Abdominal pain

OBSERVATION - if the cause is unknown, labs/vitals are stable and additional work up is needed to determine ongoing symptoms

ACUTE INPATIENT:

Clinical Findings - MUST have ONE:

- diverticulitis on imaging-
- mental status changes
- temp> 38 and wbc 15
- vomiting protracted – continuing at time of admission (must be documented)

Clinical Interventions - BOTH:

1. npo
2. ivf @ **125ml/hr (please note rate)**
3. If diverticulitis start abx

Adult Asthma

OBSERVATION if patient has had a positive response to ER tx and is expected to be ready for dc/ w/in 24 hrs

Clinical Findings - Must have ONE:

- PEF 40-69%
- 0xygen sats 89-90% or less
- Persistent wheezing (Must document)

Acute INPATIENT:

Clinical Findings - Must have ONE:

- PEF 26-39%
- 0xygen sats less than 89% **MUST BE DOCUMENTED**
- Persistent wheezing (Must document) following op treatment including the emergency department

OR

- history of sudden severe exacerbation/critical care admission

Clinical Interventions - ALL 4 MUST be ordered

1. short term beta agonist
2. corticosteroids – including oral
3. oxygen to maintain sat > **or equal to 91 % or baseline**
4. pulse oximetry

Chest Pain

OBSERVATION: clinical risk factors/suspect ACS – tele, serial labs and imaging ordered

Clinical Findings: **Must have ALL FOUR**

1. initial troponin negative
2. EKG negative for ischemia or unchanged from baseline
3. SBP>90
4. pain resolved

Clinical Interventions: Must have all ordered:

1. asa
2. continuous cardiac monitoring

If not ordered **MUST** be documented why contraindicated

Acute INPATIENT: clinical evidence of STEMI/NSTEMI/Unstable Angina

STEMI: confirmed by ECG

NSTEMI:

Clinical Findings – MUST have BOTH :

1. Positive troponin
2. Pain or resolving pain

Unstable Angina- Must have ONE and be clearly documented:

Clinical Findings:

- pain at rest
- new onset chest pain
- increased in duration/crescendo pain

AND

evidence of NEW EKG changes (or paced rhythm) (MUST be documented)- ONE:

- st depressions
- t wave inversions (t wave flattening does not apply)
- paced rhythm

Clinical Interventions for STEMI, Nstemi and Unstable Angina : Must have all ordered:

1. thrombolytic therapy if indicated
2. beta blocker or ca channel blocker
3. asa
4. antiplatelet includes po
5. anticoagulation
6. continuous cardiac monitoring

If not ordered **MUST** be documented why contraindicated

Cellulitis –

OBSERVATION if expect to discharge
after 24hrs of IV antibiotic therapy with transition to po

ACUTE INPATIENT:
Clinical Findings – Must have ONE:

- animal/human hand/face bite
- progression despite 24 hrs outpatient abx clearly documented
- purpura/petechiae
- skin involvement of at least 50 % limb

Clinical Interventions – Must have BOTH:

1. iv antibiotics
2. and blood cultures **(PLEASE ORDER BC's)**

Congestive Heart Failure

Note that BNP's are not included in below criteria

OBSERVATION: - good ER response to interventions and expect dc w/in 24 hrs

Clinical Findings: ALL

- dyspnea
- oxygen sat < or equal to 91% on ra or with chronic baseline oxygen **O2 ROOM AIR MUST BE DOCUMENTED**
- hemodynamic stability

Clinical Interventions:
beta blocker **AND** ACE or ARB unless contraindicated and **MUST** document

Acute INPATIENT:

Clinical Indicators - Must have ONE:

- oxygen < or equal to **89%** on room air or on their chronic baseline **O2 ROOM AIR SAT MUST BE DOCUMENTED**
- sustained hr 100-120

Clinical Interventions- Must have ONE:

- oxygen requirements of at least 4 liters
- IV diuretics
- beta blocker po unless contraindicated
- ace inhibitor po unless contraindicated

COPD Exacerbation:

OBSERVATION- Clinically has had impressive response to ER treatment and is expected to turn around and discharge w/in the next 24 hrs

Clinical Findings - Must have ONE:

- dyspnea
- oxygen sat ra >90% or at baseline **MUST DOCUMENT ROOM AIR SATS**
- positive response to ER treatment
-

Clinical Interventions - Must have ONE ordered**:**

- bronchodilators
- corticosteroids
- vital signs with pulse oximetry q4h

ACUTE INPATIENT:

Clinical Findings – Must have ONE:

- dyspnea AND (must have one of the following findings)
- oxygen sat < or equal to 89% **MUST DOCUMENT ROOM AIR SATS**
- arterial pco2 45-54 mmhg AND arterial ph 7.31-7.35(on room air unless chronic oxygen)
- continued deterioration despite documented outpatient treatment including ER >3hrs
- stridor
- unresponsive to >2 days of outpatient corticosteroids/diuretics

Clinical Interventions – BOTH ordered**:**

1. bronchodilators > or equal to **6x/24 hrs (q4 hrs)**
2. corticosteroids (oral or IV)

DVT /PE

DVT

Typically, these patients can be discharged from the ED if the ability to afford the medication (insurance coverage) and education about LMWH can be taught. If unable to afford Care Management would assist, if education barrier is the primary issue the patient is most appropriate for observation for additional RN education about LMWH administration. This status is NOT appropriate for a patient who is high risk.

OBSERVATION:

Clinical findings:

- **evidence of dvt on imaging**

Clinical Interventions - MUST HAVE ONE:

- **LMWH (sq)**
- **unfractionated heparin (sq/iv)**

Must initiate Coumadin on DAY ONE

If your patient is high risk examples: recurrent dvts's, history of pe, and hypercoagulability disorders. Please document why and make the patient inpatient.

PE

Always most appropriate for the INPATIENT setting

ACUTE INPATIENT:
Clinical Findings:

- **evidence of PE on imaging**

Clinical Interventions: start either UFH sq/iv or LMWH

1. **UFH- iv - loading dose, continuous dose and scheduled PTT to follow for therapeutic range**
2. **LMWH (sq)**

GI Bleed – Upper and Lower

If bleeding is controlled, vitals and labs stable, and
plan is for diagnostic colonoscopy/endoscopy- it is **OBSERVATION**

OBSERVATION:

Clinical Findings: **ALL:**

2. bleeding controlled
3. stable h/h
4. serial labs
5. prep colonoscopy/endoscopy

Clinical Interventions: **Must have ONE** ordered**:**

- ivf @125 hr unless contraindicated
- vital signs q4
- serial labs

Acute INPATIENT :

Clinical Findings – Evidence of active bleeding (upper bleed- hematemesis and lower bleed-melena) documented **and MUST have one of the following:**

- hct <25 % and a hgb <8.3
- heart rate >100
- sbp drop 30% or syncope
- inr > 2

Clinical Interventions - MUST have ONE ordered**:**

- blood products
- IVF @ 125ml /hr unless contraindicated
- NPO

Ileus/Small Bowel Obstruction

– OBSERVATION is NOT appropriate

ACUTE INPATIENT:

Clinical Findings:

- imaging confirmed ileus/obstruction

Clinical Interventions: Must have BOTH:

1. npo
2. ivf @**125ml/hr (please note rate) if rate not clinically appropriate please document contraindication.**

Pneumonia:

Observation is appropriate for the patient with a single lobe infiltrate, otherwise healthy, vitals within normal limits that there is limited concern for deterioration due to co-morbidities (examples: copd and asthma). If not discharged to home these patients are expected to be discharged within 24 hrs.

Acute INPATIENT:

Clinical Findings:

Confirmed by imaging - **AND ONE of the following**:

- oxygen saturations < or equal to 89% **MUST DOCUMENT RA SATS**
- involving at least 2 lobes on CXR
- wbc >12 with a shift

ALSO: MUST have 2 of the below risk factors documented:

- continued deterioration despite at least **2 days** of outpatient treatment
- acute mental status changes
- bun >19.5
- age >65
- resp rate >30 and sustained

Clinical Interventions - MUST order ALL below

1. anti infective(includes oral)
2. blood cultures
3. dvt prophylaxis
4. pulse oximetry with vital signs q4h

Pancreatitis

OBSERVATION is not typically appropriate for these patients as they will usually not dc w/in 24 hrs or less

ACUTE INPATIENT:

Clinical Findings - Must have TWO:

- abdominal pain
- amylase/lipase 3 x upper limit normal
- pancreatitis on imaging

Clinical Interventions- Must have BOTH:

1. npo
2. ivf@ **125ml/hr**- if contraindicated, must document why reduced rate

Pre-Syncope/Syncope

Observation: most appropriate with telemetry ordered UNLESS active CAD requiring acute intervention.

Inpatient – Syncope along with an ACTIVE CAD process requiring tele and acute interventions during this hospital admission

Examples:
CHF- requiring IV lasix
Arrhythmias- requiring IV intervention
Unstable angina requiring IV intervention
Other severe co-morbidities requiring acute intervention

TIA/STROKE

TIA

Observation is ALWAYS most appropriate for patients

Clinical Findings:

- **Symptoms resolved or resolving and an ABCD score <3**

ABCD scores are predictors in the risk of stroke following a TIA score range 0-7
> 3 is high risk and urgent diagnostics are recommended.

Age:	Blood Pressure:
1pt -greater than 60	1pt sbp>140 or dbp >90

Clinical features of TIA:
2 pts unilateral weakness with or without speech impairment
1 pt speech impairment without weakness

Duration
2 pts tia >60 mins
1pt tia 10-59 mins
1pt diabetes

Must have BOTH:

1. **outpatient work up unavailable in 48 hrs**
2. **neuro deficit resolved**

Clinical Interventions:- Must have BOTH:

1. **q4h neuro assessment**
2. **asa, antiplatelet or anticoagulation scheduled**

Please include ABCD score in your documentation

Stroke

Acute Inpatient: Always most appropriate

STROKE - Always Inpatient (if thombolysis contraindicated must be documented)

Clinical Findings - evidenced on imaging with ONE:

- **ischemia,**
- **hemorrhage**
- **thrombosis**

Must have ONE of the ongoing neuro deficits:

- **aphasia/dysarthria**
- **acute diplopia, blindness, visual field loss**
- **dysphagia**
- **paresis/paralysis**

Clinical Interventions- MUST HAVE ALL:

- **Neuro assessment q4h**
- **Cardiac monitoring**
- **Aspiration risk assessment- NPO if indicated and swallow eval**
- **PT/OT initiated**