POLICY:	**Nurse Managed Care in the Emergency Department**
Program Area:	**Critical Care (ER, Observation, SCU)**
Section:	**General**
Reference Number:	**CLI.5110.PL.002**
Approved by:	**Regional Lead – Acute Care & Chief Nursing Officer**
Date:	Issued 2024/Sept/23 Revised

Patients and Families were engaged in the development of this policy.

PURPOSE:

The purpose of this policy is to support nursing assessment, interventions, and guide decision-making for nurse managed care in the Emergency Department (ED).

BOARD POLICY REFERENCE:

Executive Limitation (EL-02) Treatment of Clients
Executive Limitation (EL-01) Global Executive Restraint and Risk Management

POLICY:

Southern Health-Santé Sud (SH-SS) is committed to client safety and well-being across the continuum of care. Nurse managed care is a model for providing safe and efficient patient care in the ED using the tools and processes included in this policy.

Patients may present to facilities without an open emergency department (ED) in Southern Health-Santé Sud (SH-SS) seeking assessment and/or treatment for health concerns. This may occur in acute care facilities experiencing a temporary change in service, Transitional Care Unit (TCU) facilities or Personal Care Home (PCH) facilities. Nurses working in SH-SS health facilities have a duty to provide care to patients presenting to facilities without an open ED. According to the College of Licensed Practical Nurses of Manitoba (CLPNM), College of Registered Nurses of Manitoba (CRNM), and College of Registered Psychiatric Nurses of Manitoba (CRPNM) in the Duty to Provide Care practice direction document:

> If an individual presents to a nurse's place of work seeking emergency care that is beyond the service level provided in that practice setting, the nurse is expected to apply employer policies, use critical thinking, and act as any reasonable and prudent nurse would in the situation.

Nursing scope of practice is formally directed by professional regulations and legislation. While operating within regulations/legislation, each individual nurse is responsible to determine their own safe professional scope of practice based on their education, certifications, knowledge and experience. It's recognized that SH-SS nurses working in different programs (acute care, TCU, PCH) have different certification requirements and different knowledge and experience.

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SH-SS nurses are able to work to their full scope of practice for the position they are hired, following the essential functions and basic duties contained in SH-SS position descriptions (i.e. a Nurse Practitioner (NP) working a Registered Nurse shift in ED is able to work to full NP scope of practice).

Acute care facilities, may not have an open emergency department due to:

- A temporary Suspension of ED services; or
- Specifically defined hours of open ED operation that are less than 24 hours per 7 days a week.

Suspension of ED services are usually unplanned and do not afford consistent opportunity for broad and robust public notifications. This is considered an unusual circumstance. As per ORG.1010.PL.001 Suspension of Services policy, public notice is posted at the ED's entrance doors at the affected site.

Acute care facilities with an open emergency department may consider implementing nurse managed care for clinical situations including:

- When an ED is in a Safety Risk Level 3 or 4 overcapacity alert situation as defined in *Capacity Management Protocol* (CLI.4110.PL.XXX) – *under development*; or
- As an option for patients when an ED is experiencing greater than four (4) hours wait times; or
- To assist with ED staffing shortages; or
- To facilitate efficient patient flow in the ED.

DEFINITIONS:

Abandonment - for the purposes of this policy, when a nurse discontinues care after receiving a client assignment without:

- Arranging for suitable alternative or replacement services; or
- Allowing the employer a reasonable opportunity to provide for alternative or replacement services.

Canadian Triage and Acuity Scale (CTAS) - a five-level triage scale that enables hospitals to classify patients according to the type and severity of their presenting signs and symptoms.

- Level I – Resuscitation
- Level II – Emergent
- Level III – Urgent
- Level IV – Less Urgent (Semi-Urgent)
- Level V – Non-Urgent

Duty to Provide Care - a nurse's professional and ethical responsibility to provide safe and competent nursing care to a patient, for the time-period that the nurse is assigned to provide service.

Nurse Managed Care in the Emergency Department - provision of health care services informed by the nursing process. Assessments include triaging and identifying the patient's acuity level based on the Canadian Triage and Acuity Scale (CTAS). Nursing interventions are based on applicable scope of nursing legislation and regulation, within each nurse's knowledge and skills/competencies.

Patient - for the purposes of this policy, patient refers to any individual(s) presenting to a SH-SS facility seeking assessment and/or treatment for health concern(s).

Scope of Practice - the range of activities that nurses are both educated and legally authorized to perform.

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Suspension of Services - a temporary change in service that may vary in duration. It mayoccur as a result of staff shortages and/or any unexpected temporary change in service wherea service or program is unable to meet required standards of practice in safe delivery of careto the patient for a defined period oftime.

IMPORTANT POINTS TO CONSIDER:

The Regulated Health Professions Act of Manitoba (RHPA) provides an exemption to reserved acts in section 5(3) when rendering first aid or temporary assistance in an emergency (i.e. the administration of EPINEPHrine when anaphylaxis is suspected).

Under the Regulated Health Professions Act (RHPA), Registered Nurses (RNs) are authorized to perform Reserved Act 2: Order or receive screening or diagnostic tests; and Reserved Act 10a-b: Ordering x-rays. Licensed Practical Nurses (LPNs) have not yet transitioned to the RHPA and are not yet authorized to perform these reserved acts.

PROCEDURE:

Nurse Managed Care in an Acute Care Facility Without an Open ED

1. Register and triage the patient as per CLI.5110.PL.005 Triage and Waiting Room Monitoring policy.
   Suggested script for staff: "You may not have seen the posted notification thatED services are temporarily unavailable. If you wish, there are nurses here that can see you, provide nursing care and give you further direction.
   If short staffed, recommend that staff also state "We are currently short-staffed and there may be a wait for you to receive nursing care".
2. Patients Triaged CTAS Level 1 and 2 (many of the following actions should be occurring **simultaneously** ifpossible):
   2.1. Implement nursing interventions within individual scope of practice, experienceand skill set using Emergency Department Adult Clinical Decision Tool (CLI.5110.PL.002.FORM.01) or Emergency Department Pediatric Clinical Decision Tool (CLI.5110.PL.002.FORM.02) to provide treatment. 2.2. Access help:
   - ➢ If a physician is on site but not in the ED, call a Code Blue (CLI.4510.PL.002) or Code 25 (CLI.4510.PL.003).
   - ➢ In the event that a physician is on site but not on duty or on-call for the ED, that physician has a legal duty to provide assistance to the patient when asked to do so by nursing staff.
   - ➢ Call 911 to initiate immediate patient transfer to the closest alternate ED.
3. Patients Triaged CTAS Level 3:
   3.1. Implement nursing interventions within individual scope of practice, experienceand skill set using Emergency Department Adult Clinical Decision Tool (CLI.5110.PL.002.FORM.01) or Emergency Department Pediatric Clinical Decision Tool (CLI.5110.PL.002.FORM.02) to provide treatment. 3.2. Advise patient that immediate medical assessment by physician is recommended.
   - ➢ Instruct the patient to seek further medical assessment by physician at nearest ED. Inform the patient that the receiving ED will be contacted and their medical information will be forwarded.
   - ➢ Provide patient or caregiver with written instructions to seek a medical assessment at the nearest ED.
     - o Contact nearest ED, forward medical information and provide verbal report.

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Suggested Script for the nurse: "I have assessed and treated you. According to SH-SS guidelines, you need to see a physician at the nearest ED. I will let the ED know you are coming and send them the information from this visit.

3.3. Assess and recommend the mode of transportation (personal vehicle or Emergency Response Services) that best meets the patient's level of acuity and functionality.
   - ➢ If Emergency Response Services (ERS) is medically necessary and is the recommended option, call 911 to initiate immediate patient transfer to the closest alternate ED.
   - ➢ If transfer by ambulance is not medically necessary and a personal vehicle is the recommended mode of transportation, provide the patient/designate with the name, address and directions to the nearest ED.

4. Patients Triaged CTAS Level 4 and 5:

4.1. Implement nursing interventions within individual scope of practice, experience and skill set using Emergency Department Adult Clinical Decision Tool (CLI.5110.PL.002.FORM.01) or Emergency Department Pediatric Clinical Decision Tool (CLI.5110.PL.002.FORM.02) to provide treatment. 4.2. Advise patient if immediate medical assessment by physician is recommended or not. ➢ No need for immediate medical assessment by physician.
   - o Advise patient and provide written instructions
     - Explain options of where to seek further medical assessment if they choose (i.e. walk-in clinic, quick care clinic, nearest ED) and,
     - To present to an alternate ED if their condition changes or worsens. Provide the patient/designate with the name, address and directions to the alternate ED.

Suggested Script: "I've assessed and treated you. According to Southern Health-Santé Sud's guidelines, you don't need to see a physician at this time. I'll give you written instructions to follow up with your regular doctor. If you wish, you can visit a walk-in clinic, quick care clinic, or the nearest emergency department for a medical assessment."

- ➢ Immediate medical follow up by physician recommended.
  - o Instruct the patient to seek further medical assessment by physician at nearest ED. Inform the patient that the receiving ED will be contacted and their medical information forwarded.
  - o Provide patient or caregiver with written instructions to seek a medical assessment at the nearest ED.
  - o Contact nearest ED, forward medical information and provide verbal report.

Suggested Script for the nurse: "I have assessed and treated you. According to Southern Health-Santé Sud's guidelines, you need to see a physician at the nearest ED. I will let the ED know you are coming and send them the information from this visit.

4.3. Assess and recommend the mode of transportation (personal vehicle or ERS) that best meets the patient's level of acuity and functionality.
   - ➢ If ERS is medically necessary and is the recommended option, call 911 to initiate immediate patient transfer to the closest alternate ED
   - ➢ If transfer by ambulance is not medically necessary and a personal vehicle is the recommended mode of transportation, provide the patient/designate with the name, address and directions to the nearest ED.

5. Patient Right to Refuse

5.1. All patients presenting to an ED that is not open require registration, triage and nursing assessment as per CLI.5110.PL.005 Triage and Waiting Room Monitoring.

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Suggested script for staff: "You may not have seen the posted notification that ED services are temporarily unavailable. If you wish, there are nurses here that can see you, provide nursing care and give you further direction.

5.2. If the patient refuses to seek further medical attention and/or refuses recommended ERS transportation and leaves the facility:

- When a patient leaves the ED prior to completing the registration process, where minimal patient information has been obtained to identify the individual, document assessment findings, any interventions and details related to the patient leaving on a *Safety Event Report* (ORG.1810.PL.001.FORM.01). Be very descriptive when completing the Safety Event Report. For example: "White female, approximately 50 years of age, presented to ED at (time) with complaints of abdominal pain and left the ED prior to being assessed by a nurse. Client left the building walking."
  - This documentation serves to record a patient having presented to ED and then leaving prior to registration.
- When a patient leaves the ED following completion of the registration process but prior to discharge, document assessments, any interventions and details related to the patient leaving on the Triage and Emergency Department Record (CLI.5110.PL.005.FORM.01) or in the discharge summary in EDIS.
  - Clearly describe the patient's condition upon discharge and all discharge instructions provided.
  - This documentation serves to record a patient having presented to the ED and then leaving prior to discharge.
  - If a risk of serious harm is identified, follow *Personal Health Information Disclosure Due to Risk of Serious Harm* (CLI.4110.PL.016) policy.

6. Documentation:

6.1. Document all assessments and interventions on applicable forms.

6.2. Document discharge instructions on the *Discharge Instructions Record: Emergency Department* (CLI.5110.PR.012.FORM.01) and retain copy in patient health record.

7. Evaluation:

7.1. Managers review the Safety Event Reports.

7.2. Identify any trends and risks and opportunities for improvement, educate staff accordingly and consult the Acute Care leadership as required.

<u>Nurse Managed Care in an Acute Care Facility With an Open ED</u>

1. Register and triage the patient as per CLI.5110.PL.005 Triage and Waiting Room Monitoring.
2. Patients Triaged CTAS Level 4 and 5 are to implement nursing interventions within individual scope of practice, experience and skill set using Emergency Department Adult Clinical Decision Tool (CLI.5110.PL.002.FORM.01) or Emergency Department Pediatric Clinical Decision Tool (CLI.5110.PL.002.FORM.02) to provide treatment.
3. Patient Right to Refuse-Follow direction in section 5.2 above.
4. Documentation:

4.1. Document all assessments and interventions on applicable forms.

4.2. Document discharge instructions on the Discharge Instructions Record: Emergency Department (CLI.5110.PR.012.FORM.01) and retain copy in patient health record.

5. Evaluation:

5.1. Managers review the Safety Event Reports.

5.2. Identify any trends and risks and opportunities for improvement, educate staff accordingly and consult

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Nurse Managed Care in a Transitional Care Unit (TCU) and Personal Care Home (PCH)

See *Nursing Care of Unscheduled Patients Who Present to TCU or PCH* (CLI.6410.PL.035) policy – *under development.*

SUPPORTING DOCUMENTS:

CLI.5110.PL.002.FORM.01	Emergency Department Adult Clinical Decision Tool
CLI.5110.PL.002.FORM.02	Emergency Department Pediatric Clinical Decision Tool
CLI.5110.PL.002.SD.01	Accessing Health Care Services Emergency Department Poster

REFERENCES:

CLI.4110.PL.007	Information Transfer at Care Transitions – Interfacility Transfers
CLI.4110.PL.007.FORM.01	Manitoba Information Transfer Referral Form
CLI.4110.PL.016	Personal Health Information Disclosure Due to Risk of Serious Harm
CLI.4510.PL.002	Code Blue
CLI.4510.PL.003	Code 25
CLI.5110.PL.005	Triage and Waiting Room Monitoring
CLI.5110.PL.005.FORM.01	Triage and Emergency Department Record
CLI.5110.PR.012	Discharge Instructions: Emergency Department
CLI.5110.PR.012.FORM.01	Discharge Instructions Record: Emergency Department
CLI.5310.PR.004	Interfacility Transfers
CLI.5310.PR.004.FORM.01	Interfacility Transport Checklist
ORG.1010.PL.001	Suspension of Services
ORG.1810.PL.001.FORM.01	Safety Event Report
CLI.4110.PR.002	Anaphylaxis Management Post Immunization in Community
CLI.6410.PL.035 – *in development*	Nursing Care of Unscheduled Patients Who Present to Transitional Care Unit and Personal Care Home
CLI.4110.PL.XXX – *in development*	Capacity Management Protocol

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