, the disposition of the patient will be determined by the director of the emergency department or his/her designee
5. Consultation and diagnostic evaluation will be limited to that needed to determine the appropriate disposition. For patients to be admitted, more extensive evaluation and consultation can proceed, but will not delay admissions to the hospital. Consultation and diagnostic evaluation which delay admission to the hospital may be limited by the ED attending.
6. Should further evaluation reveal that the patient's care is better provided on another service, then the admitting service bears the responsibility for interservice communication and transfer.
7. All cases which are felt to be inappropriate admissions or dispositions should be referred to the director of the emergency department.
8. Upon notification of a bed assignment by Admitting, the primary nurse will be notified.
9. Inpatient admitting orders may be written by the Admitting Service prior to the patient being transferred. The absence of written orders will not, however, delay the transport of the patient.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.14a

**Subject:
Return of Admitted Patients to the Emergency Department**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. Patients who are admitted to patient care areas in the hospital from the ED must not return to the ED for further treatment once they have arrived at the accepting hospital care area.
2. Any request for variance from item (1) must be reviewed and approved by the Chairperson or Vice Chairperson of the ED.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.14b

**Subject:
Length of Stay in the ED Greater than 8 Hours**

**Effective Date:
January 1, 1996**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. For all patients seen in the emergency department, the period of observation and stabilization is not to exceed eight hours.
2. At the end of eight hours the patient must be admitted to an in-patient service, discharged from the emergency department, or transferred to another institution in accordance with DOH 405.19 regulations and COBRA regulations as per ED policy #4.09.

PROCEDURE:

1. The nursing station clerk will call admitting to arrange for a bed..
2. In the event that the patient is to be admitted to an ICU and there is no bed available the Attending/Director of the Intensive Care Unit with insufficient beds will coordinate an appropriate ICU bed.
3. Patients will be transferred to another institution in accordance with DOH 405.19 regulations and COBRA regulations as per ED policy #4.09.
4. Admitted patients awaiting an inpatient bed will have their ED chart split and the following inpatient paperwork will be initiated:
 - a. Admitting nursing note is documented on the progress note.
 - b. Admitting nursing data base and IPC form.
 - c. Medication, TPR, and I&O sheets are initiated.
 - d. A medication reconciliation plan will be initiated and attached to the patients chart.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.15

Subject:
Injury Prevention of Unconscious, Confused or Irrational Patients

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Schedule Revision:
March, 2013

POLICY:

1. The arrival of an unconscious, confused or irrational patients will immediately be brought to the attention of the charge nurse. These patients will be protected from injury by the side rails being placed up in conjunction with continuous monitoring and/or restraints. The stretcher/bed must be placed in the lowest position when the patient is not under the direct observation of an emergency department staff member. All actions taken for safety and/or restraint (including the lowering of the stretcher/bed) must be documented in the patient's chart.
2. The Emergency Department attending is responsible for providing a medical evaluation on all patients who are under the influence of drugs or alcohol or who are difficult to manage.
3. Restraints will be applied in accordance with the Stony Brook University Medical Center's Administrative Policy and Procedure Manual #PC:0008.
4. The Emergency Department and the Comprehensive Psychiatric Emergency Program will work collaboratively to provide a safe environment for irrational or difficult to manage patients.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.16

**Subject:
Radiation Accidents/Radioactive Contamination**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. The ED has the capability of receiving patients who have been exposed to radiation or who have been radioactivity contaminated.
2. Any patients presenting to the ED with radiation exposure or radioactive contamination will necessitate activation of the hospital's disaster plan.
3. The ED will follow the procedure for radiation accidents and radioactive contamination described in the hospital's disaster plan.
4. In case of radiation accidents/radiation contamination please notify the Stony Brook University Medical Center Radiation Safety office at 444-3196 during office hours. Other times call the hospital operator for on-call numbers.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.17

**Subject:
Social Work Services Consultation**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

Patients that present in Emergency Medicine who should be referred for Social Work intervention (at any hour) include the following:

1. Suspected Child Abuse/Neglect;
2. Spouse, Adult or Elder Abuse;
3. Rape or Sexual Assault;
4. Cardiac Arrest or Severe Trauma. Adult patients that have a potential permanent disability, all pediatric patient/families and patient deaths pronounced in the Emergency Department that have family or significant others present.
5. Homeless (included in this are individuals removed from their home or refusal by a caregiver/significant other to have patient return to their home);
6. Runaways.

Other referrals which might require Social Work intervention will be discussed between staff. The Social Worker can clinically assess the nature of the emergency and the type of required intervention, whether it is face to face or by telephone.

Drug and Alcohol Abuse;
Consent and AMA issues;
Patient and family emotional reactions to ED;
Transfers of Pediatric Patients;
Transportation;
Referrals from community agencies for assistance;
Family/patients requesting assistance, specific to need for home care, placement or adjustment to illness;
Financial concerns, specific to hospital bills, home care and/or prescriptions.

PROCEDURES

1. The Emergency Department Social Worker will be notified between the hours of 1-9 p.m., Tuesday - Saturday.
2. The Social Worker Service Department will be contacted during business hours when the Emergency Department Social Worker is unavailable Monday - Friday, 8:00 a.m. to 5:00 p.m., ext. 4-2552.
3. All other times the on-call Social Worker should be contacted through the hospital switchboard on their long range beeper for consultation.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.18
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**Subject:
Rape/Sexual Molestation**

**Effective Date:
March, 1994**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. The Emergency Department staff will inform all adult patients with suspected rape/sexual assault of their right to report the incident to the police and will assist the patient in this reporting. (There is no legal obligation for the patient to report to the police.) If the assault occurred within the previous 96 hours, the patient is eligible for collection of forensic evidence by a SANE regardless of whether or not Law Enforcement is involved.
2. Staff will follow the child abuse policy in Stony Brook University Hospital Administrative Manual #PC:0003 for any child reporting rape/sexual assault. If a child reports assault by a family member or caretaker, the staff will report the incident to the police/ CPS (Child Protection Service). If law enforcement is involved in a case of a patient less than 18 years of age, a CAC referral (Child Advocacy Center) will be issued (631-439-0480).
3. To ensure patient privacy and confidentiality, the patient will be escorted from triage to a private room where triage will occur, whenever possible.
4. If the patient is medically stable and the assault is acute (within 96 hours), the patient should be offered the opportunity to have an exam and evidence collection performed by a Sexual Assault Nurse Examiner (SANE). The triage nurse will refer to the SANE on-call schedule and page the examiner. The patient should be placed in the "virtual" SANE room on the First Net System.
5. If the patient is not accompanied by either a family member or friend, with the patient's permission, the Emergency Department staff should attempt to locate someone who the patient wishes to be present during the time spent in the Emergency Department (ED) and can accompany the patient upon discharge from the ED. It is required that the patient be offered the services of an ERC (Emergency Room Companion). The ERC can be contacted Monday-Thursday from 9am-9pm and on Friday from 9am-5pm at 631-360-3730. During all other times they may be contacted via pager at 631-556-1044. The triage nurse will contact the ERC.
7. If a SANE and ERC are not involved, Social Work Services will be contacted while the patient is in the Emergency Department to begin the process of counseling and to provide referrals and follow-up care.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.18
Page 2 of 3**

**Subject:
Rape/Sexual Molestation**

**Effective Date:
March, 1994**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

7. The patient history and brief medical examination will be conducted in a private room ensuring both privacy and confidentiality.
 - 7a. Patients who elect to have evidence collection by a SANE will be medically cleared by the Emergency Department physician and transported to the SANE exam area. The SANE lab panel will be drawn prior to the patient leaving the ED for the SANE room.
 - 7b. Staff will make an effort to minimize disturbance of clothing and /or areas which could be potential sources of evidence.
 - 7c. If the patient needs to void, a non sterile specimen will be collected with minimal wiping.
8. For patients not seen by a SANE, the patient's medical history will be recorded by the Emergency Department staff on the medical record, and a patient assessment for treatment of Sexual Abuse will be completed.
9. Patients who report an acute assault (within 96 hours) and are not seen by a SANE will be provided a medical examination including evidence collection utilizing a sexual assault evidence kit. Evidence collection kits are maintained in the Emergency Department or may be provided by Law Enforcement. The kit will be turned over to the police if the patient provides written consent. If the patient declines to have the kit turned over to the police, all collected evidence will be maintained in the ED as per policy 5.18a (Rape Kit/Maintaining Evidence). Disposition of kit must be charted in the patients medical record.
10. Antibiotic prophylaxis for gonorrhea and chlamydia will be administered for appropriate patients who request prophylaxis. The patient will be informed of the need for a VDRL and genital cultures in 2-4 weeks and HIV testing in 3 months to determine if additional therapy is needed.
 - 10a. Vantin 200mg by mouth (one dose) for Gonorrhea.
 - 10b. Zithromax 1 gram by mouth (single dose) for chlamydia.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.18
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**Subject:
Rape/Sexual Molestation**

**Effective Date:
March, 1994**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

- 10c. Following HIV risk assessment, HIV Post Exposure Prophylaxis is to be offered if indicated and desired: Combivir 1 tablet by mouth every 12 hours X 4 weeks and Viread (tenofovir) 300 mg by mouth daily X 4 weeks. The first dose is to be given during the ED encounter.
- 10d. Patients will be assessed for Tetanus and Hepatitis B immunization status (see policy #5.43) Tetanus, HBIG and Hepatitis B vaccine may be offered if indicated.
11. Any female patient who is the victim of sexual assault and is of reproductive years will be treated in accordance with the Emergency Contraception policy #9.02
12. An Emergency Department nurse will be assigned as primary nurse for all suspected rape/sexual assault cases.
13. The patient will be discharged with written instructions for medical follow-up and counseling provided if it is decided safe to do so.

Specific SANE Procedure:

1. Once a determination is made that a SANE will be called in for a patient examination the patient will remain in the ED until the SANE arrives.
2. The SANE, upon arrival, will see the ED charge nurse to obtain the patient's chart and any lab test results which are available. At this time the ED charge nurse will ensure that the SANE has their Stony Brook ID and properly completes the SANE log which will be kept in triage.
3. The SANE will bring the patient to the SANE room for the examination. If lab results have not yet been completed the SANE will call the ED and the results, when available, will be faxed to the SANE room.
4. The SANE nurse will escort the patient out of the hospital via the ED, give their completed chart to the ED charge nurse who will discharge the patient from the First Net system and then process the paperwork (paperwork scanned in the ED and then given to the registrar). If the SANE nurse feels that further evaluation/treatment is needed in the ED then this will be brought to the attention of the ED charge nurse and the patient will be seen in the appropriate area of the ED prior to discharge.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.18a

**Subject:
Rape Kit/Maintaining Evidence**

**Effective Date:
March, 1994**

**Reviewed/Revised as of:
March, 2012**

**Schedule Revision:
March, 2013**

POLICY:

1. Evidence kit will be collected as per policy 5.18 (Rape/Sexual Molestation).
2. If the patient refuses to have the completed kit turned over to the police the ED will maintain the completed rape kit for 30 days.
3. The completed kit, along with the chain of evidence form, will be kept in a double locked refrigerator in the SANE Room. The rape kit log book must be properly completed each time a rape kit is placed into or withdrawn from the refrigerator.
4. If a patient calls the ED to change his/her decision regarding the disposition of the completed rape kit (the patient now wants the kit turned over to the police) the patient will be referred to VIBS who will coordinate turning over the kit to the police.
5. If after 30 days the patient has not requested that the kit be turned over to the police the kit may be considered infectious waste and disposed of as such.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.19

Subject:
Release of information to the Medical Examiner (ME)

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. All patient deaths in the ED will be reported to the Medical Examiner's office by the physician on-duty or his designee and this will be documented on the medical record by recording: date of the call; time of the call; person contacted; ME case number.
2. The ED staff must not ask for permission for a post-mortem exam until the ME office is contacted:
 - If the ME accepts the case, then the death certificate will be signed by the ME. The ME has the legal right to perform a post-mortem exam without consent.
 - If the ME accepts the case but decides to forego a post-mortem exam, then the ED staff may ask permission for a post-mortem from next-of-kin.
 - If the ME refuses the case, the death certificate is signed by the private physician or ED physician. The ED staff may ask permission for a post-mortem from next-of-kin.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.20a

Subject:
Animal Bites - Notifying the Dept. of Health

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. Any animal bite will be reported to the Bureau of Epidemiology and Public Health Detection, Suffolk County Department of Health Services, by the ED physician or his designee and this will be documented on the medical record by recording: date of the call; time of the call; person contacted.
2. The Bureau of Public Health Detection should be faxed a report of the animal bite to fax number 631-8853-3073.
3. As per NYS Sanitary Code Section 2.14, notification to the local health department must be made **prior** to starting rabies post exposure prophylaxis, except in those cases where prior notification would compromise the health of the patient. The Suffolk County Department of Health Services, Division of Public Health, Bureau of Epidemiology should be contacted during normal business hours at 631-853-3055. During off hours the department can be contacted by calling the Suffolk County Fire Rescue and Emergency Services (FRES) at 852-4815 and they will page/contact the on call personnel in the Department of Health.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.20b

Subject:
Pesticide Poisoning - Notifying the Dept. of Health

Effective Date:
October, 1999

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. Any patient with a confirmed or suspected pesticide poisoning must be reported to the State Commissioner of Health within 48 hours.
2. The number to call is 800-322-6850.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.21

**Reference Manual
Code: ND:IV:09**

**Subject:
Patient Discharge**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The attending physician in the Emergency Department must approve all discharges, and sign the medical record prior to discharge.
2. After attending M.D. approval an M.D., P.A., or R.N. may discharge the patient.
3. All patients will receive written discharge instructions related to their condition which specify actions to be taken, appropriate follow up care and any contact agencies necessary.
4. The patient or significant other will sign the medical record to indicate that they received and understood the discharge instructions.
5. A minor may only be discharged to the custody of a parent, legal guardian or adult family member.

PROCEDURE:

1. The attending physician, physician assistant, or nurse practitioner will outline the patient's discharge plan and review it with the patient.
2. The nurse will review the discharge plan/instructions with the patient.
3. The R.N., P.A. or M.D. discharging the patient will provide a summary or the discharge plan, either preprinted or in writing. The patient or significant other will sign indicating they received and understood the discharge instructions.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.22

**Subject:
Infection Control**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The hospital Healthcare Epidemiology Program for isolation procedures will be adhered to by all ED staff. The orientation of all ED staff will include infection control. All staff must adhere to universal precautions including hand washing and the appropriate use of protective barriers, and care in the use of and disposal of needles and other sharp instruments
2. All patients who present to triage with a potentially communicable disease will have appropriate isolation precautions instituted immediately. These patients will be triaged expediently and then will be placed in a single room whenever possible or in a double room with curtains drawn if necessary.
3. All patients with MRO codes (M, B, V, C, N) are to be isolated as per Healthcare Epidemiology policy (IC:5:12) on Multiple-Resistant Organisms.
4. All patients requiring respiratory isolation (ie. TB, Chicken Pox, Measles, Multi Dermatomal Zoster, SARS and Smallpox) will be placed in ED Acute rooms 4 or 9, Critical Care room 4, or Green rooms 3 or 4, or pediatric room 7 or 8 which are negative pressure isolation rooms. Negative pressure is assured only when doors are closed completely. The air flow monitor in rooms should register less than negative .001WC when the door to the room is closed in those rooms with a digital monitor or the light on the monitor should turn from red to green to denote that negative pressure is being maintained.
5. Precautions will be taken so that patients with suspected infectious disease will spend the minimal amount of time in the ED.
6. All ED staff will comply with SBUMC policy for hand hygiene (IC:0003).

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.22a
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**Subject:
Bloodborne Pathogen Exposure in Patients/Healthcare Workers Presenting to the
ED**

**Effective Date:
Dec. 31, 1990**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The following information is required before a bloodborne pathogen exposure individual can be treated appropriately:
 - A. Source of exposure and evaluation as per the CDC guidelines (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>) described as low, moderate, or high risk.
 - B. Date of last tetanus immunization.
 - C. Date of completed Hepatitis B vaccine series, if performed.

2. All individuals who have had a significant bloodborne pathogen exposure as per CDC guidelines will receive blood testing for at least the following:
HepB sAb (if unknown status)
HepC Ab
HIV after consent and counseling

3. Treatment of Individuals Who Sustained a Bloodborne Pathogen Exposure:
 - A. Draw lab work as stated in number 2.
 - B. Give HBIG (hepatitis immune globulin) .06ml/kg IM. The 1st dose of the Hepatitis Vaccine, Recombivax 0.5 cc IM should be administered if not previously vaccinated or vaccination status is unknown.
 - C. Give dTp 0.5cc if patient is not up-to-date.
 - D. Provide wound management.
 - E. Refer employees to Employee Health at the next available business day for follow up. All other patients should be advised to follow-up with their private physician and advised of the need, if appropriate, for the final two doses of the Hepatitis Vaccine.
 - F. Refer to attached CDC Guidelines for HIV Postexposure Prophylaxis (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>)
If prophylaxis is provided, the following baseline labs should be drawn:
Pregnancy test
CBC
Hepatic panel
Chem 7
UA
Amylase (if Indinivir/Crixivan is prescribed)

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Emergency Department**

**Manual Code: 5.22a
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**Subject:
Bloodborne Pathogen Exposure in Patients/Healthcare Workers Presenting to the
ED**

**Effective Date:
Dec. 31, 1990**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

4. The source patient, if known, should have the following blood testing performed:
 - HepB sAG
 - Hep B core Ab
 - Hep B sAb
 - Hep C Ab
 - HIV after consent and counseling under the direction of covering LIP.

5. "Sterile" Sharp Injury
 - A. Give dTp 0.5ccs if patient is not up-to-date.
 - B. Local wound management.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.22b
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**Subject:
Bloodborne Pathogen Exposure in Prehospital Emergency Response Employees
(ERE) Presenting to the ED**

**Effective Date:
August. 31, 2008**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The following information is required before a bloodborne pathogen exposure patient can be treated appropriately:
 - A. Source of exposure and evaluation as per the CDC guidelines (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>) described as low, moderate, or high risk.
 - B. Date of last tetanus immunization.
 - C. Date of completed Hepatitis B vaccine series, if performed.

2. All patients who have had a significant bloodborne pathogen exposure will receive blood testing for at least the following:
HepB sAb (if unknown status)
HepC Ab
HIV after consent and counseling

3. Treatment of Patients Who Sustained a Bloodborne Pathogen Exposure:
 - A. Draw lab work as stated in number 2.
 - B. Give HBIG (hepatitis immune globulin) .06ml/kg IM. The 1st dose of the Hepatitis Vaccine, Recombivax 0.5 cc IM should be administered if not previously vaccinated or vaccination status is unknown.
 - C. Give dTp 0.5cc if patient is not up-to-date.
 - D. Provide wound management.
 - E. Patient should be advised to follow-up with their private physician and advised of the need, if appropriate, for the final two doses of the Hepatitis Vaccine.
 - F. Refer to attached CDC Guidelines for HIV Postexposure Prophylaxis (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>)
If prophylaxis is provided, the following baseline labs should be drawn:
Pregnancy test
CBC
Hepatic panel
Chem 7
UA
Amylase (if Indinivir/Crixivan is prescribed)

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.22b
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**Subject:
Bloodborne Pathogen Exposure in Prehospital Emergency Response Employees
Presenting to the ED**

**Effective Date:
August. 31, 2008**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

4. The source patient, if known, should have the following blood testing performed:
 - HepB sAG
 - Hep B core Ab
 - Hep B sAb
 - Hep C Ab
 - HIV after consent and counseling
 - A form, titled “Informed Consent to Perform a Confidential HIV Test and Authorization for Release of HIV-related Information for Purposes of Providing Post-exposure Care to a Health Care Worker Exposed to a Patient’s Blood or Body Fluid” (DOH-4054, Rev 8/05 available at <http://www.nyhealth.gov/forms/doh-4054-pdf>,
5. "Sterile" Sharp Injury
 - A. Give dTp 0.5ccs if patient is not up-to-date.
 - B. Local wound management.
8. As per NYS DOH regulations the patient or their primary care physician may be told the HIV status of the source patient as long as the following procedures are completed:
 - a. An incident report documenting the details of the exposure, including witnesses to the incident, if any, is on record with the patient’s supervisory staff (we do not need to see a copy of the report but the patient must inform us that the report was completed)
 - b. The patient or the patient’s primary care physician requests disclosure of the source patient’s HIV status.
 - c. The ED physician must review, investigate and evaluate the incident and certify that:
 - i. The information is necessary for immediate decisions regarding initiation or continuation of post-exposure prophylactic treatment for the ERE provider; and

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.22b
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**Subject:
Bloodborne Pathogen Exposure in Prehospital Emergency Response Employees
Presenting to the ED**

**Effective Date:
August. 31, 2008**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

- ii. The ERE provider's status is either HIV negative or unknown and that if the source patient's status is unknown, the ERE provider has consented to an HIV test; and
- iii. If the ERE provider's test result becomes known as positive prior to the receipt of the source patient's HIV status, no disclosure of the source patient's HIV status will be made to the ERE provider.
- d. Documentation of the request for disclosure of the source patient's HIV status must be documented in the ERE provider's medical record.
- e. If the physician determines that a risk of transmission has occurred or is likely to have occurred in the reasonable exercise of his/her professional judgment, the ED physician may release the HIV status of the source patient if known. In the disclosure process the name of the source patient shall not be provided to the ERE provider. Redislosure of the HIV status of the source is prohibited except when made in conformance with Public Health Law Article 21, Title III.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.23

**Subject:
Visitors**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

The Emergency Department is a medical setting. As such, patient privacy must be maintained. The staff endeavors to allow patients to have visitors, and at the same time, protect the patients' right of confidentiality. The visitor policy is designed to balance visiting and patient privacy.

1. Pediatric patients (under age 18) may have parents or guardians remain with them. Visitors may be asked to leave the room when necessary for patient care or privacy for any patient in the treatment room. Visitors should wait in the main waiting room.
2. Adult patients may have one visitor. Visitors may be asked to leave by the nurse or physician, and should be given an explanation of why they must leave the room and when they may return.
3. All visitors must remain at the bedside of the patient.
4. Children under age 14 are not permitted to visit patients in the Emergency Department. If, however, the child is accompanying a parent or sibling, and there is no other caregiver available, the child should remain with the parent. Efforts should be made by the staff to assist the parent in locating an alternative caregiver when necessary.
5. Visitors are to remain in the main waiting room near triage when not in the ED.
6. In order to provide optimal patient care to all of our patients visitors may be asked to leave all patient care areas in the ED at the request of the attending physician or charge nurse. To assure safe and effective care public safety may be asked to assist in this process.
7. When medically able, patients may go to the waiting room to visit their family.
8. Visitors are not permitted to bring food or drinks into the ED without the permission of the nurse or physician caring for the patient.
9. All ED visitors will be issued a visitor badge that is to be worn at all times while in the ED.

**** Exceptions to this policy may be made, however, exceptions must be approved by the ED attending or the nurse in charge.**

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.24
Page 1 of 2**

**Subject:
Medical Record**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. A medical record will be recorded on every patient who is encountered in the E.D. for evaluation and treatment. This record will become part of the hospital medical record.
2. Every medical record is signed by the attending physician prior to patient discharge.
3. All documentation on the medical record will be in blue or black ink.
4. All entries in the medical record will be signed with full signature, title, charting ID number, date and time.
5. Each page of the medical record is to be clearly labeled with the patient's name, encounter number and medical record number.
6. The medical record from the ED will be a legible, easily understandable reflection of the patient's encounter including: date, time and means of arrival, vital signs, history, chief complaint, examination, care given prior to arrival, clinical impressions, plans, orders, results of treatments, results of tests or procedures, disposition, condition on discharge, discharge plan and patient understanding of discharge instructions.

PROCEDURE:

1. When a patient presents for treatment, the triage officer will complete the triage portion of the Triage and Initial Order page of the ED Encounter and Treatment Form section 1.
2. The examining physician or PA will record the History and Physical on the Health Care Practitioner Note of the Encounter and Treatment form.
3. Physician orders will be initially written on the Triage and Initial order form and then additional orders can be added to the MD/RN progress note of the ED Encounter and Treatment form and signed off by the nurse.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.24
Page 2 of 2**

**Subject:
Medical Record**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

4. Medications administered, intake and output, and vital signs are recorded on the Vital Sign and Medication Sheet of the ED Encounter and Treatment Form.
5. Progress notes and procedure notes are recorded on the MD/RN progress notes of the ED Encounter and Treatment Form.
6. Disposition, condition, diagnosis and patient discharge instructions are documented on the Patient Sheet of the ED Encounter and Treatment Form. The last copy is given to the patient at the time of discharge. At the time of discharge, the instructions are reviewed with the patient or parent and their understanding of the instructions is documented by their signature.
7. The medical record is burst at the time of patient discharge and distributed according to the printed instructions on the bottom of each page.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.39

**Subject:
Patients Pronounced Dead in the Emergency Department**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

If a patient is pronounced dead in the Emergency Department the following steps will occur and be documented in the medical record:

- 1.) Notification of the next of kin by the Emergency Department attending physician or designee.
- 2.) Notification of the Suffolk County Police Department with suspected criminal cases.
- 3.) Notification of the Medical Examiner's (ME) office by the Emergency Department attending physician or designee including date and time of notification, ME case number, and person notified.
- 4.) The New York Organ Donor Network should be notified of any death in the emergency department so that they can determine if patient meets tissue donor criteria, (see Stony Brook University Medical Center Administrative Policy and Procedure Manual #RI:0029).
- 5.) Notify private physician (if known).
- 6.) Log personal property and sign over to the Admitting Department. If the death is potentially criminal, all patient clothing must be placed in a paper bag and turned over to the Medical Examiner's office or the police and documented.
- 7.) If case not accepted by the Medical Examiner and a postmortem is agreed to by the next of kin, then:
 - a.) Emergency Department attending physician must have consent signed.
 - b.) Notify the Admitting Department.
- 8.) Emergency Department attending physician must complete the death certificate (if not an Medical Examiner case or private physician refuses or is unable to be reached).

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.41

**Subject:
Poisonings**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. All ED staff will be familiar with access to the Stony Brook University Medical Center's Information System (UHIS) concerning poisons and antidotes by coding DRUG/DRUG on the hospital computer.
2. All ED staff will be familiar with the regional poison control center in case additional information is required.

New York City Poison Control Center 1-800-222-1222

- 3.) The Emergency Department will work with the Pharmacy as per Stony Brook University Medical Center Administrative Policies and Procedures Manual #PC:0076.
- 4.) The antidote box will be locked and kept in the Critical Care area. After use, or if the lock is broken the box will be set to Pharmacy for restocking.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.42
Page 1 of 2**

**Subject:
Pediatric Immunizations**

**Effective Date:
October, 1995**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. In keeping with Public Health Law (PHL) 2805-h, 4405-a, and 4710-a all patients under the age of 18 seen in the ED and discharged out of the hospital will be evaluated for their immunization status.
2. An immunization status must be documented in the patient chart on the immunization status assessment forms in accordance with the NYS DOH Recommended Immunization Schedule (attached). For patients age 6 and above, this may consist of a statement that the child is in school and has not been informed of any deficiency in immunization status by the school. However, specific or approximate dates of previous tetanus-diphtheria immunization must be recorded in the medical record for patients up to 18 years of age. Unless a medical contraindication is present and recorded in the medical records, a tetanus-diphtheria booster (pediatric dose for patients under age seven, adult dose for patients age seven or above) will be offered before discharge for those without a documented dose within 10 years.
3. Acceptable evidence of immunization history include either a verbal history of immunizations from the patient, parents, or guardian, or written documentation from the patient's medical record. This history must be documented in the patient's chart on the immunization status assessment form by either the treating physician, the treating PA, or the treating NP.
4. Patients 15 months of age or older who have not been previously immunized with Hib should be offered one Hib immunization unless a contraindication is present and recorded in the medical record on the immunization status assessment form.
5. Patients under 15 months of age who have not been appropriately immunized with Hib (as per NYS DOH Recommended Immunization Schedule) should be offered one Hib immunization unless a contraindication is present and recorded in the medical record on the immunization status assessment form. Appropriate referral for addition Hib immunizations should be made as per number 8 below.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 5.42
Page 2 of 2**

**Subject:
Pediatric Immunizations**

**Effective Date:
October, 1995**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

6. Patients under age 6 who do not have appropriate immunization (as per NYS DOH Recommended Immunization Schedule) against measles, mumps, rubella should have an MMR immunization offered unless a contraindication is present and recorded in the medical record on the immunization status assessment form.
7. A record of all immunizations provided must be made in the medical record (date the vaccine was given, manufacturer and lot number of the vaccine, and the name and title of the person administering the vaccine) on the immunization status form and on a certificate (immunization card) to the patient.
8. Patients needing immunization and whose parents refuse immunization or have a temporary medical contraindication to immunization documented in the medical record on the immunization status form must be referred for immunization. Referral consists of providing patients with educational materials on immunization and the phone number of their usual health care provider, if known, or if they cannot name their usual health care provider, the phone number of the pediatric clinic 444-2585 will be given to the patient.
9. Information regarding the benefits and risks of immunizations must be provided to the patient's parent or guardian prior to administration of vaccine. Copies of these benefits and risks are available at the nursing station.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.43

**Subject:
Tetanus Prophylaxis**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The status of tetanus immunization will be recorded on the medical record for any patient presenting to the ED for wound management.
2. Every patient receiving tetanus immunization in the ED should be told verbally and in writing by the nurse.
3. Documenting administration of tetanus is required with tetanus lot number and expiration date.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.44

**Subject:
Rabies Prophylaxis**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Any wild animal bite or animal bite suspicious for possible rabies will be reported to the Bureau of Epidemiology and Disease Control, Suffolk County, Department of Health, by the ED physician or his designee (manual code 5.20).
2. As per NYS Sanitary Code Section 2.14, notification to the local health department must be made prior to starting rabies postexposure prophylaxis, except in those cases where prior notification would compromise the health of the patient.
3. An infectious disease consultation will be requested for all patients with possible rabies exposure.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.45

**Subject:
Major Adult Trauma**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. For major adult trauma (17 and older) the adult trauma response team will be activated by calling the Emergency page operator (321).
2. Criteria for calling an adult code "T" include any of the following:
 - BP < 80 systolic
 - Respiratory rate <8 or >28 or requiring positive pressure ventilation
 - Glasgow Coma Score <9
 - Penetrating injuries proximal to the knee or elbow
 - Spinal cord injury or limb paralysis
 - Amputation, except digitsIn the absence of any of the above, the paramedic, ED attending or ED nurse may use their clinical judgement to call a code "T".
3. The Adult Trauma Response team consists of:
 - Trauma Service General Surgery Residents on-call
 - Anesthesiology Resident on-call
 - Respiratory Therapy on-call
4. The senior Emergency Medicine resident or senior Trauma resident serves as Team Leader for all adult trauma resuscitations under the supervision of the ED attending on-duty and/or the Trauma Service attending.
5. Specialty consultations are requested as needed.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.46

**Subject:
Major Pediatric Trauma**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. For all major pediatric trauma (16 and younger) the pediatric trauma team will be activated by calling the emergency page operator (321).
2. Criteria for calling a pediatric code "T" include any of the following:
 - BP < 70 systolic
 - Respiratory rate <10 or >28 or requiring positive pressure ventilation
 - Pulse <50 or >120
 - Glasgow Coma Score <14
 - Penetrating trauma except limb
 - Spinal cord injury with paralysis
 - Flail chest
 - Pelvic fracture
 - Two or more proximal long bone fractures
 - Amputation, except digits
 - Multi system severe trauma

In the absence of any of the above, the paramedic, ED attending or ED nurse may use their clinical judgement to call a code "T".
3. The Pediatric Trauma Team consists of:
 - Pediatric Surgery Residents on-call
 - Pediatric Residents on-call
 - Anesthesiology Resident on-call
 - Trauma Service General Surgery Residents on-call
 - Respiratory Therapy on-call
4. The Senior Resident, Pediatric Surgery, serves as team leader for all pediatric trauma resuscitations under the supervision of the ED attending on-duty and/or the Pediatric Surgery attending.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.47

Subject:
Adult and Pediatric Medical Resuscitations

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. Resuscitations are performed under the supervision of the attending physician in the ED, unless another service has taken over the responsibility for the patient and that service's attending is present.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.48

Subject:
Documenting Waste of Prehospital EMS Medications

Effective Date:
April, 2011

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. Prehospital EMS agencies may request pursuant to DOH regulations cited below that emergency department nursing staff or other licensed health care providers may witness and record as witnessed controlled medication wasted by EMS
2. If requested emergency department nursing staff should not sign for any controlled medication waste from prehospital EMS agencies.

Note: This policy refers to 10 NYCRR 80.136 which states that “partial doses remaining after the parental administration of a portion of an ampule or unit dose of a controlled substance may be destroyed and properly disposed of provided that; a notation is made on the administration record; and the destruction is witnessed by a second certified emergency medical technical member of the ALS Agency, the agent, or other licensed health care provider.”

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 5.49

**Subject:
Pediatric Medication Administration**

**Effective Date:
March, 2007**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. Drug calculations for each pediatric (less than 12 years old and less than 40 kilograms) medication will be based upon the patient's actual weight to be documented in kilograms.
2. The physician will order medications via CPOE.
3. All injectable medication dosage calculations are to be done by 2 registered nurses, independent of each other.
 - a. Each nurse independently checks the order, calculates the dose, and matches the results for verification.
 - b. If the nurse's results are not identical, the calculation should be redone and a third nurse should be asked to independently check the calculations. If there is still no agreement the physician is to be consulted.
4. After independent double check completed by two RN's, each RN witness the order in the eMAR.
5. All medications are to be administered in accordance with the Medication Administration Procedure ND:VI:01

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 7.01

Subject:
ED Control Register (ED log)

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

1. All patients seeking evaluation and treatment in the ED will be registered in the ED computerized log by the control register (nursing station clerk or registration clerk).
2. The ED computerized log will record the following information on each patient:
 - name
 - age
 - sex
 - date
 - time
 - encounter number
 - triage category (record ambulance name)
 - means of arrival
 - chief complaint
 - discharge diagnosis
 - disposition
 - time of departure
 - ED attending on-duty
3. Dead on arrival patients will be entered in the ED log.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 8.00

**Subject:
Quality Control**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. When authorized a copy of the ED record will be provided to the physician or facility responsible for follow-up care.
2. X-ray results and laboratory test results are available to the ED physician in a timely fashion. These results are available to the physician or facility responsible for follow-up care when authorized.
3. The ED call-back program is responsible for notifying and recalling those patients who may require additional x-rays or those for whom a more definitive x-ray interpretation has been made.
4. The ED call-back program is responsible for notifying and recalling those patients who may require additional or repeat laboratory tests.
5. Patient transfer is conducted according to protocol (manual code 4.09).
6. ED patients who receive blood transfusions are reviewed by the hospital medical board's Blood Utilization Committee.
7. ED medical records are reviewed every 24 hours by the ED follow-up office to check for any unforeseen critical values or results.
8. Surgical specimens removed from patients in the ED are labeled and sent to the Pathology Laboratory.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 8.01
Page 1 of 2**

**Subject:
Follow-Up Program - Call Back**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

A follow-up program shall be in effect to provide information and intervention, when necessary, for clients post Emergency Department encounter and are initiated by the following two sources:

- a. Direct physician referral.
- b. Lab/x-ray/chart review based on abnormal findings received after patient discharge from the Emergency Department.

PROCEDURE:

- a. Direct Physician Referral
 1. The Emergency Department attending will file a follow-up worksheet with the patient's name, medical record number and reason for referral to the Follow-Up Department.
 2. The follow-up office RN will be responsible for initiating patient/family contact in the event of urgent/critical findings post patient discharge.
- b. Lab/X-Ray/Chart Review
 1. All Emergency Department laboratory and x-ray reports are reviewed daily by the Emergency Department attending physician or follow-up nurse.
- c. Follow-up staff will:
 1. Review charts, laboratory/radiology results.
 2. Ascertain that an appropriate party is being reached.
 3. Identification by the follow-up caller of name, institution, department, and purpose of call.
 4. Attempt to determine level of contacts; understanding of medical information; and interpret information in appropriate language.
 5. Determine perceived health status (better, same, worse).
 6. Ascertain further relevant clinical data by interview.
 7. Inform of significant laboratory/radiological data.
 8. Question whether plans for follow-up care were made and assist if needed.

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Emergency Department**

**Manual Code: 8.01
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**Subject:
Follow-Up Program - Call Back**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

9. Based on the client's perceptions, "clinical data" related and chart/lab/x-ray data, a decision is made by the follow-up caller for appropriate follow-up action.
10. Answer questions relating to Emergency visit, review discharge instructions. Clarify, to the level of clinical competence. health care inquires. Assist, when necessary, in obtaining follow-up appointments.
11. Request the patient to state, when possible:
 - a. Reasons to return to Emergency Department.
 - b. Instructions for health care management.
 - c. Telephone numbers of health care referrals.
12. Document on follow-up progress note the disposition of all calls. The progress note becomes part of the permanent medical record.
13. Attempts to notify the patient's private doctor will be made when clinically deemed necessary for the patient's best care or when requested by the patient. (see policy #5.04)

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 8.02

**Subject:
Patient Follow-Up Procedure**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
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**Scheduled Revision:
March, 2013**

POLICY:

The Emergency Department physician may plan a return visit to the Emergency Department for a patient, in certain limited circumstances when the nature of the patient's problem seems self-limited. These include wound checks, suture removal, cast checks, clinical follow-up when no other sources are available.

The following patients may be seen routinely in the Emergency Department for follow-up:

- 1.) Wound checks as clinically indicated.
- 2.) Suture removal (option given to patient).
- 3.) Patients who need rapid follow-up to check the progress of an illness, and have no alternative source of follow-up.
- 4.) Patients whose condition has changed or deteriorated and need to be reassessed in an expeditious manner.

**Stony Brook University Medical Center
Emergency Department**

Manual Code: 8.03

**Subject:
Telephone Advice**

**Effective Date:
October, 1995**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. All telephone medical advice will be given by the attending physician or follow-up RN.
2. Medical advice will not be given by telephone except in the following circumstances:
 - a. The caller is in need of first aid or basic life support information or other necessary activities to stabilize a patient pending immediate transfer to the hospital by the most appropriate means.
 - b. Follow-up advice by a treating attending physician or follow-up nurse to clarify discharge instructions will be provided as requested.
 - c. In all other situations, with the exception of the follow-up program as described in policy 8.01, the patient will be instructed to obtain medical care at the hospital as the earliest appropriate time.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 8.04
Page 1 of 2**

**Subject:
Transportation Vouchers**

**Effective Date:
June, 2007**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

For patients who state that they do not have any transportation home after discharge and no financial means to obtain a taxi, the following procedure will be followed:

1. During the hours that the ED is covered by a social worker on premises, the social worker will be notified and assist the patient in securing transportation.
2. When there is no social worker on premises, the Clinician or Charge RN will assist the patient in arranging transportation home. The assigned AOD/ADN will be responsible for assisting the clinician or charge RN if necessary.
3. If the patient has Medicaid, the Clinician/ Charge RN or Patient needs to call the County Department of Social Services at (631) 854-5801 and state that the patient was seen in the Emergency Department and needs authorization for a Medicaid cab to go home. They will need the patients Medicaid card number for approval. The County will make arrangements for a Medicaid cab to pick the patient up.
4. If the patient does not have Medicaid or any other means of transportation or money to secure a taxi cab, a taxi voucher will be issued by the Clinician/Charge RN.
5. The Clinician or Charge RN will call Lindy's Taxi service at (631) 732-0044 and obtain a voucher price for the cab fare based on the patient's destination. If the voucher fare exceeds One Hundred Dollars, The AOD on duty must be notified and will assess the need for a taxi voucher or explore alternative means of transportation.
6. The transportation authorization form will be completed by the Clinician or Charge RN and include the following information:
 - a, Name of Person(s) to be transported

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Emergency Department**

**Manual Code: 8.04
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**Subject:
Transportation Vouchers**

**Effective Date:
June, 2007**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

- b. Encounter number
- c. Destination
- d. Authorized charge amount (written in words i.e.: five dollars and fifty cents)
- e. Signature of Clinician or Charge RN.

The white copy of the form will be given to the patient to be used as payment for the taxi fare. The yellow copy will be placed in the transportation log book.

- 7. For patients who have frequent visits and need transportation frequently, a referral is to be made to Social Work at (631) 444-2552. Leave a phone message with the patients name, encounter number and concern.
- 8. The Clinician or Charge RN will enter the following information on the "Transportation Log" which will be kept in a binder at the triage desk:
 - a. Date
 - b. Name of patient
 - c. Encounter number
 - d. Destination
 - e. Approved fee.
- 9. On a monthly basis, the ED Nurse Manager will review the transportation log and identify outliers. Findings and costs will be reported to the Associate Director of Nursing for the Emergency Department.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 9.00
Page 1 of 2**

**Subject:
Continuous Quality Improvement (CQI)**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

POLICY:

1. The ED staff is dedicated to providing an effective CQI program in accordance with guidelines established by the hospital medical board's CQI Committee and the Executive Quality Committee of the governing body.
2. The ED CQI program is reviewed at least yearly by the hospital medical board's CQI Committee, the Executive Quality Committee of the governing body and the nursing quality management committee.
3. The ED Director is responsible for the overall CQI program in the ED.
4. The ED Management Group is responsible for assisting the ED Director in effecting the ED CQI program. This group is comprised of: the ED Director, the ED Associate Director, the Assistant to the ED Director, the ED Nurse Manager, the Quality Improvement Coordinator, the EMS Director and the ED Administrator.
5. The EMS Committee of the hospital's medical board (manual code 2.11) is responsible for assisting the ED Director in effecting the ED CQI program.
6. The quality of patient care and the medical records are reviewed every 12 hours by the ED attending going off-duty (manual code 8.00). ED deaths, deaths within 24 hours of admission, complications or errors in management will be recorded by the ED attending at that time. This list will be submitted for review at the ED CQI Conference.
7. The ED CQI Conference will meet once each month and is open to all ED staff. Cases will be presented, reviewed and discussed. A judgment concerning whether or not the standard of care was met will be made and recorded. ED staff will be instructed and counseled as required. This will be recorded. Remedial activities, if suggested, will be recorded and documentation of completion of these activities will be submitted to the ED Director or his designee.

(CONTINUED)

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 9.00
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**Subject:
Continuous Quality Improvement (CQI)**

**Effective Date:
July 1, 1989**

**Reviewed/Revised as of:
March, 2012**

**Scheduled Revision:
March, 2013**

8. The ED Management Group and the EMS Committee will conduct periodic audits and assessments of ED services in order to improve patient care. The results of these studies will be recorded, reviewed, and interpreted. Recommendations and actions will be documented. Follow-up assessment will be conducted and documented to test the effectiveness of the actions in improving patient care.
9. The Emergency Department Clinical Service Group provides an interdisciplinary forum for physicians, nurses, administrators, ancillary and support staff to define and measure performance against key dashboard indicators for quality, service, cost and operations effectiveness and to improve performance. Clinical and operational dashboards and performance improvement initiatives are developed by the clinical service group and presented periodically to the executive quality committee and the nursing quality management committee.
10. Members of the ED Management group and the Clinical service Group will represent the ED on other clinical service groups (ICU, Trauma) or CQI teams to improve the quality of patient care and patient throughput in the ED.

**Stony Brook University Medical Center
Emergency Department**

**Manual Code: 9.01
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Subject:
Identification and Treatment of Domestic Violence

Effective Date:
July 1, 1989

Reviewed/Revised as of:
March, 2012

Scheduled Revision:
March, 2013

POLICY:

It is the policy of Stony Brook University Medical Center to appropriately identify, assess and treat all patients who are victims of domestic violence.

DEFINITIONS: Domestic Violence is the physical or psychological abuse of one family member by another. It ranges from verbal harassment to murder. In the majority of cases, victims' injuries are the result of beating, kicking or choking, often weapons are involved. Most domestic violence in families escalates and does not occur in singular episodes. While it is recognized that the majority of victims of domestic violence will present in the emergency department, many individuals will be seen in other areas of the hospital. Individuals suffering from chronic or degenerative diseases as well as pregnant women are often the victims of domestic violence. Domestic violence encompasses spouse abuse, child abuse, sibling, abuse of elderly family members and abuse of individuals living together.

PROCEDURES:

- 1.) Identification:
 - A.) All hospital staff should report instances of suspected domestic violence to the appropriate physician or nurse who will contact the social worker.
 - B.) The presence of domestic violence should be considered if any of the following situations are present:
 - 1.) Patients who admit to physical abuse.
 - 2.) Patients denying physical abuse but having unexplained bruises, fractures, lacerations, or multiple injuries in various stages of healing. Common sites of injury include: face, head, chest, abdomen and genitals.
 - 3.) Injuries are inconsistent with explanation given by the patient.
 - 4.) Substantial delay between time of and presentation for treatment.
 - 5.) Patient describes in a hesitant, embarrassed, or evasive manner the circumstances surrounding the alleged "accident".

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- 6.) Repeated use of emergency department or other medical unit. Medical history reveals many "accidents" or remarks by nurse or physician indicating that injuries were of suspicious origin.
- 7.) Family member or friend accompanies the patient and insists on staying close to the patient and makes hostile or threatening statements to the patient, appears to be under the influence of alcohol or drugs, or otherwise exhibits suspicious behavior.
- 8.) Patients that present with vague medical complaints, i.e., hyperventilation syndromes, vague pain syndromes or with serious psychosocial problems, i.e., suicidal or homicidal ideation or depression.
- 9.) Any patient referred to the Emergency Department by EMS personnel transported to the hospital by ambulance.

2.) Referral to Social Work Services:

- A.) When it is believed that a patient being treated by Stony Brook University Medical Center is the victim of domestic violence a social worker should be called immediately. During regular working hours, the social worker assigned to the unit where the patient is should be called. During other than normal working hours, the on-call social worker should be called through the ADN.
- B.) The Department of Social Work Services will coordinate the services provided to victims of domestic violence.
- C.) The social worker will provide assessment, counseling, review the available options with the patient and make referrals when appropriate. They will also follow-up with patients following discharge.
- D.) It is required that the patient be offered the services of an ERC (Emergency Room Companion). The ERC can be contacted Monday-Thursday from 9am-9pm and on Friday from 9am-5pm at 631-360-3606. During all other times they may be contacted via pager at 631-556-1044.

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3.) INTERVIEWS:

All hospital personnel including physicians, nurses and social workers are expected to convey an attitude of concern, interest and confidentiality to the patient. Whenever possible, the number of interviews should be limited and involve the social worker.

- A.) Patients should be interviewed alone in a private setting.
- B.) Accompanying family members or friends should be asked to leave the examination area.
- C.) All interviews must be documented in the medical record.

4.) EVIDENCE:

- A.) The treating physician should offer to take color photographs of the patient's injuries. It should be explained to patients that nothing will be done with the photographs without their specific permission.
- B.) All torn or blood stained clothing and/or weapons used should be placed in a sealed envelope or bag. The patient's name and the name of the individual putting it in the bag should be clearly written on the outside.
- C.) When notified, University Police will pick up the evidence, leave a voucher, and will secure the investigatory evidence on main campus as per University Police procedures.

5.) EDUCATION:

The Emergency Department will provide regular education for its staff in the identification and treatment of domestic violence victims.

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POLICY:

1. In compliance with New York State Public Health Law SBUMC has initiated this policy as part of the overall plan to address the needs of female sexual assault victims who are of reproductive years.
2. Any female patient who is the victim of sexual assault and is of reproductive years will be given the NYS DOH brochure "Emergency Contraception for Rape Survivors".
3. Hospital staff (or specialized SANE personnel) will inform the patient of the availability of emergency contraception as well as its use and effectiveness
4. Hospital staff (or specialized SANE personnel) will discuss all treatment options to a sexual assault survivor.
5. Hospital staff (or specialized SANE personnel) will provide emergency contraception (emergency contraception must be provided-a prescription for emergency contraception is not an acceptable alternative) to the sexual assault victim upon her request, unless the victim has a pre-existing pregnancy.

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**STATE OF NEW YORK DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299
Antonia C. Novello, M.D., M.P.H., Dr.P.H. Dennis P. Whalen
Commissioner Executive Deputy Commissioner**

April 7, 2007

Dear Chief Executive Officer:

This letter is written to clarify the Department's expectations with respect to the provision of Emergency Contraception (EC) to the victims of sexual assault in accordance with §2805-P of the Public Health Law. New York State hospitals are mandated by law to include the following actions as part of their overall plan to address the needs of female sexual assault victims who are of reproductive age:

- The Department's brochure "Emergency Contraception for Rape Survivors" or a Department approved substitute must be given to all victims of sexual assault. This brochure contains information regarding the availability of emergency contraception, its efficacy and use, side effects, and post administration follow up.
- Hospital staff must inform the patient of the availability of emergency contraception, its use and effectiveness. While the "Emergency Contraception for Rape Survivors" brochure contains some of this information, it is not intended to replace the thoughtful explanation of treatment options to a sexual assault survivor.
- The hospital must offer emergency contraception and provide it to the sexual assault victim upon her request, unless the victim has a pre-existing pregnancy.

To further clarify requirements and expectations, the Department has attached to this letter a Question and Answer document, a copy of the law, a Department of Health Publications catalog, and the "Emergency Contraception for Rape Survivors" brochure. This brochure has been translated into Spanish, Creole, Hindi, Chinese, Korean, Arabic and Russian.

It is the Department's expectation that all New York State hospitals are, and will remain, in full compliance with the law requiring the provision of emergency contraception. The Department stands ready to investigate any allegation of non-compliance, which could result in citation, enforcement, and delays in the Certificate of Need review process.

Should you have any questions regarding the provision of emergency contraception, you may call the Bureau of Hospital and Primary Care Services at (518) 402-1003.

Sincerely,
Martin J. Conroy
Director
Bureau of Hospital & Primary Care Services

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**New York State Department of Health
Emergency Contraception
Question and Answer Document**

Q: What is Emergency Contraception (EC)?

A: Emergency contraception is simply a higher dose of the same hormones used in common birth control pills. It is most effective if it is taken within 12 hours of the rape. But, it can still work if it is used within three days (72 hours) after the rape, and can even be taken up to five days (120 hours) after the rape. The longer you wait, however, the less likely it is that emergency contraception will keep you from getting pregnant.

Q: What are the medical contraindications of emergency contraception?

A: Of the millions of women worldwide who have taken EC, there have been no serious contraindications noted that would endanger a woman's health.

Q: If EC were administered to a woman who is found to be pregnant, would EC affect the pregnancy?

A: No. EC would have no effect on an existing pregnancy. Hospitals are not required to offer EC to a woman who has a pre-existing pregnancy.

Q: Are allergies to EC common?

A: No. Allergies to EC would be considered extremely rare.

Q: Is a sexual assault exam a prerequisite to obtaining EC?

A: No. A sexual assault victim need not have a sexual assault exam prior to obtaining EC.

Q. Can I require patients to report the sexual assault to police as a condition of receiving EC?

A. No. Hospitals may not put any conditions on receipt of EC or pressure victims to report the assault to police.

Q. Some physicians do not wish to offer EC, or would like the provision of EC left to their discretion. Is that acceptable?

A. Provision of EC to rape victims is mandated by law and is the standard of care for victims of sexual assault. Non compliance with the law can leave a hospital vulnerable to legal liability and citation/enforcement by the Department of Health.

Q. Is it acceptable to offer a prescription for EC, instead of providing EC?

A. It is not acceptable to offer a prescription for EC for several reasons. Timeliness of receipt is a significant factor in effectiveness, and any delay introduced by having EC unavailable will increase the likelihood that pregnancy will result. Also, it is unacceptable to require sexual assault victims to undertake a search for an open pharmacy in their traumatized condition. Further, the law mandates that EC be offered to the woman, not that a prescription for EC is offered.

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Q. We haven't been instructing all of our support staff about how to respond to EC questions. Should we do so?

A. All individuals who might be points of first contact for patients should be uniformly aware of not only the law, but also, their facility's protocol for dealing with sexual assault patients. This includes people answering the phones, both for the hospital as a whole and for the ED, the triage staff, the clerks, and other potential points of contact. Staff should also be educated about the difference between EC (preventing a pregnancy) and medications that cause abortions, since they are so often confused.

Q: Providing copies of the Department's brochure, "Emergency Contraception for Rape Survivors" to sexual assault survivors is mandated by law. Where can I obtain copies of the brochure?

A: The brochure can be downloaded and reproduced directly from the Department's website at the following link: http://www.health.state.ny.us/nysdoh/consumer/women/emergency_contr.htm. It is available in eight languages including English, Spanish, Chinese, Korean, Creole, Hindi, Arabic, and Russian. Alternatively, the brochures can be ordered in bulk from the Department. Both the publication's catalog and order form can be accessed on the Department's website at the following link: http://www.health.state.ny.us/nysdoh/publication_catalog/index.htm.

§ 2805-p. Emergency treatment of rape survivors.

1. As used in this section:

- a) "Emergency contraception" shall mean one or more prescription drugs used separately or in combination to be administered or self-administered by a patient to prevent pregnancy within a medically recommended amount of time after sexual intercourse and dispensed for that purpose in accordance with professional standards of practice and determined by the United States Food and Drug Administration to be safe.
- b) "Emergency treatment" shall mean any medical examination or treatment provided by a hospital to a rape survivor following an alleged rape.
- c) "Rape" shall mean any act defined in section 130.25, 130.30 or 130.35 of the penal law.
- d) "Rape survivor" or "survivor" shall mean any female person who alleges or is alleged to have been raped and who presents as a patient.

2. Every hospital providing emergency treatment to a rape survivor shall promptly:

- a) provide such survivor with written information prepared or approved, pursuant to subdivision three of this section, relating to emergency contraception;
- b) orally inform such survivor of the availability of emergency contraception, its use and efficacy; and
- c) provide emergency contraception to such survivor, unless contraindicated, upon her request. No hospital may be required to provide emergency contraception to a rape survivor who is pregnant.

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3. The commissioner shall develop, prepare and produce informational materials relating to emergency contraception for distribution to and use in all hospitals in the state, in quantities sufficient to comply with the requirements of this section. The commissioner may also approve informational materials from medically recognized sources for the purposes of this section. Such informational material shall be in clear and concise language, readily comprehensible, in such varieties and forms as the commissioner shall deem necessary to inform survivors in English and languages other than English. Such materials shall explain the nature of emergency contraception including its use and efficacy.
4. The commissioner shall promulgate all such rules and regulations as may be necessary and proper to implement the provisions of this section.

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IMMUNIZATION STATUS ASSESSMENT FORM

A. Ages Under 6 Years of Age:

1. Please indicate the dates of the following immunizations:

| | Approximate Date |
|-----------------------------------|------------------|
| Measles/Mumps/Rubella (MMR) | _____ |
| Diphtheria/Tetanus/Pertusis (DPT) | _____ |
| Haemophilus Influenza-B (Hib) | _____ |

B. Ages 6 Years to Less Than 18 Years of Age:

1. Have you ever been informed of any deficiency in immunization by your child's school?

YES NO

If Yes, list deficiencies: _____

2. Date of last DT or DPT: _____ Unknown
-

C. Consent/Refusal

As advised by the Department of Health, do you desire Stony Brook University Medical Center at Stony Brook to administer the appropriate immunizations? I acknowledge that I understand the benefits and risks of these immunizations and have received discharge instructions.

- YES I do desire the hospital to administer the necessary immunizations.
 NO I do not want the hospital to administer the necessary immunizations and my reason for refusal is: _____

Signature: _____ Print Name: _____

Date: _____ Relationship to Patient: _____

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If, based upon the immunization history of the patient a immunization is **indicated but a medical contraindication exists**, document the contraindication below:

Medical Provider Signature and #: _____

| Vaccine | Mfg. & Lot# | Date Given | Pt. Age | Inj. Site | Provider Signature/Title |
|-------------|-------------|------------|---------|-----------|--------------------------|
| MMR #1 | | | | | |
| MMR #2 | | | | | |
| Hib #1 type | | | | | |
| Hib #2 type | | | | | |
| Hib #3 type | | | | | |
| Hib #4 type | | | | | |
| DT | | | | | |

Patients needing additional immunizations **or** those patients whose parents refuse immunization **or** those patients who have a temporary medical contraindication to immunization must be referred for immunization. Referral consists of providing patients with educational materials on immunization and the phone number of their usual health care provider, if known, or if they cannot name their usual health care provider, the phone number of the pediatric clinic 444-4660 will be given to the patient.

Form Completed by(Signature & #)_____