



ieMR Advanced

FirstNet Business Rules

March 2018 v0.2



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FirstNet – Emergency Business Rules

Purpose

The purpose of this section is to detail the underlying business rules that facilitate the successful operation of the FirstNet system module within the ieMR.

Scope

The scope of this document is to identify and define the business rules applicable when the FirstNet module of the ieMR is implemented.

This document applies to the following stakeholders, but is not limited to:

- ED (including Triage, Resuscitation (Red Zone), Acute (Purple, Green and Orange Zones), Fast Track (Blue Zone) and ED Short Stay Unit (ESSU))
- Inpatient Teams and Units (IPU)
- Patient Flow Unit. (PFSU)
- CATCH

Related Documents

- Code Brown Mass Casualty Registration and Documentation in the Emergency Department
- ED Guidelines
- ESSU Guidelines
- LCCH Digital Release General Business Rules
- LCCH Emergency Department Unknown Patient Procedure
- LCCH FirstNet Business Continuity Procedures
- Pathology Troubleshooting Guide
- Quick Reference Guides
- Radiology Troubleshooting Guide

FirstNet Check In / Check Out

Overview

All Emergency Nursing and Medical staff will use the FirstNet check in process at the beginning of every shift. This allows them to be assigned to patients for the duration of their shift. This will also act as the sign on sheet each day.

Subsequently, at the end of each shift Emergency staff will use the FirstNet check-out process to remove themselves from the department and reassign their patients to the oncoming clinician.

Checking In

Fields to be completed on Check In are:

- Provider (defaults with your name)
 - Note* SMO's must always check in as an SMO. In instances where the SMO is also the treating clinician, the generic SMO (SMO_TC) user account must be assigned into the Treating Clinician column
- Display Name (defaults to your initials)
- Provider Role
- Default Relation
- Associated Provider Colour
- Assign All Tracking Teams
- Available Provider Check Box (defaults to checked)

All other fields are to be left blank and are not utilised during the Check In process.

Choosing a provider role and default relation

Provider Role and Default Relation must be selected based on the table below.

Staff Type	Provider Role	Default Relation
Emergency Administration Officers	Clerk	Admin Officer – Clinical Access
Emergency Nurses CN, RN, EN	Nurse	Primary Nurse
Emergency SMO's and Fellows	Snr Medical Officer	Senior Medical Officer / Consultant
Emergency Nurse Practitioner	Treating Clinician	Nurse – Practitioner
Emergency Registrar	Treating Clinician	Medical Officer – Registrar
Emergency SHO/JHO	Treating Clinician	Medical Officer – Resident
Emergency Intern	Treating Clinician	Medical Officer – Intern
Medical Students in Emergency	Treating Clinician	Medical Officer – Student
Assistant In Nursing	Nurse	Nurse – Assistant In Nursing
Nursing Students in Emergency (includes USIN)	Nurse	Nurse – Student

Choosing an Associated Provider Colour

The follow colours are to be used to delineate roles within the Emergency Department.

Role	Colour	RGB Code
Clinical & Registered Nurses	Teal	0,128,128
Enrolled Nurse	Green	0,128,0
Student Nurse (including USIN)	Yellow	255,255,128
Consultant	Black	0,0,0
Fellow	Grey	128,128,128
Nurse Practitioner	Red	255,0,0
Registrar	Blue	0,128,255
Resident (SHO/JHO/Intern)	Maroon	128,0,64
Medical Student	Yellow	255,255,128
Agency/Casual Pool Nurses	No Colour	
Administration Officer	Purple	128,0,255

Checking Out

On check out ensure that all patients in the Assigned Patients box are reassigned to the provider that you have handed over to and the Available Provider check box is unchecked.

FirstNet Pre-Arrival

Overview

- The FirstNet Pre-Arrive patient system functionality is used to capture and manage pre- arrival information related to the patient
- Pre-arrival notifications can only be entered by Emergency Staff and CATCH
- A pre-arrival notification can be received by the LCCH ED from persons such as:
 - Inpatient specialist team.
 - General practitioners
 - Queensland Ambulance Service (QAS) (equivalent to our Urgent referral requiring possible resuscitation)
 - Other Health facilities

Capturing pre-arrival information

Pre-arrivals must be entered via the pre-arrivals tab in either LaunchPoint or tracking list. The following information must be captured within the Pre-Arrival Form:

- A minimum of two (2) patient identifiers (e.g. DOB, Family name, Given name)
- The patient's presenting complaint and relevant clinical details
- The patient's location must remain as "Pre-Arrival"

All patients including urgent referrals >15 minutes ETA should be entered as a Pre-Arrival.

Canceling pre-arrival information

- If a patient is no longer expected to arrive and a Pre-Arrival Form exists within FirstNet for the patient, the ED Clinician must cancel the patient's Pre-Arrival Form
- Pre-Arrival forms that are not attached to a patient's electronic medical record will be removed automatically from the FirstNet ED Tracking List after 72 hours

Attaching pre-arrival information

Once the patient has arrived to the LCCH ED and has been is triaged, the pre-arrival form information related to the patient will need to be attached to the patient's electronic medical record by the ED Triage Nurse.

Nursing: Quick Registration

Overview

A patient who has presented to the LCCH ED must be Quick Registered and Triageed by the Emergency Triage Nurse.

The FirstNet Quick Registration system functionality is used to rapidly register new patients within HBCIS and create a new emergency encounter within a patient's electronic medical record. If there is a need to commence meaningful treatment for example in resuscitation, once the quick registration screen is finalised, documentation can commence against the encounter and the ED AO can print off patient labels and wristbands before triage assessment has been completed.

Once Quick Registration is complete it will automatically open the FirstNet Triage Assessment Form. This form is used to capture and manage Emergency Triage information related to the patient's presentation.

Searching For a Patient

- For Quick Registration, the ED Triage Nurse must search for a patient via FirstNet by initially populating the patient's information into the respective search fields:
 - Date of Birth (DOB) and
 - Sex (either Male or Female)
- The search results will dictate whether the next step is:
 - Add Encounter or
 - Add Person

Add Encounter: Patient has a pre-existing CHQ URN

For patients who have previously presented to LCCH or a CHQ Community Clinic and have been registered within the hospital's Patient Administration System (PAS), HBCIS, a new emergency encounter will be added to the patient's electronic medical record via FirstNet.

- Patients will have a pre-existing CHQ URN if they have had a previous interaction with any of the following:
 - Have had a previous LCCH ED emergency encounter
 - Have been admitted as an Inpatient at LCCH e.g. booked admission
 - Have had a previous LCCH OPD encounter or referral
 - Have had a previous CHQ Community Clinic encounter or referral
- When positive patient identification has occurred, the ED Triage Nurse must select the correct URN and demographic information related to the patient from the search result window
- The ED Triage Nurse must select "Add Encounter" for the patient who has an existing CHQ URN
 - "Add encounter" must not be used for patients found in the system with a URN from another facility – these patient's will need to be added via the "Add Person" button
- Within the Quick Registration screen itself, the ED Triage Nurse must ensure:
 - The patient's family and given names have been pre-populated
 - The patient's sex and DOB is prepopulated
 - All mandatory fields are completed
- Once Quick Registration is completed, the patient will be automatically assigned a FIN for their new emergency encounter

Add Person: Patient has no pre-existing CHQ URN

If the patient's URN and demographic information via FirstNet is not found follow the next steps:

- Confirm the correct spelling of the patient's given and family names and Patient's DOB
- If no result, select Add Person
- A URN must only be issued through ED Quick Registration
- For patients who have not been previously allocated a CHQ URN, FirstNet will automatically allocate a new URN from a pre-determined sequence, assigned by LCCH Health Information Management Service (HIMS)
 - FirstNet will automatically allocate new URNs even during HBCIS downtime

- Within the Quick Registration screen itself, the ED Triage Nurse must ensure:
 - The patient's family and given names have been pre-populated
 - The patient's sex and DOB is prepopulated
 - All mandatory fields are completed
- Once Quick Registration is completed, the patient will be automatically assigned a URN as well as be automatically assigned a FIN for their new emergency encounter

Quick registering an unknown patient

- If a patient is unable to be positively identified, the triage nurse is to access the ED Unknown Patient Log Book (found in Red Zone) and utilise the next available name for registration e.g. UNKNOWN 'ONE', UNKNOWN". Refer to the Management of the Unknown Patient at LCCH Emergency Department Procedure for more information
- The triage nurse uses the name provided within the Unknown Patient Log book to search for the patient and selects "Add Person"
- The triage nurse completes the Quick Registration process
- The patient's unknown demographic information will already be populated. Any additional mandatory fields need to be completed

Resolving Quick Registration errors

- A Quick Registration is deemed successful when the patient's URN is captured within HBCIS and all mandatory fields are populated with either Not Stated or Unknown
- A Quick Registration is deemed unsuccessful if a patient's URN is entered into HBCIS and all mandatory fields are blank
- A Quick Registration can fail for one or more of the following reasons, but is not limited to:
 - A symbol, number or unknown character is captured within the patient's Family Name
 - The patient's first and/or family name exceeds the 23 character limit within HBCIS
 - The patient's information already exists in HBCIS
 - HBCIS account expiration (for PASLink interface)
 - PASLink Downtime
- Depending on the reason for failure, an email will be sent to the following email addresses:
 - CHQ_EmergencyAdmin@health.qld.gov.au (ED)
 - CHQ_HBCIS_QR@health.qld.gov.au (HIS)

- Tsv-District-IT-Alerts@health.qld.gov.au (HBCIS Support Queensland)
- If the Quick Registration failure is a single notification, the ED AO is required to perform a manual patient registration in HBCIS (Refer to section Full Registration)
- If there are multiple Quick Registration failure notifications, the ED AO must escalate this via phone to the Information Service Centre 1800 198 175
- The ED AO staff member must be informed of any PASLink issues. Once the error has been resolved, ED will be informed via phone and email
- ED AO staff will need to follow up with the Information Service Centre if notification has not been received within 30 minutes from the point of PASLink failure

Wrong patient is selected during Quick Registration process

- If the triage nurse selects the wrong patient during the patient search and quick registration process, this needs to be rectified as soon as the error is identified via the cancel encounter function
- Any open orders will need to be cancelled
- Any documentation will need to be marked as 'written in error – wrong patient'
- Pathology and Radiology departments are to be notified if any investigations have already been completed
- ED AO to notify HIMS that a wrong patient encounter has been added to a patient
- ED AO will cancel the incorrect encounter
- The Triage Nurse will repeat the patient's Quick Registration and Triage process (back dating to the original triage date and time) this time selecting the correct patient details

Nurse: Triage Assessment Form

Overview

LCCH ED Model of Care is based on the principles of Timely Emergency Decisions and Interventions.

- The LCCH ED Triage process involves Quick Registration (including patient search), Triage Assessment and streaming
- Patients will be triaged as per the Australasian Triage Scale (ATS)
- Patients will be assigned a patient care stream according to one of the three streaming codes that best meets their current clinical need at time of triage:
 - Resus
 - Acute

- Fast Track
- Patients will be located into a bed space or room (both physically and on FirstNet)

Completing the Triage Assessment Form

The ED Triage Nurse must complete the following workflow mandatory fields as part of the patient's Triage Assessment:

- **Presenting complaint**
 - This field is be used to describe the patient's reason for visit including enough detail to support the triage tracking acuity assigned. The Triage Assessment includes information related to the patient's ABCD and pain assessments, identification of any relevant medical conditions. Presenting complaint information needs to be as detailed and concise as possible. Note* This field is limited to 255 characters
- **Tracking acuity (ATS)**
 - Triage Category - This field must be completed in accordance with the Australasian Triage Scale
- **Visit reason**
 - This field must be populated with one of the reference values listed in the drop down box
- **Type of visit**
 - This field must be populated with the patient's presentation type – the reason why the patient presented to ED. The most common visit reason is "Emergency presentation"
- **Tracking Team**
 - Stream i.e. Resus Stream, Acute Stream, Fast Track Stream
- **Weight**
 - If unable to complete a weight at triage an order for weight must be completed
- **Allergies**
 - Enter via the Allergies/Medication Hx tab
 - If the patient has no known allergies, this must also be documented
- **Pain assessment**
 - Pain score must be recorded for every patient
- **Vital Signs**
 - If the ED Triage Nurse completes vital sign observations of the patient during the triage process (to assist with assigning an appropriate triage category), this information must be populated in the relevant observation fields within the Triage Assessment form

Editing the Triage Assessment Form

- Triage Assessment (including Triage Category) can be edited within the first “ten” minutes if it’s a genuine mistake
- A triage record can only be edited by accessing the triage form via the documentation section of the patient chart. All changes to the record are kept for auditing purposes and are viewable via the forms textual rendition

Capturing allergy information

- The ED Triage Nurse will attempt to capture allergy information related to the patient during the Triage Assessment process
- If the patient has no known allergies, this must also be documented
- This information will be used to print the correct coloured identification wristband for the patient

Reviewing Alerts information

- The ED Triage Nurse will review alert information related to the patient during the Triage Assessment process via the Problem List tab.
- This information will be used to guide decisions for:
 - Triage Category
 - Streaming zone
 - Infection Control measures

Assigning a patient location

Once Quick Registration is completed, the patient will be automatically assigned to the “Triage” location.

- The ED Triage Nurse must re-assign the patient’s location from “Triage” to an appropriate ED location within FirstNet
- The patient must be assigned to an available location on the FirstNet ED Tracking List following LCCH TEDI streaming principles
 - Resus Stream:
 - All patients that have a Triage Acuity of 1 or 2 will be allocated to a bed location in Red Zone
 - Acute Stream:

- Bed locations within Purple and Green zones will be numbered A, B, C or S according to how beds are to be utilised within the department
- The triage nurse should allocate patients to “A” beds first, followed by “B” beds and then “C” beds
- If there are no acute beds available, patients may be placed in the Waiting Room as an Acute Wait
- “S” beds are to be utilised for patients stepped down from red zone thus the triage nurse should not allocate patients directly to these beds
- Fast Track Stream:
 - Patients allocated to Fast Track will be allocated to the Waiting Room
- If a patient has a risk of a highly infectious disease (e.g Measles/Chicken Pox) they may be placed directly into Orange Zone regardless of stream

Attaching a Pre-Arrival Form

- If the patient has an existing Pre-Arrival Form within FirstNet, the ED Triage Nurse will manually attach this information to the patient’s electronic medical record at the completion of the Triage Assessment

Triaging Initiated medication and activities

The Triage Nurse can nurse initiate Medications and activities from Triage to be completed by the bedside nurse prior to MO/NP assessment. The following orders can be placed by the Triage Nurse:

- Approved Nurse Initiated Medication’s
- Activities
- Trial of Fluids
- Baby bare weights
- Blood glucose and ketones
- Ward Test Urine

Triaging an inpatient who is transferred into ED (excl. HITH)

If a patient has been transferred in from an inpatient unit and has an open CHQ inpatient encounter, quick registration is not required

- The ED AO will transfer the patient in HBCIS from their inpatient location into the EMRGV location
- This will automatically populate the patient onto the FirstNet Tracking screen

- The triage nurse will update the patient location on the FirstNet Tracking screen
- The patient will be triaged by launching the triage form using the Triage icon on the FirstNet Tracking screen

*** Please note patient LOS will be much greater than expected as the LOS will commence from the initial encounter creation date and time

Triaging a HITH patient

If a patient presents and is actively admitted under HITH, Quick Registration is required with a new emergency encounter to be created.

- The ED Triage Nurse will Quick Register the patient as per normal processes
- The ED AO will register the patient as per normal processes
- If the patient is to be admitted, the HBCIS HITH admission is to be discharged as at the time the patient was triaged. The new admission occurs via normal processes, flipping the emergency encounter
- If the patient is discharged home, the HITH admission remains unchanged and the patient is discharged in FirstNet via the Depart Process

Administration: Full Registration

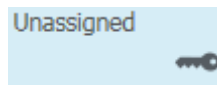
Overview

- Once a patient has been Quick Registered and Triaged by the ED Triage Nurse within FirstNet, the patient will be streamed to a bedspace or the waiting room location whereby the ED AO will complete a full registration
- The ED AO must ensure the patient's registration information (demographics information) has been captured within HBCIS
- Emergency ieMR encounter labels are printed via FirstNet so that any paper-based clinical hospital information/documentation can be labelled appropriately for scanning
- Patient identification wristbands are printed via FirstNet in order to identify the patient by their full name, DOB and URN while being actively treated in LCCH ED

Registering a FirstNet-allocated URN in HBCIS

- FirstNet will automatically allocate a new URN to patients who have not previously presented to CHQ. Allocation of the URN will occur once the Triage Nurse completes the Quick Registration
- If the FirstNet Quick Registration process fails for a new patient (indicated by email notification), the patient will need to be manually registered in HBCIS, using the FirstNet automatically allocated URN

- The Patients URN can be found on LaunchPoint
- Full registration of a patient in HBCIS cannot occur until the patient has been Quick Registered in FirstNet
- Patient's requiring registration will have a key icon in the LaunchPoint Status column



Changing Key Fields in HBCIS

- A patient's name and DOB are classified as Key Fields in HBCIS
- A Key Field Change (KFC) refers to any change made to a patient's name and/or DOB
- KFCs can only occur when confirmation is received that the patient's name/DOB is incorrect or has been legally changed
- KFCs cannot occur for a patient who has open orders (according to the current date) against their current encounter

Manually allocating and registering a URN in HBCIS

- A URN will be manually allocated and registered in HBCIS for the following patients:
 - Inter-hospital transfer patients who are admitted to an inpatient ward via ED after hours
 - Boarder patients (babies or otherwise) (refer to section 24.0 ED Boarder Patients)
 - Downtime patients (for FirstNet/ieMR downtime periods only, refer to section 27.0 Downtime).
- Manually allocated URNs must be sourced from the "1,000,000" range URN pool (Non-ED Patient List). This will be managed by LCCH HIMIS (Health Informatics)

Searching for and/or updating patient demographic information in HBCIS

- Searching for demographic information related to a patient within HBCIS will continue as per current business processes
- Updating demographic information related to a patient in HBCIS will continue as per current business process

Recording a Patient's local catchment and PHI

- A patient's local catchment and private health insurance status should be recorded in the Nursing Comments on LaunchPoint post patient registration (e.g. M | LOGAN)

Completing the Patient Election Form

- Patient Election Form (PEF) will continue to be completed by the patient - as per current process. The PEF will remain on paper
- Communication of the PEF completion to the Emergency team will be completed via documenting in the Admin Comments on LaunchPoint (e.g. PEF)

Note: There are additional financial-related forms that will be completed by patients in some cases. These forms will also remain on paper.

Printing emergency ieMR encounter labels

- Clinical documentation related to a patient must be labelled using the correct ieMR encounter label. (i.e. emergency encounter for ED patient presentations)
- Emergency ieMR encounter labels will be printed from FirstNet
- The correct encounter (i.e. currently open emergency encounter) for the patient must be selected prior to printing the ieMR encounter labels.
- Unused ieMR encounter labels are to be discarded on discharge from Emergency
- If a patient is admitted as an inpatient, the patient's clinical forms that have been labelled with emergency ieMR encounter labels do not need to be re-labelled with inpatient ieMR encounter labels

Printing a patient identification wristband (PPID)

- A patient must be fitted with an identification wristband upon commencing active treatment within ED
- The patient's allergy status must be confirmed by the ED Triage Nurse prior to printing a patient's identification wristband
- A patient who does not have an allergy will have a white identification wristband
- A patient who does have an allergy will have a red identification wristband
- After triage, if it is found that the patient does have an allergy, the allergy information must be captured within the patient's electronic medical record by the treating clinician, a new red identification wristband printed and the patient's original white identification wristband destroyed

- The patient's armband does not need to be reprinted on admission as the Emergency encounter will be 'flipped' into the inpatient encounter

Completing the Arrivals Conversation

- The following mandatory fields must be completed within the ED Arrivals conversation:
 - Arrival Information tab:
 - Mode of Arrival
 - Insurance
 - Compensable Status
 - Interpreter Required
 - eARF Number (for QAS patients)

Cancelling duplicate patient records (at Triage)

- If a duplicate patient is identified within FirstNet at Triage, the ED AO must inform the ED Triage Nurse as soon as possible.
- The ED AO must cancel the patient's duplicate encounter/registration and instruct the ED Triage Nurse to re-perform the Quick Registration, searching for the patient's correct URN and adding a new emergency encounter.
- The duplicate URN must be rectified as per current business processes.
 - Duplicate details must be captured in HBCIS in the PMI field
 - Email CHQ_HBCIS_QR@health.qld.gov.au with URNs, patient names and the way the duplicate URN was created. CC the Emergency BPIO and Data Manager
- If the URN has failed to be registered in HBCIS from FirstNet, the ED AO must manually register the duplicate URN. All URNs need a patient identity associated with them

Cancelling duplicate patient records (once orders are placed)

- If orders have been placed for a patient within FirstNet, the patient must continue to receive treatment under the URN in use
- The ED AO must note within the Nursing Comment column of the FirstNet ED Tracking List that a "Duplicate Record exists for URN xyz"
- The duplicate URN must be rectified as per current business processes

- Duplicate details must be captured in HBCIS in the PMI field.
- Email CHQ_HBCIS_QR@health.qld.gov.au with URNs, patient names and the way the duplicate URN was created. CC the Emergency BPIO and Data Manager
- Once discharged, the patient's URNs will be merged by CHQ HIMS in due course

Quick Reference Guide links

- FirstNet Assign Provider and Check In (ED Administration)
- FirstNet ED Details – Patient Registration (ED Administration)
- FirstNet ED Details – Compensable and Insurance Identification (ED Administration)
- FirstNet – Key Field Changes (ED Administration)
- FirstNet Patient Triage and Registration Process (ED Administration)
- FirstNet Printing Patient Encounter Labels and Wristbands (ED Administration)

Category 1 patient resuscitative event requiring a resuscitation team response

Overview

Indications for initiation of a Category 1 patient resuscitative event requiring a resuscitation team (inclusive of major trauma “Trauma Respond”) are based upon clinical assessment of:

- Airway
- Breathing
- Circulation and
- Disability (neurological) compromise

Documenting clinical information during the resuscitative event

- Clinical documentation for resuscitative event in the interim will remain on the paper using the:
 - Resuscitation Data Sheet and,
 - Trauma Assessment/Admission form where required for a Trauma Respond
- Clinical documentation includes but not limited to:
 - QAS handover

- Primary Survey
 - Vital Signs
 - Clinical Interventions
 - Medications, blood and fluid administration
 - Clinical Procedures
 - Clinical Comments
- The completed documentation is filed in the patient's chart for later scanning into the patient's Electronic Medical Record

Pathology and Radiology ordering during a resuscitative event

- Pathology and medical imaging processes will remain as per current business process and will be ordered via OERR
- Positive patient identification must be confirmed via the scanning function in order to ensure printed pathology labels are correct prior to attaching to specimen tubes
- Each pathology label must have the collector's initials and the date and time of collection prior to being attached to the specimen tube/s
- Pathology specimen tubes must be labelled at the patient's bedside, at the time of collection

Medical Officer: Ordering Medications, Intravenous Fluids & Blood Products retrospective documentation

- Verbal (clinical) ordering of medications, intravenous fluids and blood products will be captured as per current business process on the:
 - Resuscitation White Board
 - Resuscitation Data Sheet
- At the conclusion of the resuscitative event, the following orders must be retrospectively placed by the ED Medical Officer:
 - Medications
 - Fluids
 - Blood administration – “Urgent Blood Administration” e.g. Packed Cells, FFP and Platelets
- Ensure order times are back dated to reflect the resuscitative data sheet

Drug Nurses: Preparing and administering medications, fluids & retrospective documentation

- Documentation of Medications and Fluids Balance administered during a resuscitative events and captured by the nurse scribe will remain on paper as per current business process via the:
 - Resuscitation data sheet
- At the conclusion of the resuscitative event the Medications, blood product and fluid administration will be documented and signed for retrospectively via the MAR.
- Ensure administration times are back dated to reflect the resuscitative data sheet

Documenting the resuscitative event

- A note documenting the resuscitative event must be entered in ieMR
- The naming convention Team Role Reason must be used e.g. “Resus- SMO-Trauma”

Nursing: Zone Assessment and Treatment

Overview

Patients presenting to the Emergency Department will follow the LCCH ED patient flow principles of Timely Emergency Decisions and Interventions (TEDI). Patients will be allocated to a location that best meets their current clinical need at time of triage and located into a room or bed space. The allocated areas are identified as:

- Red Zone for RESUS streamed patients.
- Purple and Green Zones for ACUTE streamed patients
- Blue Zone for FAST TRACK streamed patient

The ED Primary Treating Nurse has the following tasks to complete for every patient who presents to the Acute Zones in the LCCH ED for care:

- Clinical Handover
- Assign and unassign care
- Primary Assessment
- Appropriate systems assessments
- Vital Signs
- Managing Deterioration
- Capturing Allergies and Alerts

- Pain assessment
- Documenting patient care activities
- Creating an ED Progress note where applicable

The FirstNet ieMR module provides access to the patient's electronic medical record where the above outlined clinical information can be documented by the ED Primary Treating Nurse.

Performing Clinical Handover for patients at change of shift

- If there are patients already present in the bed space the oncoming nurse will receive clinical handover at the bedside from the off going nurse and Reassign the Nurse provider.
- The ED nurses at the bedside will open up the LaunchPoint Summary screen. Using the information in the screen they will:
 - Verbally confirm the patient's name, date of birth and UR number corresponds to the patients wristband
 - Triage chief complaint, Allergies and Alerts
 - Review Vitals- Latest time assessed and navigate to MDP trend
 - Review Medications
 - Review Labs
 - Review History- Medical, Family Procedure and Social
 - Review Documents- ED note, ED progress notes
- The oncoming ED Primary Treating Nurse will receive handover regarding the reason for the patient's ED presentation from the patients existing treating nurse
- The outgoing ED Primary treating nurse will complete the Handover ED iView to indicate that handover has been completed
- The outgoing nurse must reassign their patients on check-out

Assigning a Nursing provider (allocating nurses to patients)

- The ED Primary Treating Nurse must assign themselves as a provider to a patient prior to commencing clinical documentation within the patient's electronic medical record
- By being assigned as a provider, the clinician does not need to define their relationship to a patient every time the patient's electronic medical record is accessed
- A timestamp will be captured by FirstNet when any provider is assigned to a patient. This information will be used for ED reporting purposes

Performing Primary Survey activities and documentation

- The ED Primary Treating Nurse must complete a Primary Assessment (documented within the ED Paediatric Assessment Form in FirstNet) of the patient
- Airway, Breathing, Circulation and Disability information related to the patient's ED presentation must be captured within the patient's Primary Assessment form
- If there are any abnormalities detected, the ED Primary Treating Nurse must document the abnormality and treat the patient as required
- The ED Primary Treating nurse must then alert the appropriate ED Consultant and/or Registrar of the patient's condition
- The ED Primary Treating Nurse will then document any further interventions that have been implemented and the name of the Medical Officer alerted
- If documentation is required, the ED Primary Treating Nurse will document in the Progress Note Blank using the ED naming convention (e.g. Resus RN review)

Perform Vital Signs Observations

- A full set of vital signs is required to establish a base line CEWT score. Blood Pressure (BP) is only required if presenting problem dictates the need
- Vital signs information related to the patient are captured within the Interactive View – ED Paediatric Systems Assessment – Vital Signs section of the patient's electronic medical record
- The ED Primary Treating Nurse must view the Managing Deteriorating tab in the menu bar and review appropriate Early Warning Signs notifications have been triggered and validated

Managing Patient Deterioration (CEWT)

- If a managing deterioration warning is displayed for the patient within the Managing Deterioration tab of the patient's electronic medical record, "0 minutes" must be selected prior to acknowledging/suspending the warning
- When a patient's vital signs observations are outside the normal ED ranges, the ED Primary Treating Nurse must notify the relevant ED Consultant, Registrar and/or Nursing Team Leader when a managing deterioration warning has been displayed for the patient
- The ED Primary Treating Nurse must perform all critical patient care activities necessary prior to documenting the action/s taken for the patient within the patient's electronic medical record

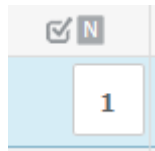
- The ED Primary Treating Nurse must complete the clinician notification band in the Paediatric Condensed iView for all CEWT escalations

Capturing Allergies/adverse effect information

- The ED Primary Treating nurse must confirm the patient's allergy status
- The ED Primary Treating Nurse must capture allergy information related to the patient if such information has not been previously captured during Triage
- If the patient does not have any known allergies, "No known allergies" (NKA) is documented within the patient's electronic medical record
- All allergies are to be classified as mild unless anaphylactic or food related in which case they are classified as severe

Documenting ED activities (nursing tasks)

- An ED Patient will have nursing tasks listed in real-time via LaunchPoint Activities Tab (accessed via the LaunchPoint Nursing activities column within FirstNet). Patient Care, Assessments and Other tasks related to the patient's care will be listed
- The ED Primary Treating Nurse must view the LaunchPoint Nursing Activities column on a regular basis. This column will show the number of activities currently required to be carried out for the patient. Please note that orders that have been placed and are not yet due will not show as an activity until the due time



- Tasks must be initiated via the LaunchPoint Activities Tab using the "document" button. This will ensure that once a task (i.e. ED Assessment Paediatric) is completed, the task will be removed from the patient's LaunchPoint Activities tab
- The ED Primary Treating Nurse must document the completion of clinical tasks and activities in real time, so that other members of the patient's care team remain informed
- Nursing activities can be ordered as required by nursing staff

Creating an ED Progress Note

- The ED Primary Treating Nurse will create an ED Progress Note in order to document the clinical care activities performed for the patient that is not captured in other areas of patient's electronic medical record
- The following information must be captured within the patient's ED Progress Note:
 - Used for the recording of condition changes and treatment response
 - Progress notes should include justification for continued stay or reasons for cancellations
 - Any information that is necessary for other clinicians to refer to
- A new progress note should be created for any new information. This ensures that all documentation from multiple clinicians remains in chronological order. An addendum/modification should be avoided
- Changes pertinent to a previously written note can be added as an addendum

Medical Officer: Workflow

Overview

- The ED Primary Treating Doctor will complete the following where applicable for every patient who has presented to the LCCH ED for care:
 - Presenting complaint
 - History of present illness Primary Assessment
 - Past Medical History (Family, Procedure, Social), Problems and Diagnoses
 - Allergy/adverse effect
 - Physical examination
 - Assessment and management plan
- The FirstNet ieMR module provides access to the patient's electronic medical record where the above outlined clinical information can be documented via the ED Doctor Workflow page

Assigning a Senior Medical Officer/Treating Clinician provider

- The ED Treating Doctor must assign themselves as a provider to the patient via LaunchPoint prior to commencing clinical documentation within the patient's electronic medical record
- By being assigned as a provider, the clinician does not need to define their relationship to the patient every time the patient's electronic medical record is accessed
- A timestamp will be captured by FirstNet when any provider is assigned to a patient. This information will be used for ED reporting purposes

Reassigning/Handing over a patient

- The ED Treating Doctor must reassign/hand over their assigned patients to the appropriate ED Treating Doctor on shift when required within FirstNet/ED LaunchPoint (i.e. between shifts). This is to be done via the Check In / Check Out process

Reviewing Triage Assessment documentation

- The ED Treating Doctor must review the patient's Triage Assessment documentation captured by the ED Triage Nurse. This is to be viewed via the ED Doctor Workflow

Documenting Presenting Complaint and History of Present Illness

- The ED Treating Doctor must capture information related to the patient's Presenting Complaint and History of Present Illness via the ED Doctor Workflow within the patient's electronic medical record

Reviewing and documenting Past Medical History, Problems

- The ED Treating Doctor must review the patient's pre-existing medical history (if applicable)
- The ED Treating Doctor must add (via the Problems field) new historical medical information related to the patient if applicable
- The ED Treating Doctor is expected to document the following problem types:
 - Active (this encounter)
 - Inactive (chronic)
 - Resolved (historical)

Documenting an Emergency Diagnosis

- A diagnosis recorded for an Emergency presentation must be entered with a diagnosis type of "working" which will ensure the presentation is funded
- The working diagnosis must remain unchanged throughout the patient journey
- If the inpatient team want to record a diagnosis type other than working, it must be added as a new diagnosis

Documenting allergies/adverse effect information

- The ED Treating Doctor must confirm the patient's allergy status by marking them as reviewed
- The ED Treating Doctor must capture allergy information related to the patient if such information has not been previously captured during Triage or by the ED Primary Treating Nurse
- If the patient does not have any known allergies, "No known allergies" (NKA) is documented within the patient's electronic medical record

Documenting alerts information

- The ED doctors should record any relevant alerts (e.g. Infection Control, Patient Safety etc.)

Documenting physical exam information

- The ED Treating Doctor must capture information related to the patient's physical exam via the ED Doctor Workflow within the patient's electronic medical record

Documenting assessment and management plan information

- The ED Treating Doctor must capture information related to the patient's assessment and management plan via the ED Doctor Workflow within the patient's electronic medical record

Creating an ED Progress Note

- The ED Treating Doctor will create an ED Progress Note that includes all information documented as part of the ED Doctor Workflow within the patient's electronic medical record
- Naming convention of Team, Role, Reason must be used
- If further information is required, a new ED progress note should be created. Addendums should be avoided unless correcting previously entered information

Altering mandatory notification criteria (Early Warning Signs (EWS))

- The ED Treating Doctor will not alter the patient's mandatory notification criteria. This must only be done by the patient's admitting team (as part of managing a patient's deterioration).

Consultation Requests (Inpatient or Allied Health)

- The ED Treating Doctor will order an Inpatient and or Allied Health consultation if required
- The referral to specialty field must be completed as part of the consultation order
- The ED Treating Clinician must enter their individual Novell password in order to sign and place the consultation order for the patient

- Once the consultation order is placed electronically, this must be followed up by a phone call to the relevant Inpatient/Allied Health service
- The status of the consultation order is “Ordered” at this stage
- The ED Treating Doctor will be prompted to capture a working diagnosis for the patient in the patient’s electronic medical record
- Once the consultation has been provided to the patient, the Inpatient Medical Service/Allied Health specialty will update the patient’s consultation order to “Completed”
 - If a patient has no outstanding consultation requests the consultation icon on LaunchPoint will be dithered
 - If a patient has had one of several consultations requests completed the consultation icon status bar will show the progress of all consultations. To see the status of each consult hover your mouse over the icon

Order Name	Date/Time	Ordered By	Status
Consult to Oncology	27/09/17 11:00:00	R4EDDoctor, Karter	Ordered
Pharmacist Clinical Review	17/08/17 11:31:08	SYSTEM, SYSTEM	Ordered



FirstNet Discharge – Ed Service Complete

Overview

Once the required healthcare services have been delivered and their Emergency episode of care is complete, the patient will depart from Emergency

Preparing the patient to depart ED

- Prior to departing the patient from Emergency, the relevant ED Clinician must:
 - Complete the discharge medication reconciliation
 - Review and remove all outstanding pathology, radiology and patient care orders for the patient (as required)
 - Complete and print the Emergency Statement of Attendance for the patient
- The ED Primary Treating Nurse must:
 - Complete discharge documentation
 - Document the removal of Peripheral IV Lines from the patient within the patient's electronic medical record (as required)

Capturing and printing a patient's Statement of Attendance

- The ED Treating Medical Officer will complete the patient's Statement of Attendance prior to the patient departing Emergency from within the FirstNet LaunchPoint via the Discharge Process
- The ED Treating Medical Officer must capture a working diagnosis for the patient. This information will be captured within the patient's Statement of Attendance
- The ED Treating Medical Officer must print the patient's Statement of Attendance and provide this to the patient

Use of the "Exit" location

- The "Exit" location can only be used when:
 - A patient is departing ED to go to an inpatient location excluding Short Stay
 - A patient has physically left the Emergency Department and mandatory fields have been left incomplete
 - A patient is physically exiting Short Stay to be discharged home

FirstNet Admission – Inpatient Ward (excluding Short Stay)

Overview

A patient whose health requires further assessment, observation, investigation, treatment and input from specialist inpatient teams will be admitted to a hospital inpatient ward.

FirstNet system functionality in use is:

- Patient referral for consultation to an IPU treating team
- Placing an Admit to Inpatient order,
- Various admit events,
- Capturing bed management comments,
- Capturing delay information,
- Capturing departure information,
- Capturing a working diagnosis and
- Flipping the patient's emergency encounter to an inpatient encounter

Patient referral to inpatient team

- If the patient requires inpatient team consultation and admission, a phone call will be placed to the inpatient team by the senior doctor in ED
- The ED Treating Clinician must also place a Consult Order within FirstNet to capture the referral time
- The ED Treating Clinician will commence the ReAdI Form
- The Treating Clinician/Zone SMO or Zone TL will enter into the clinical comments screen the admission narrative to identify treating team, IPU review status, admission ready status and communicable disease screen result:
 - e.g. INP Onc I Referred I Not Ready I Screen: Droplet

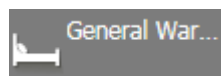
Inpatient Team Consultation Attend

- When the inpatient team attends Emergency to review the patient they will change the consult order to "complete"
- This can be completed in FirstNet or PowerChart Orders tab

Placing an admit to inpatient order and commencing the ReAdl process

The ReAdl process will be used for all inpatient admissions including ESSU. The responsibilities for completing the ReAdl process will be by the ED SMO, Zone TL and bedside treating nurse:

- The ED Senior Medical Officer will place an “Admit to Inpatient” order. The “Admit to Inpatient” order must contain the following information:
 - “Bed requirements”. Only the following options are to be used at LCCH:
 - General Ward Bed
 - HITH
 - ICU
 - Mental Health
 - Short Stay
 - The order’s date and time
 - Diagnosis
- Completion of the “Admit to Inpatient Order” will update the LaunchPoint status column with the bed icon



- Once the “Admit to Inpatient” order is placed, the patient will then appear on the Bed Management LaunchPoint
- The Zone Nurse Team Leader will complete the Communicable Disease Screen for cohorting bed placement
- ED Treating team nurse will complete the preparation for admission/handover checklist on the ReAdl Form

Patient’s “Emergency care is complete”

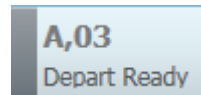
For a patient’s Emergency Care to be completed they must have:

- Time critical medications given
- An Interim Care Plan in place or have had a plan documented by the inpatient team
- Analgesia charted
- IVC inserted (if required)
- Fluids charted (if required)

- Risk assessment completed (CEWT)
- Be clinically stable

Once the Patient's Emergency care is complete the treating clinician/nurse should mark the patient as Departure Ready

The patients 'Depart Ready' status is shown in the room column of LaunchPoint



Capturing “ED to Inpatient admission” information

Once the patient has been accepted for admission and is 'Emergency Care Complete' the EFC will capture the Admitting Team and Admitting Consultant information via the ED-INPT admission conversation in FirstNet.

The following fields must be completed:

- Admission Specialty
- Admission Unit
- Admitting Doctor

Note* Known patients of sub specialty teams should be admitted under their previous admitting doctor and not the admitting doctor of the day.

- When care is complete the Zone team leader will notify the EFC that the patient is ready for admission and a bed can be booked with the Patient Flow Unit
- The Emergency Flow Coordinator will review the “Admit to Inpatient” order within FirstNet
- The EFC will text the Bed request details to the PFNM. In order for them to organise the patient's inpatient ward bed the text narrative will be:
 - ED bed request
 - Pt location
 - UR number
 - Treating team

e.g. ED bed request GZ 32 UR 999999 Gen Paeds

Inpatient Admission on HBCIS (AO)

- The Emergency AO can complete the admission to Emergency Virtual once the patient is 'Depart Ready' and has an 'Admit to Inpatient' Event. The admission time to be used is the Depart Ready time and can be found by accessing the 'Set Events'

- The completion of the PEF paperwork can also be recorded in the admin comments by including “PEF” at the beginning of the comments
- Once the HBCIS admission is complete the ED AO will update the admin comments column to include “HBCIS” signalling that the HBCIS admission has been completed

Flipping an emergency encounter to an inpatient admission

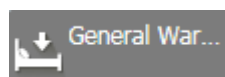
- For those patients who are admitted to an inpatient location within HBCIS, their emergency encounter will automatically “flip” to an inpatient encounter in ieMR
- The patient’s inpatient encounter will retain the same FIN as was allocated to the patient’s emergency encounter
- Any open or in progress pathology, radiology, patient care and consultation orders placed against the patient’s emergency encounter will still be available/visible within the patient’s inpatient encounter

Acknowledging the Bed Request (PFNM)

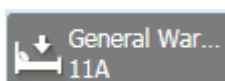
- If the admitting ward can be identified the PFNM will update the status of the patient’s Admit event to “Bed-Assigned” when the inpatient bed request has been received from the ED EFC
 - This will capture the time it has taken to acknowledge/respond to the ED inpatient bed request
- If the admitting ward cannot be identified, the PFNM will update the Bed Management comments to “AWA” when the inpatient bed request has been received by the ED EFC
- This communicates to the ED that PFNM has received the bed request, but is unable to allocate at this time and is not time stamped

Allocating an Inpatient Bed (PFNM)

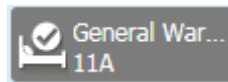
- The PFNM will locate and allocate inpatient beds as per current business process
- The PFNM will add a “Bed Assigned” event for the patient. The “Bed Assigned” event will display in the LaunchPoint ‘status’ column



- The PFNM will specify the ward allocated in the Bed Management Comments (located in the LaunchPoint Status column)



- When the ward is ready to take the patient, the PFNM will add a “Bed Ready” event for the patient. The Bed Ready event will display in the LaunchPoint Status column



- The Events “Bed Not Ready” and “No Bed” are not to be used at LCCH under any circumstance

Capturing Delay information

If there are delays in moving the patient from ED to an inpatient bed the EFC/ED Zone nursing team leader will capture the delay information within the FirstNet Delay Conversation.

- Delay Reasons will only be added to the ‘Extended Delays’ section of the Delay Conversation
- Where applicable choose a delay reason from the drop down boxes, or alternatively record the reason for delay in the ‘Extended ED LOS Comment 4’ free text box

When entering delay reasons it is important to note as much detail as possible. Sometimes there may be more than one delay in getting the patient to the ward in this case use the free text box and allocate times next to each delay. The staff member recording the delay, must also initial any free text delay comments (e.g. 1200-Bed not available, awaiting discharges-JA). Recording reasons for delays accurately is important in identifying blocks to patient flow and can help develop strategies for improvement that would otherwise be difficult to record.

Emergency to Ward Handover (Nursing)

- A patient clinical handover will be performed as per current business process
- A patient clinical handover must occur at the bedside
- A patient clinical handover will be supported by:
 - the ED ReAdI process Checklist
 - the ED Nursing Summary page SBAR tabs via FirstNet and any clinically relevant documentation
- The ED Nurse handing over the patient must complete the Nursing Handover Communication iView band in the presence of the inpatient nurse receiving care of the patient
- The ED Nurse will move the patient to the exit location once the patient physically departs and inform the ED AO

Physically departing ED to an inpatient location

The ED AO will identify a patient who has left the department by the patient appearing in the exit location. The ED AO will complete the following information within the FirstNet ED Departure conversation when the patient physically departs but before transferring them on HBCIS:

- “Departure Status” field – i.e. “Admitted (excl. ED bed)”
- “ED In-Pt Ward (EDIP) Pt – “Yes”
- “Admitted Destination” – ward allocation
- “Admission Specialty”
- “EDIP Admit Date” – the date of departure from ED
- “EDIP Admit Time” – the time of departure from ED

Once the departure conversation is completed, the Emergency AO will transfer the patient on HBCIS to the inpatient ward location. The HBCIS transfer will trigger the patient to automatically be removed off the FirstNet Tracking screen.

It is important to note the following:

- The EDIP Admit Date and Time is what stops the NEAT clock for admitted patients for reporting purposes. This should reflect the time the patient was placed in the “Exit” location
- The FirstNet Departure conversation (as specified above) must be performed prior to the patient being transferred to an inpatient ward on HBCIS as this will drop them off the tracking board
- ED Inpatients do not have their actual departure time completed in FirstNet as this would close the Inpatient Encounter
- When the patient is physically exiting ED to be taken to their inpatient ward location, the bedside nurse will update the patient’s location to “Exit” within FirstNet. This frees up the patient’s bed in FirstNet whilst the HBCIS ward transfer is occurring
- Patients being admitted to PICU will require their medications to be suspended and entered in MetaVision by PICU staff – See Medication Business Rules for further information

FirstNet Admission – Short Stay Unit

Overview

The purpose of the Emergency Short Stay Unit (ESSU) is to provide an efficient, high turnover area for Lady Cilento Children’s Hospital (LCCH) Emergency patients requiring a short period of observation or acute admission for up to 24 hours duration, allowing discharge whenever their clinical condition allows.

FirstNet system functionality in use is placing an Admit to Inpatient order, various admit events, capturing bed management comments, capturing delay information, capturing departure information, capturing a working diagnosis and flipping the patient’s emergency encounter to an inpatient encounter.

Admitting a patient to ESSU

- The Zone ED SMO must liaise with the ESSU SMO in order to identify that there is an appropriate patient for ESSU admission
- The Zone SMO or Zone TL will enter into the clinical comments screen the admission narrative: identify ESSU disposition, SMO review status, admission ready status and communicable disease screen result:

e.g INP ESSU | Seen | Ready | Screen: Droplet

Placing an admit to inpatient order and commencing ReAdI process

The ReAdI process will be used for all ESSU admissions. The responsibilities for completing the ReAdI process will be by the Zone ED SMO, Zone TL and bedside treating nurse:

- The ED Senior Medical Officer will activate an “Admit to Inpatient” order. The “Admit to Inpatient” order must contain the following information:
 - “Bed requirements” e.g. Short Stay
 - The order’s date and time
 - Diagnosis
- The Zone Nurse Team Leader will complete the Communicable Diseases Screen for cohorting bed placement
- The ED Nurse will complete the handover checklist in the ReAdI Form

Patient’s “Emergency care is complete”

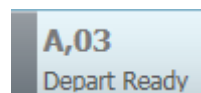
For a patient’s Emergency Care to be completed they must have:

- Time critical medications given

- A plan documented by the referring SMO
- Analgesia charted
- IVC inserted (if required)
- Fluids charted (if required)
- Risk assessment completed (CEWT)
- Be clinically stable

Once the Patient's Emergency care is complete the treating clinician/nurse should mark the patient as Departure Ready.

The patients 'Depart Ready' status is shown in the room column of LaunchPoint.



Capturing “ED to Short Stay admission” information

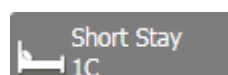
Once the patient has been accepted for admission and is 'Emergency Care Complete' the Zone TL/EFC will capture the Admitting Team and Admitting Consultant information via the ED-INPT Conversation in FirstNet.

Reviewing the ‘Admit to Inpatient’ order/Admit event

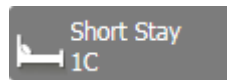
- When care is complete the Zone team leader will notify the EFC that the patient is ready for admission
- The EFC will review the “Admit to Inpatient” order within FirstNet
- Once the “Admit to Inpatient” order is placed, the patient will then appear on the FirstNet LCCH Bed Management LaunchPoint with an “Admit” event
- If there are multiple patients waiting for ESSU admission the EFC will negotiate with the Zone and ESSU TL's priority order of admission

Allocating a Short Stay Bed (EFC)

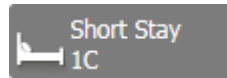
- The EFC will allocate short stay beds as per current business process.
- The EFC will add a “Bed Assigned” event for the patient. The “Bed Assigned” event will display in the LaunchPoint 'status' column



- The EFC will specify the ward allocated in the Bed Management Comments (located in the LaunchPoint Status column)



- When the Short Stay is ready to take the patient, the Short Stay TL will add a “Bed Ready” event for the patient. The Bed Ready event will display in the LaunchPoint Status column



- The Events “Bed Not Ready” and “No Bed” are not to be used at LCCH under any circumstance

Emergency to Short Stay Handover (Nursing)

- A patient clinical handover will be performed as per current business process
- A patient clinical handover must occur at the bedside
- A patient clinical handover will be supported by:
 - The ED ReAdl process Checklist,
 - The ED Nursing Summary page SBAR tabs via FirstNet and any clinically relevant documentation
- The ED Nurse handing over the patient must complete the Nursing Handover Communication iView band in the presence of the Short Stay nurse receiving care of the patient
- The patient must be moved from their Emergency location to the Short Stay ward via LaunchPoint or via the ED Floor Plan once physically departed

Physically transferring from an ED zone to ESSU

Once the patient arrives in Short Stay, the ESSU AO will complete the following;

- ED Departure conversation:
 - “Departure Status” field – i.e. “Admitted (excl. ED bed)”
 - “ED In-Pt Ward (EDIP) Pt – “Yes”
 - “Admitted Destination” – ward allocation
 - “Admission Specialty”
 - “EDIP Admit Date” – the date of departure from ED
 - “EDIP Admit Time” – the time of departure from ED

Short Stay Admission on HBCIS (AO)

- The Emergency AO can complete the admission to ESSU once the patient is physically located in Short Stay that has and “Admit to Inpatient” event. The admission time to be used is the first Short Stay location time and can be found by accessing the ‘Patient Summary Report’
- The completion of the PEF paperwork can also be recorded in the admin comments by including “PEF” at the beginning of the comments
- Once the HBCIS admission is complete the ED AO will update the admin comments column to include “HBCIS” signalling that the HBCIS admission has been completed
- If the patient has been admitted privately to Short Stay – this should be recorded in the Nursing Comments on LaunchPoint

Discharge – ESSU

Overview

Once the required healthcare services have been delivered and their inpatient episode of care is complete, the patient will depart from ESSU.

Preparing the patient to depart ESSU

- Prior to departing the patient from ESSU, the relevant ED Clinician must:
 - Complete the discharge medication reconciliation
 - Review and remove all outstanding pathology, radiology and patient care orders for the patient
 - Complete and print the Emergency Statement of Attendance for the patient
- The ED Primary Treating SSU Nurse must:
 - Complete discharge documentation
 - Document the removal of Peripheral IV Lines from the patient within the patient’s electronic medical record (as required)

Capturing and printing a patient’s Statement of Attendance

- The ED Treating Medical Officer will complete the patient’s Statement of Attendance prior to the patient departing ESSU from within the FirstNet Tracking screen – through the “Depart Process’ icon
- The ED Treating Medical Officer must capture a working diagnosis for the patient. This information will be captured within the patient’s Statement of Attendance

- The ED Treating Medical Officer must print the patient's Statement of Attendance and provide this to the patient

Discharging the patient from Short Stay

- When the patient is physically exiting Short Stay to be discharged home the ESSU Nurse Team Leader will update the patient's location to "Exit" within FirstNet.
- The ESSU AO will complete the HBCIS discharge and this will remove the patient from the tracking screen.

Note: ESSU patients must not be discharged using the FirstNet Depart Process.

Transfer from ESSU to Inpatient Ward

Overview

When a patient requires further inpatient admission from short stay, a ward transfer is required.

Placing a referral to an inpatient unit

The ESSU Treating MO contacts the relevant Inpatient Team to organise referral and admission to the IPU, this is recorded as a consultation request.

Requesting an IPU Bed

The ESSU TL will update the Clinical comments to indicate IPU admission and then will contact the EFC to request an inpatient bed.

- No further information is required to be updated in FirstNet

The EFC will text the PFMN to request the inpatient bed. E.g. ESSU Transfer Bed Request, ESSU Bed 6, UR 100000, Med Admission"

Updating admission details in HBCIS

Once an inpatient admission is confirmed the ESSU AO updates the new treating team details on HBCIS via the transfer screen.

Allocating an Inpatient Bed (PFNM)

The PFMN will update the Bed Management column with the new Inpatient ward.

No other bed events are to be utilised.

Transferring the patient

Once the patient physically departs ED, the ESSU Nurse will update the room location to “Exit” and the ED AO will complete the HBCIS transfer. This will cause the patient drop-off FirstNet.

Nursing handover will be as per the ED to Ward process – See Emergency to Ward Handover (Nursing)

FirstNet Interhospital Transfer (IHT)

Overview

The goal of IHTs is to achieve safe and effective clinical handover of patients being transferred between facilities through a standardised process, effective, well informed communication and documentation.

The ED Details Conversation is used to capture and manage information pertinent to the patient’s emergency episode of care. In particular, it will capture information relating to the patient’s departure from ED.

Identifying a patient for IHT

Patients who may be appropriate for IHT include:

- Back transfer of LCCH patients to their home or referring hospital or Catchment HHS
- Patients who present to the LCCH emergency department may be eligible for transfer to MHS as a public patient and be cared for at the Mater hospital
- Any adults presenting to ED requiring a period of observation requiring transfer to an adult ED

Organising a patient for IHT using CATCH process

- Consult with referral hospital for accepting patient
- Access online QHEPs inter hospital transfer request form
- Acceptance of patient by the accepting team at home hospital or referring hospital (Catchment HHS)
- Availability of bed for patient at accepting hospital (Catchment HHS) as ascertained via bed manger
- CEWT score reflecting patients suitability for low acuity non time critical transfer via CATCH

Printing Clinical information for a patient transferring to another facility

- Clinical information that has been captured during the patient's episode of care will be printed for the patient via FirstNet to take with them to their new hospital including:
 - The Medical Record Request using:
 - Template – R4 ED Transfer Report
 - Purpose – Further Medical Care
 - Sections – As clinically appropriate
 - Date/time range – As per ED presentation
- Note* Preview prior to printing
- Meds Transfer Report
 - Scroll to the bottom, select meds transfer report
 - Ensure LCCH is selected as the facility and locate patient

Medical Emergency Team (MET) Response Patients

See organisational MET business rules

Terms and Abbreviations

Term	Description
BMDI	Bedside Medical Device Interface/Integration
CEC	Current Encounter Chart
Demographic information	Information used to identify the patient (i.e. family name, first name, date of birth, sex, residential address)
DOB	Date of birth
eARF	Electronic ambulance report form
ED	Emergency Department
EFC	Emergency Flow Coordinator
ESSU	Emergency Short Stay Unit
EWS	Early Warning Signs/Managing Deterioration
FIN	Financial Identification Number
FirstNet	The Cerner Millennium system module for emergency medicine
HBCIS	Hospital Based Corporate Information System
HIMS	Health Information Management Service
ieMR	Integrated electronic medical record
KPI	Key Performance Indicator
LCCH	Lady Cilento Children's Hospital
NOK	Next of kin
PAS	Patient Administration System – HBCIS
PEF	Patient Election Form
PPID	Positive Patient Identification
QAS	Queensland Ambulance Service
ReAdI	Rapid Emergency Admission Destination Initiative – a strategy to improve the process of transferring admitted patients from the LCCH ED to the inpatient wards.
Resus	Resuscitation
SBAR	Situation, Background, Assessment, Recommendation
TEDI	Timely Emergency Decisions and Interventions
URN	Unique Record Number – the hospital-based patient identification number assigned to a patient that uniquely identifies that patient for that hospital facility

Document History

Version	Author	Version comments
0.1	Linda Thorburn, Stephen Leahy, Aaron Johnston & Steven Watson	Initial draft
0.2	Linda Thorburn, Stephen Leahy, Aaron Johnston & Steven Watson	Updates incorporated from feedback received by FirstNet Clinical Advisory Group (FCAG)