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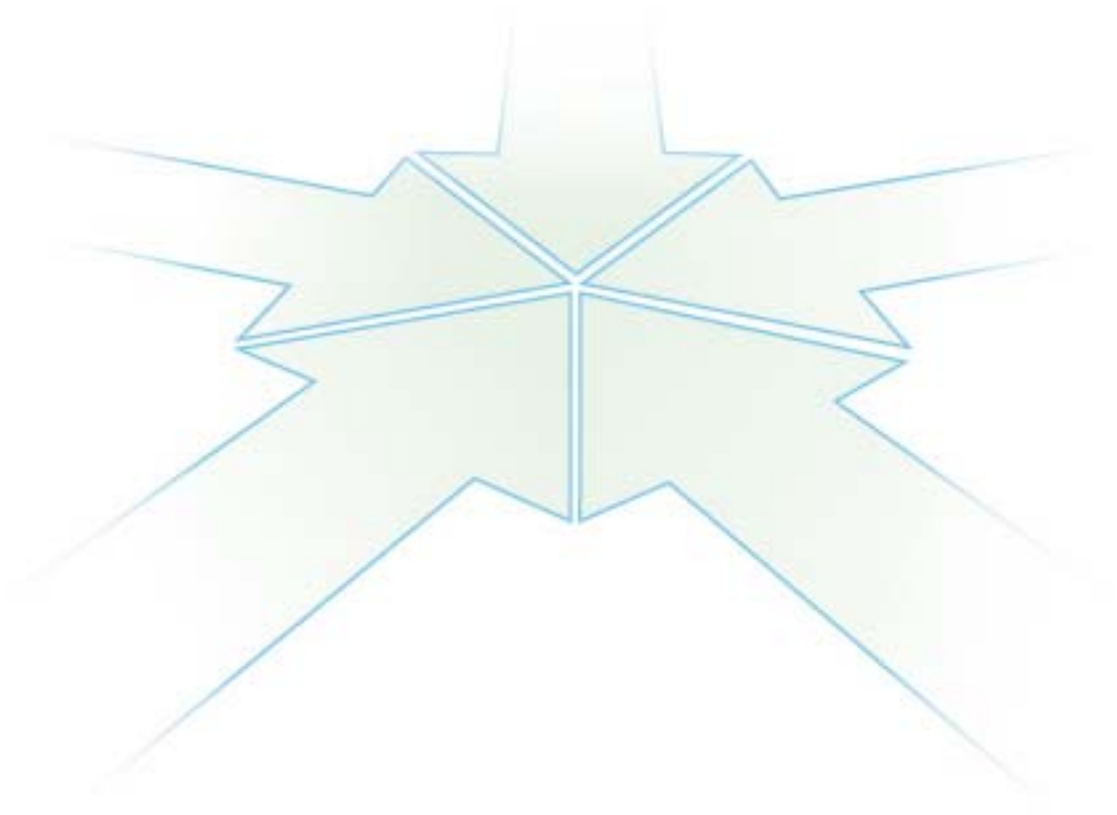
Emergency Department (ED) Medical Directives Implementation Kit

Wait Times Strategy
Emergency Department (ED) Medical Directives
ED Medical Directives Working Group



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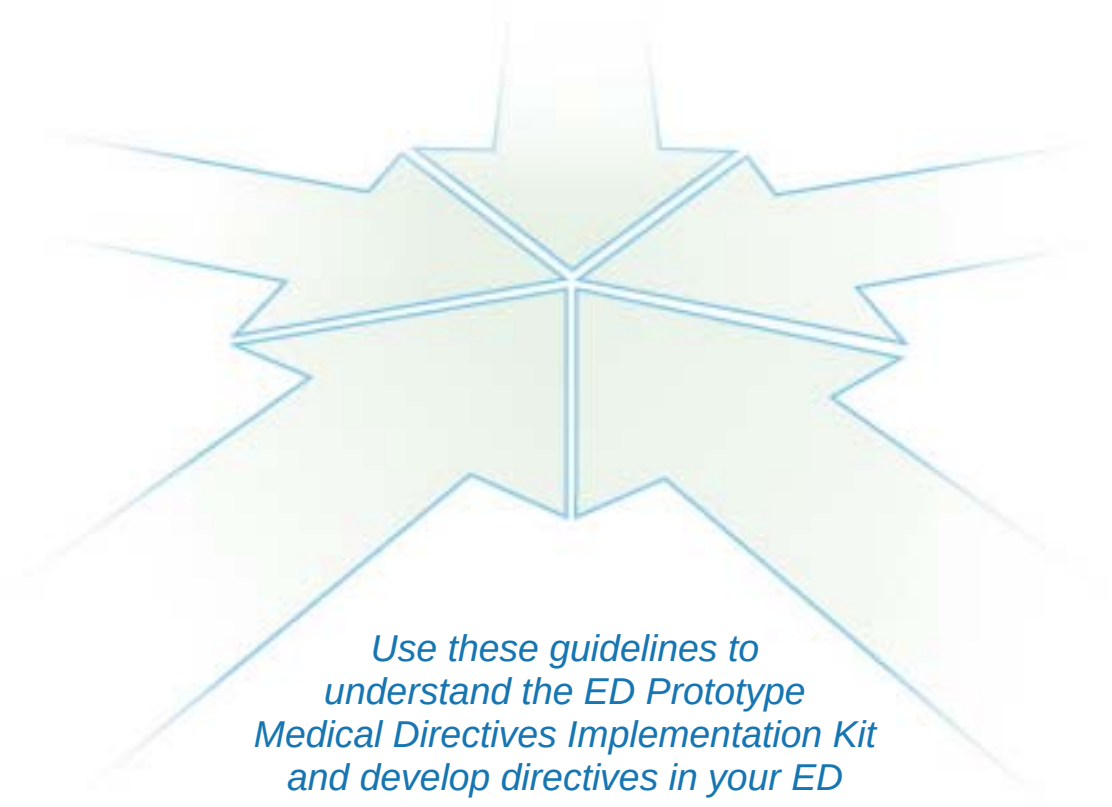
Guidelines

Emergency Department (ED) Prototype Medical Directives



Use these guidelines to understand the ED Prototype Medical Directives Implementation Kit and develop directives in your ED

ONTARIO HOSPITAL ASSOCIATION

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Table of Contents

Acknowledgements

The modules contain information and templates from the following sources:

- ***Delegation of Controlled Acts***, College of Physicians and Surgeons of Ontario, February 2007.
- ***Authorizing Mechanisms***, College of Nurses of Ontario, October 2007.
- ***An Interprofessional Guide on the Use of Orders, Directives and Delegation***, Federation of Health Regulatory Colleges of Ontario, January 2007. Developed and endorsed by colleges including the CPSO and CNO.

Readers may refer to these resources or other College publications for further information.

The prototype medical directives draw on directives developed by the:

- Child Health Network for the Greater Toronto Area, Toronto
- Grand River Hospital, Kitchener
- Mount Sinai Hospital, Toronto
- North York General Hospital, North York
- Peterborough Regional Health Centre, Peterborough
- Royal Victoria Hospital, Barrie
- Southlake Regional Health Centre, Newmarket
- William Osler Health Centre, Brampton and Etobicoke

Purpose

This implementation kit has been developed for use by Emergency Department (ED) physicians and staff in response to a recommendation "to maximize the use of medical directives within the emergency department, in order to increase efficiency of patient flow and patient care" made by the OHA/OMA/MOHLTC Physician Hospital Care Committee in its report *Improving Access to Emergency Care: Addressing System Issues* (August 2006), p.10.

Developed by a provincial Expert Panel of ED physicians and clinical staff, the implementation kit provides consensus-based information and tools drawn from current ED practices and directives along with guidelines and templates for establishing medical directives by the College of Physicians and Surgeons of Ontario (CPSO), the College of Nurses of Ontario (CNO), the Federation of Health Regulatory Colleges of Ontario (FHRCO) and other regulatory colleges, thus fulfilling regulatory and legislative expectations for practice.

What the implementation kit and directives are not:

- They are not intended to be a standard of practice or required set of directives, but rather a resource to be used as ED physicians and staff see fit. Modules and content may be adapted, adopted, or referred to in order to augment already existing directives.
- Directives are not a substitute for timely assessment of patients by physicians. Patient-specific orders provided by a physician who has seen and assumed care of a patient remains the gold standard for care. Proper directives authorize designated staff to carry out orders and expedite care before a physician is able to see a patient, but only when it is safe, effective and ethical to do so.
- Properly developed and applied directives should not increase unnecessary tests and procedures administered to patients. Instead, they optimize care by mandating physicians and teams to come to a consensus on practice issues and develop a consistent approach. In addition, time for key tests and interventions can be reduced, improving patient and staff satisfaction.

Contents

The implementation kit has been designed to enable ED physicians and staff to fulfill the following steps necessary for establishing directives:

1. Assure performance readiness (competence) of team members given the specific circumstances in each ED;
2. Assure a medical directive is written as a proper order and suits setting-specific circumstances (patients, competencies, practices);
3. Assure team input and agreement, particularly from co-implementers;
4. Assure approval and sign-off by physicians and hospital administrative authorities; and
5. Assure directives are reviewed for appropriateness as indicated.

The implementation kit contains the following modules (M):

M-1. **Performance Readiness Assessment** - to determine the appropriateness of using directives

M-2. **Performance Readiness Plan** - to establish necessary competencies, including:
a) Educational Resources – information to assure competencies
b) Quiz - to assess and demonstrate competencies
c) Implementer Performance Readiness Forms - to record agreement with directive and achievement of competencies (individual and group)

M-3. **Prototype Directives** – sample to facilitate establishment of setting-specific directives

M-4. **Sample Directive Pre-printed Order Sheets and Emergency Record –** sample options for documenting implementation of orders

M-5. **CEDIS Presenting Complaints Table** – a quick reference summarizing directive orders by presenting complaints

M-6. **Approval Forms**
a) Physician Approval Form – Staff Physicians
b) Stakeholder/Administrative Approval Form
c) Physician Approval Form - Locum, Casual Physicians
d) Physician Approval Form – New Staff (to enable new staff to sign off)

Electronic versions of the modules are available at: **www.oha.com/edmedicaldirectives**

Steps for Establishing ED Directives

1. Assure Performance Readiness

Convene a sponsoring group:

Consisting of at least the Chief Physician and representatives of administrative, implementing and co-implementing staff to complete:

- **M-1 - Performance Readiness Assessment –** assess the appropriateness of using the directives,
- **M-2 - Performance Readiness Plan** - establish thecompetencies to support using the directives

OR

- Complete the same due diligence steps using existing setting specific methods

2. Develop Proper Directive

Complete:

Medical directive(s) using the:

- **M-3 - Prototype Directives**
- **M-4 - Sample Directive Pre-printed Orders and ED Record**

OR

- Use already existing directives and tools

3. Obtain Team Input and Agreement

Identify and Consult:

Relevant stakeholders, particularly co-implementers using the:

- **M-1 - Performance Readiness Assessment** (Section 11) to identify stake-holders and guide consultations

OR

- Use already existing processes

4. Obtain Approvals

Assure Sign-off:

By physicians and staff using:

- **M-6 - Approval Forms**:
  - o Physician (Staff, Chief, Locum, New)
  - o Administrative

OR

- Use already existing processes

Physicians and Staff Begin to Practice Using Medical Directives

5. Renew Directives at Planned Intervals to Ensure They Remain Appropriate and Maintain Appropriate Corporate Records

Glossary of Terms[1],[2]

Interprofessional Term	Definition
Authorizing Mechanism	Device to sanction and enable performance of procedures, treatments, and interventions when such sanctioning is required by law, practice convention or circumstances including: • Controlled acts or restricted procedures authorized to a profession • Orders - direct orders and directives - and delegation • Practice setting mechanisms (e.g. privileges, assignments, role descriptions)
Order – Direct Order or Medical Directive	Direction given by a regulated health professional with legislative ordering authority to permit performance of a procedure. Orders are required by legislation (e.g. the Public Hospitals Act (PHA), 1990; Regulated Health Professionals Act (RHPA), 1991; Healing Arts Radiation and Protection (HARP) Act, 1990 and Laboratory and Specimen Collection Centre Licensing Act (LSCCLA), 1990), and must be provided by the profession authorized to order. There are two types of orders: • ***Direct Order*** – order given by a physician or authorizer upon assessment of the patient at the time. • ***Medical Directive*** – advance, written order given by a physician or authorizer prior to his or her direct assessment of the patient that identifies the specific conditions when the order can be implemented, and who is authorized to implement it. Directives may authorize an **implementer** to implement or activate the order and a **co-implementer** to carry it out. For example, a physician's order for labwork may be implemented by a nurse and carried out by medical laboratory technologist. In this scenario, the nurse is not ordering the labwork, but is implementing the physician's order, permitting the medical laboratory technologist to carry out the testing in compliance with their legislative requirements for a physician's order.
Authorizer	A regulated health professional authorized by legislation to give orders or prescriptions, permitting others to perform procedures or administer diagnostics and therapeutics in accordance with their legislative requirements for orders. In a hospital, those authorized to give orders and prescriptions are physicians, dentists, midwives, and for outpatients, RN(EC)s.

[1] For further information on relevant terms, see *An Interprofessional Guide on the Use of Orders, Directives and Delegation*, FHRCO, January 2007; *Delegation of Controlled Acts,* CPSO, February 2007; *Authorizing* Mechanisms, CNO, October 2007 and other health regulatory college materials.

[2] The prototype ED directives do not involve delegation in the RHPA sense, thus delegation is not mentioned in this glossary. For information regarding delegation, consult the references identified in Footnote 1 above, particularly the FHRCO Guide for an interprofessional perspective.

Interprofessional Term	Definition
Implementer	Someone authorized to implement and perform procedures or administer diagnostics and therapeutics ordered by a physician, or another health professional authorized to order.
Co-implementer	Someone authorized to perform procedures/administer diagnostics and therapeutics under physician orders implemented by another, subject to the co-implementer's: • Understanding that s/he is a designated co-implementer, and • Agreement with the order at the time. For an example involving co-implementers, see the Medical Directive description above.
Performance Readiness	Refers to the competencies – i.e. the demonstrated knowledge, skill and judgment – of practitioners to safely, effectively and ethically authorize or perform procedures and manage outcomes given the circumstances in a situation. It is determined by both individual competence and by the conditions within a practice setting that influence ability to practice competently. Assuring performance readiness of both practitioners and settings is a necessary precondition to authorizing and performing any test or procedure.
Circumstances in a Situation	Refers to the specific attributes in a practice setting that determine what competencies and conditions are necessary for safe, effective, ethical care that fulfills legislative and regulatory requirements. Circumstances in the situation include: • Patient condition and needs, • Team composition, competencies and care delivery processes, • Supervising physician competencies, supervision availability and practice preferences, and • Care setting characteristics such as the availability of supplies and resources and the capacity to develop and maintain delegation and directives.
Performance Readiness Assessment	A due diligence process undertaken prior to authorizing or performing any procedure to assure performance readiness and thus the appropriateness of authorizing and performing the procedure. See **Module 1**, Performance Readiness Assessment.
Performance Readiness Plan	An education and learning plan for use when a more involved, formal competency acquisition program, and/or recordkeeping is desirable. See **Module 3**, Performance Readiness Plan.

Frequently Asked Questions (FAQs)[3]

FAQs for Physicians (Of Interest to the Team)

1. **I have read the definition of a medical directive in the glossary of terms and the college references. Can you describe it in terms of everyday ED practice?**
2. **Why do we need medical directives in an ED?**
3. **Who needs to be involved in developing an ED directive and who needs to sign off?**
4. **Why do all staff physicians need to sign directives?**
5. **As a physician, what can I expect from the hospital, ED administration and from the nurses/staff acting on the directive if I sign off?**
6. **As a physician, what should I do before I sign off?**
7. **Can the Chief sign off a directive on behalf of an ED physician (approval by proxy)?**
8. **What about patients who Leave Without Being Seen (LWBS)?**
9. **Will the use of directives increase unnecessary tests and procedures?**
10. **Is this kit saying directives are a substitute for timely assessment of patients by a physician?**
11. **Why a provincial project on directives?**
12. **Once we establish directives, how often do we have to routinely renew them, and do they need to be re-approved by everyone?**

FAQs for the Entire Team

13. **Why do we need orders in an ED?**
14. **When can the order be in the form of a medical directive?**
15. **I have read the physician's FAQ document regarding who to involve in developing, reviewing and signing off directives (#3). Can you describe this in more detail?**
16. **As a nurse, how do I know when a directive is a proper order and I am fully authorized to implement a procedure pursuant to it?**
17. **When I implement a directive for a patient, what do I have to document?**

[3] Sources: *Delegation of Controlled Acts,* CPSO, February 2007; *Authorizing* Mechanisms, CNO, October 2007; An Interprofessional Guide on the Use of Orders, Medical Directives and Delegation, FHRCO, January 2007 and other health regulatory college materials.

18. **We place a copy of the directive in the chart when a directive is implemented. Is this necessary?**

19. **We work in the hospital Pharmacy, the Laboratory and in Diagnostic Imaging. When an order sheet or requisition comes to us, signed off by someone other than a physician, how do we know it is a proper order, and are therefore authorized to carry it out?**

20. **As an administrative staff member, what do I need to do to assure proper use of directives?**

21. **What does 'prototype' medical directive mean and why have the medical directives in Module 3 been developed as 'prototypes'?**

22. **How were the orders chosen for the prototype directives?**

23. **Why are the prototypes set up by orders and not by presenting complaints? Do we need to change our directives to this format?**

24. **The CEDIS Presenting Complaint Table (Module 5) makes sense. Why can't we just use it as the directive?**

25. **Do we have to use pre-printed orders to document implementation of the directives?**

26. **Why do the prototypes only apply to the period between when a patient arrives in the ED to first contact with the attending physician?**

27. **I notice the directives designate nurses as authorized to implement directives. Can other staff members be designated as implementers as well?**

28. **The nurses in our ED need a more extensive orientation to implement orders for extremity x-rays. What should be included in their orientation?**

29. **How detailed does the information in a directive need to be?**

30. **Can we adopt the prototype directives word for word?**

FAQs for Physicians (Of Interest to the Team)

1. I have read the definition of a medical directive in the glossary of terms and the college references. Can you describe it in terms of everyday ED practice?

In an ED, a medical directive is an order that you would usually give verbally or in writing on behalf of a patient, only the order is for all patients meeting specific criteria. It enables nurses or other members of the health care team to anticipate common orders and act on them before the physician has a chance to see the patient.

2. Why do we need medical directives in an ED?

In most EDs, nurses may perform interventions that, strictly speaking, require a medical directive. Common examples include starting an IV or placing oxygen on a patient. Empowering nurses to act before the physician has seen the patient allows certain basic emergency procedures to be completed more quickly and efficiently, leading to safer patient care and better patient flow. Consider two patients arriving with chest pain, one to an ED with all the directives suggested here and the other to an ED with no directives. The first patient will have the nurses start an IV, apply oxygen, obtain an EKG, send standard bloodwork and will be given ASA by the time the physician sees the patient. The other will only have their clothes removed and will be lying in a stretcher waiting for the physician to arrive. Clearly, directives can make our departments function better. Many EDs would perform some or all of the interventions suggested in the first ED without a formal set of directives; however, it is in everyone's best interest to bring practice into full compliance with all of the rules and regulations governing patient care.

3. Who needs to be involved in developing an ED directive and who needs to sign off?

The specific people to develop, review and sign off on directives and the extent to which they become involved may vary depending on the directive and hospital-specific roles and responsibilities. Those who need to sign off include:

- All physicians whose patients may receive a test or procedure under authority of a directive;
- Representatives of those implementing the directive;
- Those with administrative responsibilities for ED practice (e.g. Chief, Manager, Director);
- Those affected by the directives (e.g. physicians and staff of Diagnostic Imaging and Laboratory Services); and,
- Corporate committees with responsibility for practice (e.g. Pharmacy and Therapeutics Committee, Medical Advisory Committee. Approval by Medical Advisory Committee may or may not be required, depending on medical policy within the hospital).

4. Why do all staff physicians need to sign directives?

In the ED, at the time a patient arrives, the nurses can't always know who will become the attending physician for that patient. For a directive to be implemented safely, a physician will have to assume the care of the patient, including following up on the consequences of the directives such as interpreting results of diagnostic tests or assessing the effect of therapeutic interventions. By signing the directive, physicians indicate that they are aware of the existence of the directive, agree with its intent and are prepared to assume the care of patients for whom directives have been implemented (assuming that they are properly notified of the directives' implementation). If only some physicians sign off, it would be awkward or impossible for nurses to remember which directives had been signed by which physicians and to anticipate which physicians would be

assuming care of which patients. Thus, directives must represent only those interventions for which a consensus exists and all physicians must approve.

5. As a physician, what can I expect from the hospital, ED administration and from the nurses/staff acting on the directive if I sign off?

It is the responsibility of the hospital to provide a forum for development, review and approval of medical directives, including sign off by the hospital Medical Advisory Committee. It is also the hospital's responsibility to establish a means by which a record of the directive is appropriately maintained in accordance with applicable recordkeeping standards to ensure that the version that applies for any episode of care is readily accessible, enabling physicians, staff and the hospital to provide appropriate care and fulfill practice expectations when using directives.

The ED leadership team must ensure that the directive is properly written, articulates the patient populations and circumstances the directive is to be used for, and defines how this is to be recorded and reported.

Next, it is the ED leadership team's responsibility, along with nurses and regulated implementers themselves to ensure that they have the competencies and as necessary, the appropriate training to implement the directive. Competencies and training need to include patient assessment and screening, the indications and contraindications for implementing the directive and knowing how to record and report that the directive has been implemented.

The staff members using the directive in the ED are responsible to ensure that they are competent and practicing according to the criteria documented in the directive. The various health regulatory colleges such as the College of Nurses of Ontario (CNO) and the College of Respiratory Therapists of Ontario (CRTO) have very explicit expectations regarding the use of medical directives.

The hospital and ED leadership teams are responsible for ensuring ongoing quality monitoring and renewal of the directive.

The tools and templates provided in Modules 1 though 6, or hospital-specific ones, can be used to demonstrate fulfillment of these expectations.

6. As a physician, what should I do before I sign off?

You should review the directive to verify that you:

- Agree with its content, that it is an intervention that can be implemented safely and effectively, given the circumstances in your ED as you understand them;
- Are prepared to assume the care of patients who have had an intervention performed as authorized by the directive;
- Know how the staff will document or make you aware that a directive has been implemented so you can assume care appropriately;
- Consider the consequences on patient care if there is no directive, that is, balance the risk of the directive against the risks that may occur in the absence of a directive (usually related to delays in patient care).

If you are a regular staff member in an ED and you are presented with new directives, you should be sure you agree that the directive reflects what you understand to be clinical consensus in your ED. This is your opportunity to provide suggestions on directive content.

If you are a temporary or locum physician, you are likely neither able nor prepared to do such a detailed review. However, you still must familiarize yourself with the existing directives and processes at this ED as part of your orientation, just as you would familiarize yourself with consultant coverage, admitting processes, etc. before starting work.

Any physician who does not agree with the directive should take it up with the Chief of Staff (Chief).

We have provided some resources to ease the administrative and clerical burden on physicians through the use of batch directive sign-off forms and proxy forms, permitting Chiefs to sign off on directives for attendings under specified conditions. These are provided for convenience to be applied appropriately given the wide range of staffing circumstances in Ontario EDs. They do not alter the need for every physician to be aware and supportive of directives in use in their EDs.

For sample prototype approval forms, see **Module 6** – Approval Forms.

7. Can the Chief sign off a directive on behalf of an ED physician (approval by proxy)?

Yes, as long as both parties – the Chief and ED physician – can ensure between them that the directive is communicated and agreed upon and that both have agreed in writing to this type of sign-off. When signing off by proxy, the Chief agrees to:

- Approve directives that are agreed to by the physician, and
- Ensure the physician is kept informed of the directive.

The physician agrees to:

- Review the directive to fully understand the conditions under which it will be implemented, including knowing how staff will document or make the physician aware that the directive has been implemented so s/he can assume care appropriately, and
- Assume the care of patients who have had an intervention performed as authorized by the directive.

ED Chiefs and physicians electing to use this option for sign-off must be comfortable with the joint responsibilities incurred. Avenues to address any differences that may arise should be established without compromising care and the accountabilities of staff involved in carrying out the directive. Either the Chief or physician can terminate the proxy at any time. If terminated, the ED physician would need to personally sign off on a directive.

See ‘Agreement for Chief to Approve Directive(s) on Behalf of ED Physician(s)” on p. 2, **Module 6** – Approval Forms for a sample method to facilitate sign-off by proxy.

8. What about patients who Leave Without Being Seen (LWBS)?

In theory, a patient who is competent and leaves the ED at any stage of their assessment leaves at their own risk. In practice, if diagnostics ordered under a medical directive return after the patient has left and present important new clinical information that might have influenced their decision, you will want to review this information and determine appropriate action. Each hospital should have a documented process in place to deal with patients who LWBS, and this should include patients who have had a medical directive implemented before they leave.

See Appendix A, p.19 for sample policy considerations.

The prototype directives contain information for how to deal with patients who LWBS (see **Module 3** – Prototype Medical Directives – Documentation sections).

9. Will the use of directives increase unnecessary tests and procedures? The CEDIS Presenting Complaints Table (Module 5) seems to indicate this by listing a whole series of tests and procedures to administer based on a presenting complaint.

Properly developed and applied directives should not increase unnecessary tests and procedures administered to patients. Instead, they optimize care by mandating physicians and teams to come to a consensus on practice issues and develop a consistent approach. In addition, time to key tests and interventions can be reduced improving care and satisfaction.

The CEDIS is not a directive, so it cannot authorize unnecessary tests and procedures. Rather, nurses may use it as a quick reference to determine what the full range of ED directives permit, but must still refer to each specific directive to determine exactly when a test or procedure may be performed.

10. Is this kit saying directives are a substitute for timely assessment of patients by a physician?

No, directives are not a substitute for timely assessment of patients by physicians. Patient specific orders provided by a physician who has seen and assumed care of a patient remain the gold standard for patient care. Proper directives authorize designated staff to carry out orders and expedite care before a physician is able to see a patient, but only when it is safe, effective and ethical to do so.

11. Why a provincial project on directives?

There is a lot of confusion in the province about many aspects of directives, including the correct process to follow in establishing directives, the responsibilities of signing physician staff and a lot of variation in directive use from ED to ED. Our project was intended to clarify these issues, assist EDs in developing or adapting their programs to be in full compliance with all governing legislation, and to create a set of directives that represents a broad consensus of physician and nursing experts in the field. We hope this process will lead to some consistency from site to site in directive content, and broaden the use of directives in order to improve patient care and patient flow in Ontario EDs. We do *not* intend this package to become a standard or required set of directives; rather our work is a resource that each ED can use or adapt as it sees fit.

12. Once we establish directives, how often do we have to routinely renew them, and do they need to be re-approved by everyone?

Directives are routinely reviewed and renewed as often as you deem appropriate, given hospital policy and the circumstances in your ED.

All parties are expected to sign off on renewals and changes. However, some parties may agree that if changes are not substantive, they do not need to sign off every time. For example, the Lab may agree that adding a commonly accepted indication to a lab test may not warrant review and sign-off by their representatives. However, if a change has cost, equipment or specimen processing implications, review and sign-off by the Lab would be warranted.

Regardless of decisions regarding sign-off, all those involved in implementing directives should always be notified of any changes.

FAQs for the Entire Team

13. Why do we need orders in an ED?

In hospitals, orders -- either direct orders or directives -- from a physician are necessary to comply with requirements to permit diagnostic procedures and treatments under the *Public Hospital's Act* (PHA), performance of controlled act procedures under the *Regulated Health Professions Act* (RHPA) and performance of restricted acts under other pieces of health legislation, such as the *Healing Arts Radiation and Protection Act* (HARP Act) and *Laboratory Specimen and Collection Centre Licensing Act* (LSCCLA). Failure to have an order in place, when necessary, is a contravention of legislation, subject to penalties for staff and the hospital, including fines, jail terms, findings of professional misconduct and litigation proceedings.

For further information regarding orders, directives and legislative and regulatory expectations, see the CPSO, CNO and FHRCO guidelines along with other regulatory college materials

14. When can the order be in the form of a medical directive?

In any situation where an order is required, a medical directive may be used when it is appropriate to enable staff to implement procedures prior to a physician's assessment of the patient at the time. It is appropriate to use a directive when it is in the patient's best interests and the steps for establishing it can be fulfilled (see Steps for Establishing Directives, Guidelines, p.2).

15. I have read the physician's FAQ document regarding who to involve in developing, reviewing and signing off directives (#3). Can you describe this in more detail?

Basically, because of the nature of a directive, anyone affected needs to know about it and may be involved in developing, reviewing or signing off on it, depending upon their hospital-specific roles and responsibilities.

Those who may be ***involved*** in developing directives include:

- Chief physician or designate and, as desired, physician representatives.
- Representatives of implementing staff (e.g. educators, staff nurses).
- As desired, representatives of co-implementing staff (e.g. pharmacists, medical laboratory technicians, medical radiation technologists), to the extent they would like to be involved. They may wish to simply review it prior to approval.
- ED administrative staff (e.g. manager).

Those affected by implementation of the directive may ***review*** it prior to approval to ensure it is appropriate from their perspective. This includes:

- Chief physicians and representatives of co-implementing groups such as Laboratory and Diagnostic Imaging.
- Consulting physicians (representatives), when directives may affect their care of a patient. For example, Internal Medicine or Cardiology consultants may wish to review directives for patients with chest pain. (Note: These prototype directives do not contain orders warranting consulting physician review; however, EDs considering adding orders or conditions would want to keep this point in mind.)
- Corporate administrative staff and committees (e.g. Director of Nursing, affected professional practice leaders, professional practice committees).

Those who have accountabilities for practice as a result of the directives need to ***sign off*** including:

- Anyone involved in development ;
- Laboratory and Diagnostic Imaging Department (representatives);
- Administrative staff and committees in accordance with hospital-specific organizational structures and roles and responsibilities (e.g. program administrators and committees, relevant professional practice committees); and,
- Corporate committees, e.g. Pharmacy and Therapeutics Committee (for directives involving medications) and Medical Advisory Committee (MAC) (depending on hospital medical policy, MAC may not need to sign off).

The Modules contain forms to facilitate development, review and sign-off by those involved. See:

- **Module 1** – Performance Readiness Assessment, Section 14 – for a list to plan who should review and/or sign off on the directives
- **Module 2** – Performance Readiness Plan, Performance Readiness Forms – for forms enabling implementers to sign-off
- **Module 3** – Prototype Directives, Administrative and Physician Approval sections – to record approvals
- **Module 6** – Approval Forms – to obtain approval signatures

16. As a nurse, how do I know when a directive is a proper order and I am fully authorized to implement a procedure pursuant to it?

You would know you are authorized to implement a procedure under a directive when the Steps for Developing ED Directives (p. 2, Guidelines) have been fulfilled such that:

- The directive has been properly constructed – i.e., it contains specific orders, for specific circumstances under specific conditions, including indications and contraindications, designated implementers, provisions for consent, documentation and quality monitoring -- and those affected have provided input and agree it's appropriate.
- The ED Chief and all attending physicians have signed off, along with locums and casual physicians (who may sign off at the outset of a shift).
- Relevant hospital authorities - e.g. representatives of implementers, lab and diagnostic imaging and administrators (such as ED manager, Pharmacy and Therapeutics Committee, MAC) - have agreed and/or have signed off.
- You are competent and have successfully completed any necessary orientation and training to qualify as a designated implementer.

The modules contain templates and forms to facilitate nurses in determining when they are authorized to implement a procedure under a directive.

17. When I implement a directive for a patient, what do I have to document?

Communication and documentation of directive implementation is critical to providing safe care. When you implement a directive, you must document the following in the designated section of the patient record:

- Specific order,
- Name and number of the medical directive,
- Name of the attending physician (where known),
- Your name and signature, and

- Conditions for implementing the directive, implementation and patient response.

It is recommended that you document the specific order in the order section of the chart, and the information pertaining to implementation and patient response in the progress notes, nursing notes, or appropriate form (e.g. medication administration record).

The prototype medical directives contain a documentation section with information on how to document the use of directives (see **Module 3**).

18. We place a copy of the directive in the chart when a directive is implemented. Is this necessary?

Placing the directive in the chart is one way of recording implementation of a directive that readily provides a record of the orders implemented and the conditions that have been assessed to permit implementation. Other options range from writing out the orders and conditions on the order sheet and in the progress notes respectively to developing preprinted forms, or using electronic methods. Each method has its pros and cons. The main features necessary for any method include:

- Ensuring the required information -- medical directive name and number, name and signature of the implementer and where known, the name of the attending physician – are included. When EDs have more than one attending physician at a time, the directive may be implemented before the specific attending is identified. All attendings sign off on the directive in anticipation of its use, and are responsible for it as their order.
- Ensuring capacity to readily identify the content of the full directive at the time it was implemented. This means retaining a copy of the directive for the same time it is necessary to retain patient records, for a period of at least 10 years or much longer in some cases.

The documentation and communication section of the prototype directives contains information regarding documenting directive implementation (see **Module 3**). Samples of possible pre-printed orders along with a sample ED record are also available (see **Module 4**).

19. We work in the hospital Pharmacy, the Laboratory and in Diagnostic Imaging. When an order sheet or requisition comes to us, signed off by someone other than a physician, how do we know it is a proper order, and are therefore authorized to carry it out?

A medical directive is proper when the Steps for Developing ED Directives (see Guidelines, p. 2) have been fulfilled. This is indicated when the order sheets, requisitions or requests for consultation specifically refer to the directive in compliance with recommended format identifying the:

- Specific order;
- Name and number of the medical directive;
- Name of the attending physician (where known, when EDs have more than one attending physician at a time, the directive may be implemented before the specific attending is identified); and,
- Name and signature of the nurse or implementer implementing the order/directive

This information may be written out on the order sheet or requisition, or parts of it may be pre-printed. See **Module 4** for Sample Pre-printed Orders that may be used with the prototype directives along with a Sample ED Record for recording implementation of directives.

This information on how to properly document directive orders is identified in the Documentation and Communication section of the prototype directives (see **Module 3**).

20. As an administrative staff member, what do I need to do to assure proper use of directives?

Ensure that the necessary infrastructure and processes exist to enable staff to develop, review and maintain directives and to work with them safely, effectively and ethically, in accordance with regulatory and legislative requirements. This includes enabling physicians and staff to:

- Determine the appropriateness of using a directive;
- Participate in developing and approving directives;
- Readily sign-off;
- Set up and participate in any necessary orientation/training;
- Readily confirm at the point of care that the directives constitute a proper order, with necessary content and approvals;
- Appropriately document directive implementation;
- Maintain the directives on an ongoing basis, with quality monitoring including monitoring and documenting compliance with the directive, and renewal as appropriate, in fulfillment of the steps for establishing ED directives (p. 2, Guidelines).

You also need to agree to and sign off on the directives, addressing your/the hospital's accountability for ensuring appropriate practices for staff within the hospital.

The Modules contain sample tools and directive prototypes for fulfilling these responsibilities.

21. What does 'prototype' medical directive mean and why have the medical directives in Module 3 been developed as 'prototypes'?

The directives in **Module 3** have been developed as prototypes and not as directives proper because each ED must establish its own directives that suit its specific circumstances, such as patient characteristics, team competencies, hospital and physician practice patterns and care delivery models. The prototype directives offer a consensus-based sample to draw upon and adopt to suit each ED's circumstances.

22. How were the orders chosen for the prototype directives?

The orders were chosen based upon common ED practice patterns, directives and best practices identified by working group members. Each order had to fulfill the following criteria:

- Enhancement of patient flow
- Evidence-based
- Sustainable (practices unlikely to change or require updating)
- High volume (used for frequently encountered presentations)
- Practical (may be implemented by staff at all levels of experience)
- Relevant (applicable across all EDs)

23. Why are the prototypes set up by orders and not by presenting complaints? Do we need to change our directives to this format?

The prototypes have been set up this way to facilitate use, and to foster sharing and evaluation. If you find the format useful, you may wish to adopt it. However, you do not have to change your directives to this format, or ever adopt it if it does not suit your needs.

24. The CEDIS Presenting Complaint Table (Module 5) makes sense. Why can't we just use it as the directive?

The CEDIS Presenting Complaints Table can't be used as the directive on its own because it doesn't contain the indications, contraindications and other information necessary for a proper directive. However, it can be used as a quick reference or prompt once staff is fully familiar with the information in the directives. As well, using the CEDIS presenting complaints framework may offer a means of evaluating the effect of the directives on patient flow.

25. Do we have to use pre-printed orders to document implementation of the directives?

No, you do not have to use pre-printed orders. The Sample Pre-printed Orders corresponding to the prototype directives in **Module 4** are presented for your reference and convenience, in the event you would like to use them to develop pre-printed orders for documenting your ED directives.

26. Why do the prototypes only apply to the period between when a patient arrives in the ED to first contact with the attending physician?

The prototypes have been written to apply only to this period to coordinate care and minimize margins for misunderstanding, oversight and error. Once the attending ED physician sees the patient, s/he can provide orders and there is no confusion regarding how orders will be given and who is responsible. In developing your own directives, each ED can decide if this is the preferred approach for coordinating care under directives, or if you prefer to coordinate in another fashion.

27. I notice the directives designate nurses as authorized to implement directives. Can other staff members be designated as implementers as well?

This is to maximize clarity of the information being conveyed, and because all EDs are staffed with nurses. However, any practitioner with the necessary competencies, given the circumstances within an ED may be designated to implement a directive.

28. The nurses in our ED need a more extensive orientation to use a directive for extremity x-rays. What should be included in their orientation?

A more extensive orientation is often warranted to enable nurses to implement a physician's directive order for extremity x-rays safely and effectively. The components of such an orientation would include the following:

- Review of anatomy and physiology of upper and lower extremities
- History and objective assessment of limb injuries (i.e. mechanism of injury, CSM, Ottawa knee, ankle and foot rules)
- Common injury patterns as it relates to limb injuries
- Contraindications for initiation of medical directive (i.e. CSM deficits, open fracture, obvious dislocation, pregnancy, etc.)
- Documentation requirements to initiate medical directive (i.e. limb to be x-rayed, inclusion of brief history with mechanism of injury, CSM status, weight bearing, pregnant, etc.)

The prototype directive for extremity x-rays identifies relevant references and websites (see the Diagnostic Imaging Directive in **Module 3** - Prototype Directives), along with Sample Quiz Questions and Answers and a Sample Extremity X-ray Medical Directive Certification Record that identifies competency requirements (see **Module 2** - Performance Readiness Plan).

29. How detailed does the information in a directive need to be?

A directive needs to be detailed enough to ensure that anyone implementing it has the information necessary to make exactly the same decision as the ordering physician would make about what to do for whom, and when. Additionally, it must clearly identify how implementation is documented, and how to manage any untoward outcomes so all team members can coordinate to ensure safe, effective care.

30. Can we adopt the prototype directives word for word?

Yes, if they apply word for word to the circumstances in your ED.

Appendix A

Sample Policy Considerations For Patients Who Leave Without Being Seen (LWBS)

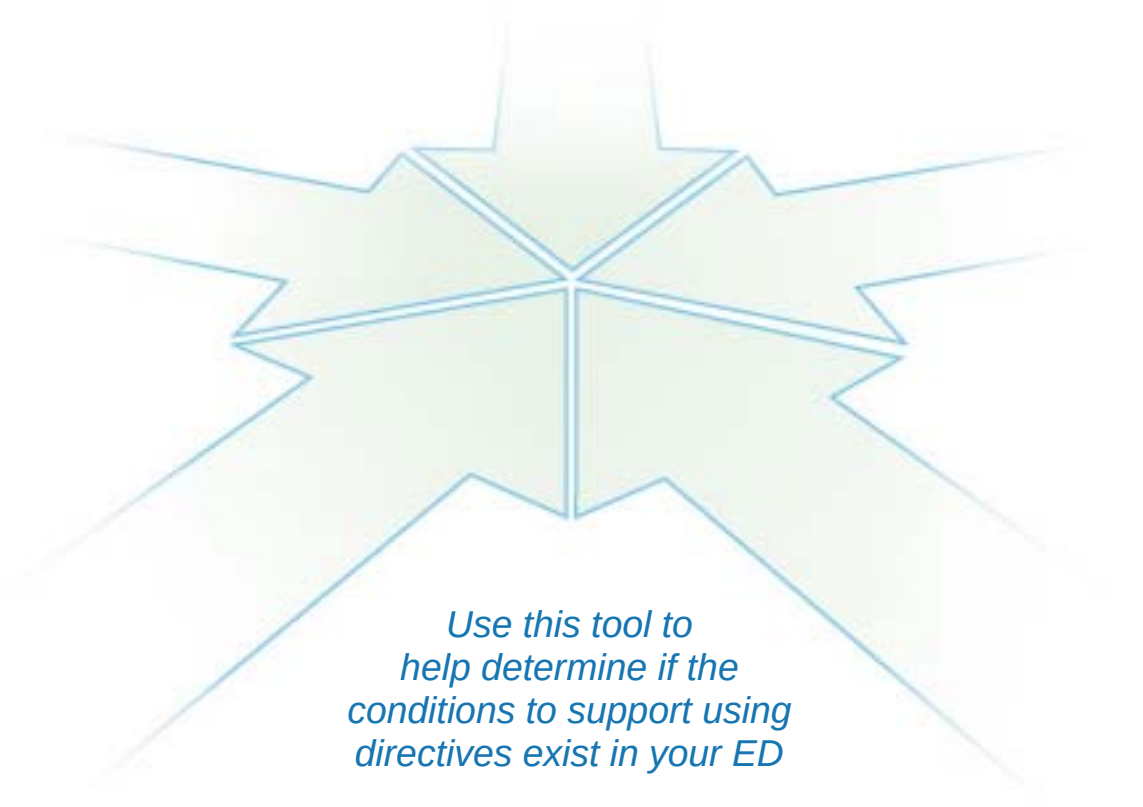
- Clarify that the decision to LWBS is the patient's and that LWBS is actively discouraged by staff.
- Assign a physician to be responsible for LWBSs on each shift.
- Establish a guideline for what warrants patient notification after a patient has left – e.g. abnormal results – and that the decision to notify needs to be made on a case-by-case basis by the assigned physician in light of the information s/he has at hand.
- Identify what the triage/assigned nurse is expected to do, for example:
    - Contact physician immediately, prior to the patient leaving, if the patient's capacity or condition are a concern
    - Ensure the chart is complete, with the record of results available for review by the physician (may assign this to support staff if appropriate)
    - Participate in patient notification as indicated, once the physician has determined the appropriate action based on his/her review of the chart
- Identify how and where to document.
- Identify whom to notify corporately in the event of any issues.

Hospital Logo

MODULE 1

Performance Readiness Assessment

ED Prototype Medical Directives Module 1 of 6



Use this tool to help determine if the conditions to support using directives exist in your ED

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Performance Readiness Assessment

For Determining the Appropriateness of Establishing Directives, Delegation and Performing Procedures beyond Principal Expectations of Practice

Template from: An Interprofessional Guide on Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Title/Procedure:	ED Medical Directives
Applicable Authorizing Mechanism:	☐ Delegation ☒ Medical Directive ☐ Direct Order ☐ Unnecessary
Authorizing Profession:	
Implementing Profession:	
Patient(s):	
Disposition:	☐ Approved ☐ Being forwarded for Approval ☐ Not Approved
Date:	

Sponsors *(This section for use in large multi-professional settings)*.

Representative(s) of Authorizing Profession:	
Representatives(s) of Implementing Profession:	
Administrative Representative(s):	

Have all applicable stakeholders been consulted: *(See Section 11 for list)*	☐ Yes	☐ No	
Is a completed Medical Directive or Delegation template attached:	☐ Yes	☐ No	☐ N/A
Is a completed Performance Readiness Plan attached:	☐ Yes	☐ No	☐ N/A

Assessment Parameters

1. Reason and Specific Benefits of the Directive or Delegation:

1.1. Does establishing the directive or delegation address patients' best interests? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

2. Authorizer:

Does the authorizer**:**

2.1. Have the scope, authority from their college, competencies and privileges (where applicable) to authorize performance? ☐ **Yes** ☐ **No** ☐ **Unsure**

2.2. Have an established or anticipated professional relationship with the patient? ☐ **Yes** ☐ **No** ☐ **Unsure**

2.3. Agree the directive applies to all his/her patients who meet the conditions? ☐ **Yes** ☐ **No** ☐ **Unsure**

2.4. Have the ability to provide ongoing supervision directly, or are other provisions for appropriate supervision in place? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

3. Implementer:

Does the implementer:

3.1. Have the scope and authority from their own college (where applicable) to perform the procedure(s) ☐ **Yes** ☐ **No** ☐ **Unsure**

3.2. Have the baseline competencies to perform the proposed procedure(s) and manage the outcomes given the:

3.2.1. predictability of the patient's condition and needs,

3.2.2. predictability of the procedure and its outcomes, and ☐ **Yes** ☐ **No** ☐ **Unsure**

3.2.3. circumstances in the situation including resources and safeguards (such as established standards of practice, written materials, back-up and supervision), and opportunities to attain and maintain competence?

Comments:

4. Consent:

4.1. Can informed consent be properly obtained? ☐ **Yes** ☐ **No** ☐ **Unsure**

Comments:

5. Review and Quality Monitoring Processes:

5.1. Is there a process in place to ensure a regular review of the directive or delegation? ☐ Yes ☐ No ☐ Unsure

5.2. Is there a process in place to address questions or concerns arising from the directive or delegation? ☐ Yes ☐ No ☐ Unsure

Comments:

6. Practice Setting Feasibility

6.1. Are the necessary human and material resources available to support the practice? ☐ Yes ☐ No ☐ Unsure

6.2. Is the practice sustainable? (For example, can new staff readily adopt the practice? If intensive resources are required to support the practice over the longer-term, is this feasible?) ☐ Yes ☐ No ☐ Unsure

6.3. Does the practice broadly support effective health care delivery? (For example, if implementers are responsible for implementing the directive or delegation or performing the proposed procedure, will other services only they can provide be disrupted? Will other team members or care delivery systems be negatively impacted? Can these effects be offset?) ☐ Yes ☐ No ☐ Unsure

6.4. Can any billing, cost or liability considerations be appropriately managed? ☐ Yes ☐ No ☐ Unsure

6.5. Are there any other situation-specific factors to consider? ☐ Yes ☐ No ☐ Unsure

Comments:

7. Risk/Benefit Analysis:

7.1. Do the benefits of proceeding by way of the directive, delegation or practice outweigh the risks? ☐ Yes ☐ No ☐ Unsure

Comments:

8. Education and Performance Readiness Plan:

8.1. Is there a plan for enabling implementers to attain the necessary competencies and achieve performance readiness? (Identify a basic plan here, or where the plan is more involved, refer to the Performance Readiness Plan.) ☐ Yes ☐ No ☐ Unsure

Comments:

9. Communication Plan:

9.1. Is there a plan for informing stakeholders and for activating the directive, delegation or practice? ☐ Yes ☐ No ☐ Unsure

Comments:

10. References to Support Practice:

10.1. Are there references to support practice? (References may be listed here or attached) ☐ Yes ☐ No ☐ Unsure

Comments:

11. Those Consulted for Input:

11.1. Have all affected stakeholders been consulted? List those consulted in the table below. Add or delete stakeholders to correspond to your practice setting. ☐ Yes ☐ No ☐ Unsure

Comments:

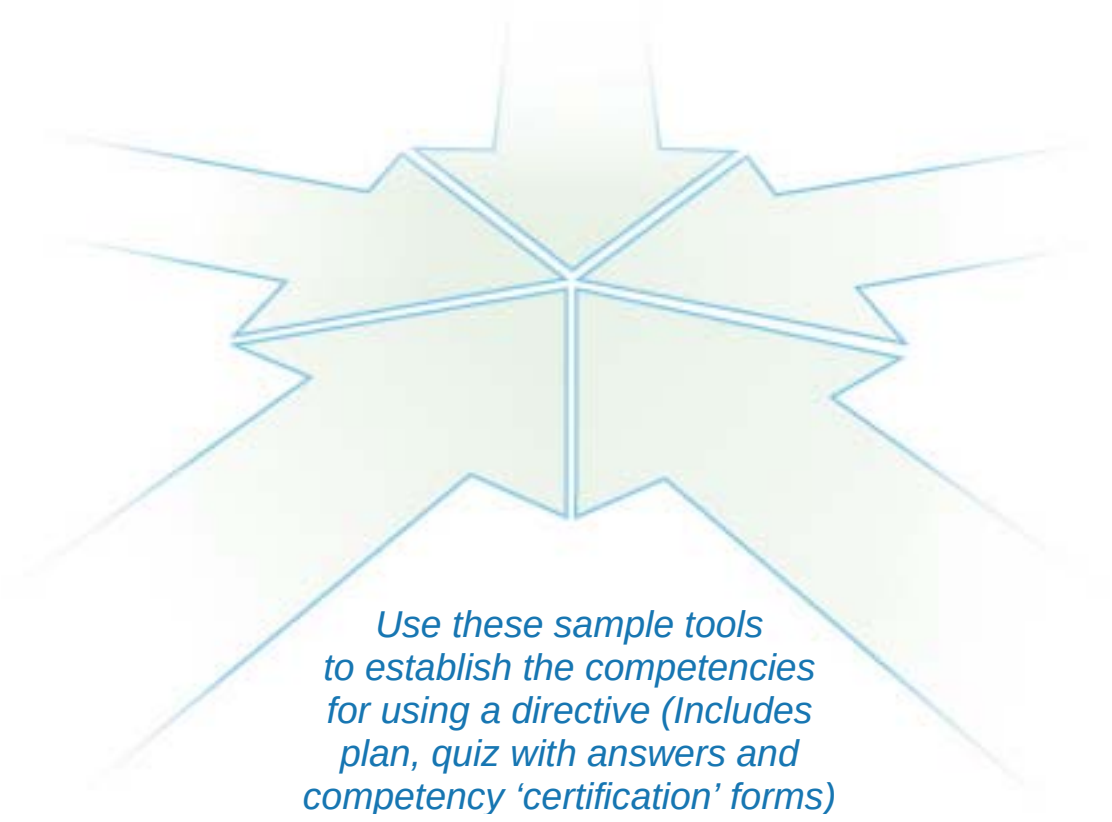
Stakeholders Consulted	Names/Positions	Agree?
1. Authorizers		☐ Yes ☐ No
2. Implementers: • Implementer(s) or representatives • Co-implementers (if applicable) • Educators (if applicable)		☐ Yes ☐ No
3. Administrators (List)		☐ Yes ☐ No
4. Professional Leaders of: • Authorizers • Implementers • Co-implementers (if applicable)		☐ Yes ☐ No
5. Applicable profession-specific groups/committees of: • Co-implementers (if applicable)		☐ Yes ☐ No
6. Program/Corporate Committees (List)		☐ Yes ☐ No
7. Pharmacy & Therapeutics Committee		☐ Yes ☐ No
8. Medical Advisory Committee		☐ Yes ☐ No

Hospital Logo

MODULE 2

Performance Readiness Plan

ED Prototype Medical Directives Module 2 of 6



Use these sample tools to establish the competencies for using a directive (Includes plan, quiz with answers and competency 'certification' forms)

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Acknowledgements:

Performance Readiness Plan Template and Implementer Performance Readiness Implementer Forms from An Interprofessional Guide on the Use of Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Sample Quizzes provided by Southlake Regional Health Centre (Laboratory Tests and Diagnostic Procedures), Mount Sinai Hospital (Extremity X-Rays), Grand River Hospital (Medications) and North York General Hospital (Therapeutic Procedures and Paediatrics)

Sample Extremity X-Ray Medical Directive Certification Form provided by North York General Hospital

Performance Readiness Plan

From: An Interprofessional Guide on the Use of Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Procedure: _____

Date: _____

Plan Endorsed by:
(name, position, signature) _____

Designated Educators
(if applicable; name, position, signature) _____

1. Competence and Authority of Educator(s) (if applicable)

Identify whether any applicable educators have the scope, authority from their College and competencies to perform and teach the procedure.

Comments:

2. Education Plan

Identify the:

2.1. Knowledge, Skills and Judgment Component (Attach any relevant slides, references and hand-outs).

For relevant information, see:

- Prototype ED Medical Directives Guidelines
- ED Medical Directives established for your ED identifying full clinical criteria and conditions. (Background: Prototype ED Medical Directives, **Module 3**)
- CEDIS Presenting Complaints Table, for a quick reference of directive orders by presenting complaints. Adapt to suit your ED-specific directives. (Background: **Module 5**)
- Extremity X-Ray Self-Learning Package. Adapt to suit your ED-specific directives. Appended.

2.2. Supervised Practice Component (If any).

2.3. Evaluation of Competence Component (Attach any relevant test materials).

For sample competence evaluation questions, see:

- Prototype ED Medical Directive Quiz. Adapt to suit your ED-specific directives. Appended.
- Performance Readiness Forms, Individual and Group. Appended.

Comments:

3. Plan for Assuring Ongoing Competence

3.1. Identify the plan for assuring ongoing competence.

Comments:

4. Practical Arrangements

4.1. Identify the arrangements for delivering the education, both initially and ongoing.

Comments:

Prototype ED Directive Quiz

Working with Medical Directives

1. Orders from physicians, dentists, midwives or for outpatients, RN(EC)s are required for treatments and diagnostic tests within a hospital.

   True False

2. Not having an order when one is required constitutes grounds for professional misconduct and may be subject to a fine or jail term.

   True False

3. The medical directives are _____ from ED attending physicians for _____ or interventions for a specific group of _____under specific _____.

4. A medical directive comes into force as a proper order once:
   a) Staff representatives have had input and agree with the directive.
   b) Relevant stakeholders (e.g. lab and diagnostic imaging) and administrators (e.g. ED manager, MAC) have signed off.
   c) All ED attending physicians have signed off, along with locums and casual physicians who may sign off at the outset of a shift.
   d) All of the above.

5. The CEDIS Presenting Complaints Table can be used as the medical directive.

   Yes No

6. Only staff members who have successfully completed the ED Medical Directive Orientation Program can implement procedures under authority of a directive, without a physician writing a direct order for the procedure.

   True False

7. To facilitate care and minimize margin for error due to lack of coordination, the directive applies to the period from _____ to _____. After this, the attending will provide direct orders (unless your ED sets up the directive differently, in which case, describe here).

8. Where in the patient record do you document:
   - The directive order, once you decide to implement it? _____.
   - Indications for implementation, implementation and patient response_____.

9. Documentation and communication of implementation of a directive is critical. Why?
   _____.

10. If an untoward or unanticipated outcome arises out of the use of the directive, you would contact the _____ for any matters related to patient care and _____ to follow-up on disposition for the directive.

11. A copy of the directive is available at _____.

12. Sign-off can be confirmed by _____.

Laboratory Tests and Diagnostic Procedures

1. A medical directive is not required for a nurse to order and perform a capillary blood glucose.
    a) True
    b) False

2. Serum drug screen is ordered under the medical directive for laboratory tests for the following patient presentations:
    a) reported ingestion
    b) altered LOC
    c) current warfarin use
    d) all of the above
    e) a and b

3. Urine for R&M should be sent when POCT urinalysis is positive for:
    a) Leukocytes
    b) Proteins
    c) Blood
    d) Nitrates,
    e) Glucose

Extremity X-rays

Ankle Injury:

A 26 year old female was playing baseball and slid into first base. She caught her foot on the base and the ankle rolled inward. She was not able to walk on it at the time of injury and still can not weight bear. The ankle is swollen and tender over the lateral malleolus, warm to touch, pedal pulse present.

1. Does she meet the Ottawa Ankle Rules criteria for an ankle x-ray? Yes No

Leg Pain

A 67 year old male presents with left ankle swelling and pain. There is no history of traumatic injury to the ankle and the patient is able to walk on it with a limp. There is moderate swelling to the entire lower leg, the foot is warm and the pedal pulse is present.

2. Does he meet the Ottawa Ankle Rules criteria for an ankle x-ray? Yes No

Foot Pain

A 20 year old male presents with right foot pain that began when he kicked in a door. He has pain in the midfoot zone. He has no other injuries and vital signs are within normal limits.

3. Which of the following findings would indicate he needs a foot x-ray?

a) A hematoma noted over the anterior foot
b) Tenderness at the lateral malleolus
c) Tenderness at the base of the 5th metatarsal

Great Toe Injury

A 40-year-old female arrives complaining of pain at the great toe. She caught her toe on a piece of furniture and felt it "snap backwards". The toe is swollen and bruised. She has no other injuries, no medical conditions and vitals are within normal limits.

4. Does she meet the criteria to have an x-ray? Yes No

Ankle Injury

A hospital employee arrives in the emergency department after Occupational Health closed. He twisted his ankle while pushing a stretcher. There is no swelling or deformity, the patient is able to walk on the injured ankle, the foot is warm and the pulse is present. There is no tenderness over the maleolus.

5. Does he meet the criteria to have an x-ray? Yes No

Left Heel Pain

A 50 year old male arrives complaining of pain over the left achilles. He was playing tennis and felt pain and a "pop" at the achilles when he lunged to hit the ball. The foot is warm, pedal pulse is present.

6. Does he meet the criteria to have an x-ray? Yes No

Ankle Injury

A 30 year old female arrives with her left foot angulated/dislocated. She slipped and twisted her ankle on the ice in her driveway while carrying groceries into the house. The foot is pale, cool and the pulse is barely palpable.

7. What is the most appropriate nursing action?

a) send the patient directly for x-ray
b) have her assessed by the physician immediately
c) splint the leg
d) apply ice

Right Knee Pain

A 19 year old male arrives complaining of right knee pain. He was ice skating and was pushed down. He landed on the ice on his right knee. The knee is swollen and painful.

8. What physical findings indicate that he requires a knee x-ray?

a) large amount of swelling
b) large hematoma
c) patellar tenderness
d) he is able to flex the knee and weight bear

Patellar Dislocation

A 20 year old with a history of patellar dislocation arrives in the emergency with obvious patellar dislocation. His knee is flexed and supported by a pillow, the patella is clearly dislocated. He is screaming in pain.

9. Should the nurse implement the medical directive to have the knee x-rayed? Yes No

Left Hand Injury

A 22 year old male arrives with a left-hand injury. He got angry and punched a hole in his apartment wall. His hand is swollen and painful, the fingers are pink.

10. Does he require an x-ray? Yes No

11. What injury does the nurse suspect?

a) boxers fracture base of the 5th metacarpal
b) fractured distal phalynx
c) the hand is an unlikely site for fractures

Right Wrist Pain

A 40 year old female arrives complaining of right wrist pain. She fell onto an outstretched wrist while skating. She has no other injuries and vital signs are within normal limits. Her wrist is painful, has an obvious deformity and swelling over the radial surface. The fingers are pink, she has no parasthesia and can move all fingers.

12. Does she require an x-ray? Yes No

13. What first aid measures can be done for this patient at triage?

a) _____
b) _____
c) _____

14. This same patient should be assessed for a scaphoid fracture. What physical findings would support the decision to order scaphoid views?

a) _____
b) _____
c) _____

Left Hand Pain

A 32 year old female slipped on the sidewalk and landed on an outstretched left hand. The injury occurred four days ago. She complains of arm pain and is not able to straighten the arm. She is not tender at the wrist, but she is tender at the lateral elbow.

15. What is the most appropriate x-ray?

a) Left elbow
b) Left elbow and wrist
c) Left forearm
d) Left wrist

16. All patients with orthopedic injuries should have the five Ps assessed and documented. What are the five Ps?

a) _____
b) _____
c) _____
d) _____
e) _____

17. List the contraindications for implementing orders for extremity x-rays.

a) _____
b) _____
c) _____

Medications

1. Which of the following statements concerning the administration of Acetaminophen or Ibuprofen for adult pain relief are correct:

a) Indicated for patients triaged as CTAS 3-5 with mild to moderate pain (≤ 7/10on pain scale)
b) Pain is related to headache, dental, ear, nose and throat, MSK or skin injuries
c) The primary clinical contraindication is abdominal pain
d) A single dose of Acetaminophen 975-1000mg or Ibuprofen 600mg can be administered either po or pr. If the preceding dose has been one of these medications, the other may be administered
e) all of the above

2. 32 year old Luke Razorblade presents to the ED complaining of a general body aches, sore throat and fever. His temperature at triage is 38.1°C. Given that he has not taken anything for the fever you can administer either Acetaminophen 975-1000mg or Ibuprofen 600mg po.

a) True
b) False

3. 66 year old Dennis Denial is triaged as CTAS 2 with chest pain (cardiac features) even though he insists it's just terrible indigestion from his Taco Bell lunch. One of the first drugs you will want to administer will be ASA 160 mg chewable tablet x 1 dose.

a) True
b) False

4. A 19 year old female with a history of substance abuse arrives by ambulance with an altered LOC and a blood sugar of 5mmol/L. Once you have established IV access you can administer the following:

a) Dextrose 50% (25 gms in 50mLs) IV push over 2-3 minutes
b) Narcan 0.4mg iv push
c) None of the above

5. In assessing a patient with a full thickness laceration, which of the following statements concerning the medical directive for tetanus immunization are correct:

a) presents with an open injury to the skin or eye
b) has completed their primary immunization and hasn't received a booster in 10 years
c) Td (Tetanus and Diptheria Toxoid) 1.0mLs is given IM in the deltoid muscle
d) A and B only
e) All of the above

6. 54 year old Drew Maurier presents to the ED with shortness of breath, B/P 150/92, P 110, RR 24,T 36.4, O2 Sat. 93%. In addition to burning the pack of cigarettes hanging out of his top pocket you want to administer Salbutamol (Ventolin) four to eight puffs or give a wet neb masking (5mg/mL);1 mL in 3 mL saline to assist his SOB. Before you can do this however, the following criteria must be met:

a) Patient has a history of asthma or COPD
b) Presents with dysphagia, muffled voice stridor and other symptoms of upper airway compromise
c) Presents with any of the following symptoms- cough ,presence of respiratory distress, wheeze, tightness or decreased breath sounds on chest auscultation
d) All of the above
e) A and C only

7. Any male patient requiring urinary catheterization who is not allergic to amide anaesthetics or has a known urethral trauma or structural abnormality can receive:

Lidocaine Jelly 2% 200mg/10mLs inserted into the urethra five minutes prior to catheterization to assist in comfort and ease of catheter passage

a) True
b) False

8. LET (Lidocaine,Epinephrine and Tetracaine) topical anaesthetic compound can be applied 30 minutes prior to suturing in which of the following situations:
    a) lacerations to the ear, nose, fingers and toes
    b) only lacerations that do not extend beyond the dermis
    c) lacerations that extends beyond the dermis to underlying structures (e.g.bone, cartilage, tendon, etc)
    d) A and C
    e) B only

9. 33 year old Sam Squint arrives from his work place after splashing a chemical in his left eye and is in a fair amount of discomfort. You have a medical directive to instill two drops of ophthalmic anesthetic eye drops to Sam's eye. Does he meet the criteria?
    a) Yes
    b) No

Another criteria for instilling these eye drops is in anticipation of Morgan Lens insertion pain caused by foreign body, thermal injury or corneal abrasion.
    a) True
    b) False

Therapeutic Procedures

1. A saline lock or peripheral IV may be initiated under the following circumstances:
    a) Signs of airway compromise, respiratory distress, shock, dehydration, bleeding, or altered LOC
    b) In anticipation of IV medication administration for pain control, blood and blood product administration, or to provide IV rehydration
    c) History of high risk mechanism of injury, infection in the immunocompromised patients, or overdose
    d) A and B only
    e) All of the above

2. Oxygen therapy may be initiated when the patient presents with signs and symptoms of one or more of the following:
    a) Respiratory distress, SaO2 </= 92%, or below established desirable range for the individual patient
    b) Hemodynamic instability
    c) There is evidence of suspected hypoxemia (chest pain, tachycardia, hemorrhage, hypovolemia, sickle cell, altered LOC, Trauma, smoke and/or toxin inhalation
    d) B and C only
    e) All the above

3. Eye irrigation with 1 L NS or Ringer's Lactate may NOT be initiated when…
    a) Penetrating eye trauma, foreign body in the eye, or signs and symptoms of ruptured globe (obvious bleeding)
    b) The patient has flushed prior to arriving in the ED
    c) The patient has not had topical ophthalmic anaesthetic instilled
    d) The patient has suffered a flash burn
    e) All of the above.

Paediatrics

1. Salbutamol and Ipratropium Bromide may be administered to a child when...
    a) The child presents with signs and symptoms of upper airway pathology e.g. stridor, drooling, muffled voice, dysphagia
    b) The child presents with audible wheezing, wheezing with retractions, spasmodic cough, dyspnea, tachypnea, or decreased air entry into lung fields on auscultation with a history of reactive airway disease
    c) The child presents with audible wheezing, wheezing with retractions, spasmodic cough, dyspnea, tachypnea, or decreased air entry into lung fields on auscultation with NO history of reactive airway disease
    d) A and B only
    e) None of the above

2. A three month old child was given a therapeutic dose of Acetaminophen two hours prior to arriving in the ED. The child's temperature is 38.5°C. I can administer Ibuprofen as per the mother's request.
    a) True
    b) False

3. The child presents to the ED with vomiting and diarrhea. The 20 kg child was started on ORT on arrival. The mother advises you the child vomited a moderate amount of emesis and just had a large watery stool while waiting in the room. You should:
    a) Stop giving the ORT as it will precipitate more vomiting
    b) The child should receive 1000 cc of ORT slowly and then be given 200cc ORT for every loose stool
    c) The child should receive 500 cc of ORT slowly and then be given 100 cc ORT for every loose stool
    d) We should start an IV to rehydrate the child
    e) None of the above

Quiz Answers

Working with Medical Directives

1. Orders from physicians, dentists, midwives or for outpatients, RN(EC)s are required for treatments and diagnostic tests within a hospital.

   True False

2. Not having an order when one is required constitutes grounds for professional misconduct and may be subject to a fine, jail term or being assessed damages in a civil proceeding.

   True False

3. The medical directives are **orders** from an ED attending physician(s) for **procedures**, **tests** or interventions for a specific group of **patients** under specific **conditions**.

4. A medical directive comes into force as a proper order once:

   a) It is clear the directive has been properly constructed – i.e. it contains all information necessary to make it a proper order (specific orders, designated implementers, indications and contraindications, consent, documentation and quality monitoring provision), and there has been an assessment of the appropriateness of use, with input and agreement from those affected by it.

   b) ED Chief and all attending physicians have signed off, along with locums and casual ED physicians (who may sign off at the outset of a shift).

   c) Relevant hospital authorities - e.g. representatives of implementers, lab and diagnostic imaging and administrators (such as ED manager, MAC) - have signed off.

   d) All of the above.

5. The CEDIS Presenting Complaints Table can be used as the medical directive.

   Yes **No**

   Because the table does not contain the indications, contraindications and other information necessary for a proper directive, it cannot be used as a directive on its own. It can be used as a quick reference or prompt once staff are fully familiar with the information in the actual directives.

6. Only staff members who have successfully completed the ED Medical Directive Orientation Program can implement procedures under authority of a directive, without a physician writing a direct order for the procedure.

   True False

7. If an untoward or unanticipated outcome arises out of the use of the directive, you would contact the attending physician for any matters related to patient care and **(Identify contacts for your ED)** to follow-up on disposition for the directive.

8. Where in the patient record do you document:
   - The directive order, once you decide to implement it? **(Identify where – orders sheets, pre-printed orders, triage record, etc)**
   - Indications for implementation, implementation & patient response? **(Identify where – progress notes, nursing notes, MAR, other documentation forms, etc)**

9. Documentation and communication of implementation of a directive is critical. Why?
Coordination of care, patient safety – an established, reliable means of documenting implementation of a directive enables the physician to assume medical care safely and effectively as well as enabling anyone else involved in care of the patient to coordinate care effectively.

10. If an untoward or unanticipated outcome arises out of the use of the directive, you would contact the attending physician for any matters related to patient care and **(Identify contacts for your ED)** to follow-up on disposition for the directive.

11. A copy of the directive is available at **(Identify where for your ED)**

12. Sign-off can be confirmed by: **(Identify how for your ED)**

Laboratory Tests and Diagnostic Procedures

1. A medical directive is not required for a nurse to order and perform a capillary blood glucose.
   a) True
   b) **False**

2. Serum drug screen is ordered under the medical directive for laboratory tests for the following patient presentations:
   a) Reported ingestion
   b) Altered LOC
   c) Current warfarin use
   d) All of the above
   e) A and B

3. Urine for R&M should be sent when POCT urinalysis is positive for:
   Leukocytes
   Proteins
   Blood
   Nitrates,
   Glucose

Extremity X-rays

Ankle Injury

A 26 year old female was playing baseball and slid into first base. She caught her foot on the base and the ankle rolled inward. She was not able to walk on it at the time of injury and still can not weight bear. The ankle is swollen and tender over the lateral malleolus, warm to touch, pedal pulse present.

1. Does she meet the Ottawa Ankle Rules criteria for an ankle x-ray? **Yes** No

Leg Pain

A 67 year old male presents with left ankle swelling and pain. There is no history of traumatic injury to the ankle and the patient is able to walk on it with a limp. There is moderate swelling to the entire lower leg, the foot is warm and the pedal pulse is present.

2. Does he meet the Ottawa Ankle Rules criteria for an ankle x-ray? Yes **No**

Foot Pain

A 20 year old male presents with right foot pain that began when he kicked in a door. He has pain in the midfoot zone. He has no other injuries and vital signs are within normal limits.

3. Which of the following findings would indicate he needs a foot x-ray?

a) A hematoma noted over the anterior foot
b) Tenderness at the lateral malleolus
c) Tenderness at the base of the 5th metatarsal

Great Toe Injury

A 40-year-old female arrives complaining of pain at the great toe. She caught her toe on a piece of furniture and felt it "snap backwards". The toe is swollen and bruised. She has no other injuries, no medical conditions and vitals are within normal limits.

4. Does she meet the criteria to have an x-ray? **Yes** No

Ankle Injury

A hospital employee arrives in the emergency department after Occupational Health closed. He twisted his ankle while pushing a stretcher. There is no swelling or deformity, the patient is able to walk on the injured ankle, the foot is warm and the pulse is present. There is no tenderness over the maleolus.

5. Does he meet the criteria to have an x-ray? Yes **No**

Left Heel Pain

A 50 year old male arrives complaining of pain over the left achilles. He was playing tennis and felt pain and a "pop" at the achilles when he lunged to hit the ball. The foot is warm, pedal pulse is present.

6. Does he meet the criteria to have an x-ray? Yes **No**

Ankle Injury

A 30 year old female arrives with her left foot angulated/dislocated. She slipped and twisted her ankle on the ice in her driveway while carrying groceries into the house. The foot is pale, cool and the pulse is barely palpable.

7. What is the most appropriate nursing action?

a) Send the patient directly for x-ray
b) Have her assessed by the physician immediately
c) Splint the leg
d) Apply ice

Right Knee Pain

A 19 year old male arrives complaining of right knee pain. He was ice skating and was pushed down. He landed on the ice on his right knee. The knee is swollen and painful.

8. What physical findings indicate that he requires a knee xray?

a) Large amount of swelling
b) Large hematoma
c) Patellar tenderness
d) He is able to flex the knee and weight bear

Patellar Dislocation

A 20 year old with a history of patellar dislocation arrives in the emergency with obvious patellar dislocation. His knee is flexed and supported by a pillow, the patella is clearly dislocated. He is screaming in pain.

9. Should the nurse implement the medical directive to have the knee x-rayed? Yes **No**

Left Hand Injury

A 22 year old male arrives with a left-hand injury. He got angry and punched a hole in his apartment wall. His hand is swollen and painful, the fingers are pink.

10. Does he require an x-ray? **Yes** No

11. What injury does the nurse suspect?

a) Boxers fracture base of the 5th metacarpal
b) Fractured distal phalynx
c) The hand is an unlikely site for fractures

Right Wrist Pain

A 40 year old female arrives complaining of right wrist pain. She fell onto an outstretched wrist while skating. She has no other injuries and vital signs are within normal limits. Her wrist is painful, has an obvious deformity and swelling over the radial surface. The fingers are pink, she has no parasthesia and can move all fingers.

12. Does she require an x-ray? **Yes** No

13. What first aid measures can be done for this patient at triage?

a) Application of ice
b) Application of splinting
c) Application of sling

14. This same patient should be assessed for a scaphoid fracture. What physical findings would support the decision to order scaphoid views?

a) Tenderness over anatomical snuffbox
b) Pain over scaphoid area with longitudinal loading of thumb

Left Hand Pain

A 32 year old female slipped on the sidewalk and landed on an outstretched left hand. The injury occurred four days ago. She complains of arm pain and is not able to straighten the arm. She is not tender at the wrist, but she is tender at the lateral elbow.

15. What is the most appropriate x-ray?

- **a) Left elbow**
- b) Left elbow and wrist
- c) Left forearm
- d) Left wrist

16. All patients with orthopedic injuries should have the five Ps assessed and documented. What are the five Ps?

- **a) Pain**
- **b) Pallor**
- **c) Pulselessness**
- **d) Paresthesia**
- **e) Paralysis**

17. List the contraindications for implementing orders for extremity x-rays.

- **a) Deficits in circulation, sensation, movement distal to injury**
- **b) Open fracture**
- **c) Pregnancy**

Medications

1. Which of the following statements concerning the administration of Acetaminophen or Ibuprofen for adult pain relief are correct:

- a) Indicated for patients triaged as CTAS 3-5 with mild to moderate pain (≤ 7/10on pain scale)
- b) Pain is related to headache, dental, ear, nose and throat, MSK or skin injuries
- c) The primary clinical contraindication is abdominal pain
- d) A single dose of Acetaminophen 975-1000mg or Ibuprofen 600mg can be administered either po or pr. If the preceding dose has been one of these medications, the other may be administered
- **e) All of the above**

2. 32 year old Luke Razorblade presents to the ED complaining of a general body aches, sore throat and fever. His temperature at triage is 38.1°C. Given that he has not taken anything for the fever you can administer either Acetaminophen 975-1000mg or Ibuprofen 600mg po.

- **a) True**
- b) False

3. 66 year old Dennis Denial is triaged as CTAS 2 with chest pain (cardiac features) even though he insists it's just terrible indigestion from his Taco Bell lunch. One of the first drugs you will want to administer will be ASA 160 mg chewable tablet x 1 dose.

a) True

b) False

4. A 19 year old female with a history of substance abuse arrives by ambulance with an altered LOC and a blood sugar of 5mmol/L. Once you have established IV access you can administer the following:

a) Dextrose 50% (25 gms in 50mLs) IV push over 2-3 minutes

b) Narcan 0.4mg iv push

c) None of the above

5. In assessing a patient with a full thickness laceration, which of the following statements concerning the medical directive for tetanus immunization are correct:

a) Presents with an open injury to the skin or eye

b) Has completed their primary immunization and hasn't received a booster in 10 years

c) Td (Tetanus and Diptheria Toxoid) 1.0mLs is given IM in the deltoid muscle

d) A and B only

e) All of the above

6. 54 year old Drew Maurier presents to the ED with shortness of breath, B/P 150/92, P 110, RR 24,T 36.4, O2 Sat. 93%. In addition to burning the pack of cigarettes hanging out of his top pocket you want to administer Salbutamol (Ventolin) four to eight puffs or give a wet neb masking (5mg/mL);1 mL in 3 mL saline to assist his SOB. Before you can do this however, the following criteria must be met:

a) Patient has a history of asthma or COPD

b) Presents with dysphagia, muffled voice stridor and other symptoms of upper airway compromise

c) Presents with any of the following symptoms- cough ,presence of respiratory distress, wheeze, tightness or decreased breath sounds on chest auscultation

d) All of the above

e) A and C only

7. Any male patient requiring urinary catheterization who is not allergic to amide anaesthetics or has a known urethral trauma or structural abnormality can receive:

Lidocaine Jelly 2% 200mg/10mLs inserted into the urethra five minutes prior to catheterization to assist in comfort and ease of catheter passage

a) True

b) False

8. LET (Lidocaine,Epinephrine and Tetracaine) topical anaesthetic compound can be applied 30 minutes prior to suturing in which of the following situations:
    a) Lacerations to the ear, nose, fingers and toes
    b) Only lacerations that do not extend beyond the dermis
    c) Lacerations that extends beyond the dermis to underlying structures (e.g.bone, cartilage, tendon, etc)
    d) A and C
    e) B only

9. 33 year old Sam Squint arrives from his work place after splashing a chemical in his left eye and is in a fair amount of discomfort. You have a medical directive to instill two drops of ophthalmic anesthetic eye drops to Sam's eye. Does he meet the criteria?
    a) Yes
    b) No

Another criteria for instilling these eye drops is in anticipation of Morgan Lens insertion pain caused by foreign body, thermal injury or corneal abrasion.
    a) True
    b) False

Therapeutic Procedures

1. A saline lock or peripheral IV may be initiated under the following circumstances:
    a) Signs of airway compromise, respiratory distress, shock, dehydration, bleeding, or altered LOC
    b) In anticipation of IV medication administration for pain control, blood and blood product administration, or to provide IV rehydration
    c) History of high risk mechanism of injury, infection in the immunocompromised patients, or overdose
    d) A and B only
    e) All of the above

2. Oxygen therapy may be initiated when the patient presents with signs and symptoms of one or more of the following:
    a) Respiratory distress, SaO2 </= 92%, or below established desirable range for the individual patient
    b) Hemodynamic instability
    c) There is evidence of suspected hypoxemia (chest pain, tachycardia, hemorrhage, hypovolemia, sickle cell, altered LOC, Trauma, smoke and/or toxin inhalation
    d) B and C only
    e) All the above

3. Eye irrigation with 1 L NS or Ringer's Lactate may NOT be initiated when…
    a) **Penetrating eye trauma, foreign body in the eye, or signs and symptoms of ruptured globe (obvious bleeding)**
    b) The patient has flushed prior to arriving in the ED
    c) The patient has not had topical ophthalmic anaesthetic instilled
    d) The patient has suffered a flash burn
    e) All of the above.

Paediatrics

1. Salbutamol and Ipratropium Bromide may be administered to a child when...
    a) The child presents with signs and symptoms of upper airway pathology e.g. stridor, drooling, muffled voice, dysphagia
    b) **The child presents with audible wheezing, wheezing with retractions, spasmodic cough, dyspnea, tachypnea, or decreased air entry into lung fields on auscultation with a history of reactive airway disease**
    c) The child presents with audible wheezing, wheezing with retractions, spasmodic cough, dyspnea, tachypnea, or decreased air entry into lung fields on auscultation with NO history of reactive airway disease
    d) A and B only
    e) None of the above

2. A three month old child was given a therapeutic dose of Acetaminophen two hours prior to arriving in the ED. The child's temperature is 38.5°C. I can administer Ibuprofen as per the mother's request.
    a) True
    b) **False**

3. The child presents to the ED with vomiting and diarrhea. The 20 kg child was started on ORT on arrival. The mother advises you the child vomited a moderate amount of emesis and just had a large watery stool while waiting in the room. You should:
    a) Stop giving the ORT as it will precipitate more vomiting
    b) **The child should receive 1000 cc of ORT slowly and then be given 200cc ORT for every loose stool**
    c) The child should receive 500 cc of ORT slowly and then be given 100 cc ORT for every loose stool
    d) We should start an IV to rehydrate the child
    e) None of the above

North York General Hospital
Including the IODE Children's Centre
Embracing Health

SAMPLE

Section 1.01 Extremity X-ray Medical Directive
Section 1.02 Certification Record

Name: _____ **Date Submitted to Clinical Educator:** _____

Extremity	Meets Expectations	Needs Improvement	Comments	Physician/Designate Signature
Article I. COMPLETED WRITTEN QUIZ • Achieved 100% on written quiz				
Article II. HAND/FINGERS • Able to identify digits (label) • Orders the appropriate x-ray as per the patient's injuries				
Article III. WRIST/FOREARM • Locates Scaphoid • Orders the appropriate x-ray as per the patient's injuries				
Article IV. ELBOW • Able to identify the olecranon and radial head • Orders the appropriate x-ray as per the patient's injuries				
Article V. KNEE • Demonstrates understanding of Ottawa Knee Rules • Orders the appropriate x-ray as per the patient's injuries				
Article VI. ANKLE/ TIB-FIB • Demonstrates understanding of Ottawa Ankle Rules • Demonstrates the knowledge of indications for tib/fib x-rays • Orders the appropriate x-ray as per the patient's injuries				
Article VII. FOOT/TOES • Demonstrates understanding of Ottawa Ankle & Foot Rules • Orders the appropriate x-ray as per the patient's injuries				
Article VIII. DOCUMENTATION • Documents assessment findings as per the Extremity X-ray Medical Directive Policy				

Implementer Performance Readiness Form - Individual

From: An Interprofessional Guide on Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

_____

(Name of Implementer)

has demonstrated performance readiness for implementing:

_____

(Name of Directive, Delegation or Practice)

and is authorized to perform the procedure in accordance with the education program (if applicable) and relevant policies and procedures for the period:

_____

and is authorized to teach in the education program: _____

(Yes or No)

Implementer	**Signature**	**Date**
Authorizer or Educator	**Signature**	**Date**

Implementer Performance Readiness Form - Group

From: An Interprofessional Guide on Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Name and Number of Directive, Delegation or Practice: _____

Unit/Area: _____ **# of pages:** _____

List Completed by:
(Authorizer or Educator's Name, Position, Signature and Initials) _____

Date Submitted: _____ **For Period:** _____

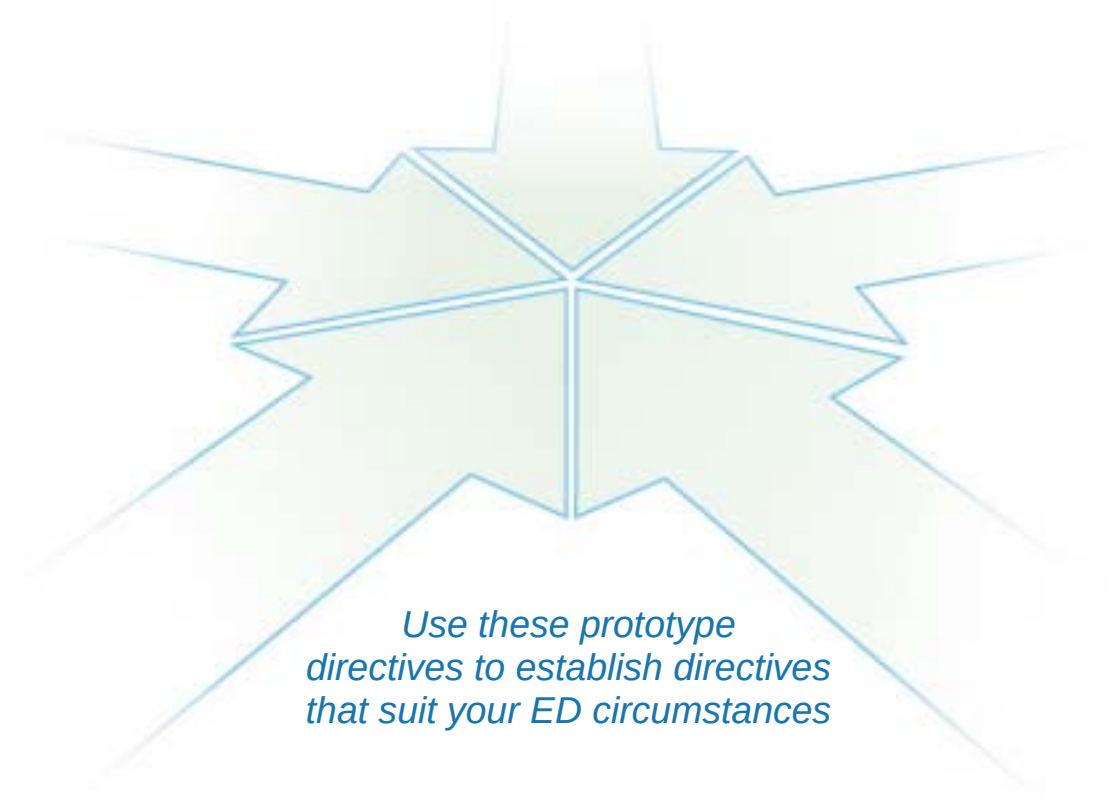
Name of Implementer	Signature	Date	Authorizer or Educator's Initials

Hospital Logo

MODULE 3

Prototype Directives

ED Prototype Medical Directives Module 3 of 6



Use these prototype directives to establish directives that suit your ED circumstances

ONTARIO HOSPITAL ASSOCIATION

Ontario Medical Association

Ontario

Table of Contents

Acknowledgements:

Medical Directive Templates from: An Interprofessional Guide on the Use of Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Prototype ED Medical Directive - Laboratory Test and Diagnostic Procedures

Title: **ED Laboratory Test and Diagnostic Procedures Directive**

Number: Assign # in accordance with hospital record-keeping policies

Activation Date:

Review due by:

Sponsoring/Contact Person(s)
(name, position, contact particulars): Typically chief or physician, and nursing staff member most responsible for developing directive

Orders:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Laboratory Test and Diagnostic Procedures Order Tables

Orders for laboratory test and diagnostic procedures as identified on the appended order tables:

1. **Laboratory Test Order Table (p. 5)**
   a) RBW
   b) Liver Profile (LFTs)
   c) Group and Screen
   d) Serum Quantitative HCG
   e) Urine Qualitative HCG
   f) Serum Drug and Alcohol Screen
   g) Cardiac Markers
   h) Serum Coagulopathy
   i) Blood Cultures
   j) Serum lactate
   k) POCT Urinalysis
   l) Urine for R and M
2. **Diagnostic Procedures Order Table (p.9)**
   a) 12 Lead ECG
   b) Capillary Blood Glucose

Recipient Patients:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Any adult patient (specify age in accordance with hospital policy, e.g. >/= 16) presenting to the ED prior to first contact with the attending physician who meets the conditions identified in this directive.

If patients have lab testing and diagnostic procedures administered under this directive but leave without being seen by the attending physician:

- Staff will forward the record of administered tests and procedures to the attending physician for disposition.

Authorized Implementers:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

All ED nurses and designated staff who have successfully completed the relevant ED Medical Directive orientation program. It is recommended that hospitals maintain a list of authorized implementers as part of the Medical Directive record.

See **Module 2** – Performance Readiness Plan for sample certification forms that may be used if desired to maintain a list of authorized implementers. Such forms may be appended to the directive, identifying them in the 'Appendix

Indications:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Laboratory Test and Diagnostic Procedures Order Tables

- Lab tests and diagnostic procedures will be administered for the period beginning from when a patient arrives in the ED to first contact with the attending physician, unless the attending physician explicitly orders implementation of the directive beyond that period.
- Prior to implementation of any directive, a patient assessment is completed in accordance with standards of practice and any applicable hospital policy. Allergies and sensitivities must be documented.
- Specific indications are identified in the appended Order Tables.

Definitions for indications used in the table:

1. **Acute Coronary Syndrome (ACS)** –as manifested by discomfort (pressure or pain, radiating or non-radiating, anterior or posterior) from jaw to umbilicus that may include any of the following:
    - Shortness of Breath (SOB)
    - Diaphoresis
    - Pallor
    - Nausea/vomiting
    - Dysrhythmias (palpitations, tachycardia, bradycardia)
    - Syncope
    - Weakness, lightheadedness, pre-syncope
    - Lethargy
2. **Fever** – Temperature >/= 38°C
3. **Hypothermia** – Temperature </= 36°C
4. **Hemodynamic instability** – as manifested by one or more of the following signs of shock:
    - Pale
    - Diaphoretic
    - Tachypnic
    - Tachycardia
    - Hypotensive
    - Altered level of Consciousness (LOC)
5. **Immunocompromised** - Patients with one or more of the following:
    - On chemotherapy for cancer,
    - On anti-tnf medication – infliximab (e.g. Remicade),
    - Organ transplant(s),
    - Splenectomy,
    - Hiv,
    - Lupus, rheumatoid arthritis and other chronic inflammatory conditions,
    - Diabetes mellitus,
    - Chronic alcohol abuse,
    - Chronic corticosteroid therapy
6. **Major bleed** – any volume loss that causes hemodynamic instability resulting from possible GI bleed, ruptured aneurysm, ruptured spleen, femur fracture, ectopic pregnancy
7. **Major trauma** - high risk mechanism of injury

Contraindications:

See appended Order Tables.

Consent:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff implementing the directive will obtain consent in accordance with the *Health Care Consent Act* and any relevant hospital policies and procedures (note these).

Guidelines for Implementing the Order / Procedure:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Laboratory Test and Diagnostic Procedures Order Tables

Blood specimens for diagnostic studies may be collected by:

1. Venipuncture,
2. Saline Lock, or
3. Accessing established Vascular Access Device (not including hemodialysis lines).

For specific guidelines, see appended Order Tables.

Documentation and Communication:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Implementing staff will document the:

- Specific lab test and diagnostic procedure order in the order section of the patient record, noting the medical directive name and number and signing off the order with implementer's name and signature as per the attending physician (when attending physician known). Ensure any requisition contains this information.
- Indications, implementation and patient response in accordance with any hospital record-keeping policies (note these)

Append any designated forms used to document implementation of this directive, identifying them in the 'Appendix Attached' section directly above. See **Module 4** – Sample Prototype Directive Preprinted Orders and ED Record for examples of forms that may be used as desired.

Note: Clear and timely notification, communication and documentation between the nurse and the physician are critical to safe, proper use of a medical directive.

Review and Quality Monitoring Guidelines:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff identifying any untoward or unintended outcomes arising from implementation of orders under this directive, or any issues identified with it will report these to (note to whom) as soon as possible for appropriate disposition. This does not include untoward or unintended outcomes or issues that are possible clinical sequelae regardless of whether a directive or direct order is used.

Additional provisions (e.g. for renewal and re-certification) may be identified here or in Performance Readiness Assessment form (**Module 1**)

Administrative Approvals:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Identify the relevant approval committees and staff members, for example: Unit or Program Administrative Staff and Committees, Educators, Professional Leaders, Professional Councils, Medical Advisory Committee etc.; and ensure a signed copy of approvals is maintained as part of the Medical Directive record, either in this section, or in an attached appendix or on designated hospital-specific sign-off forms or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

Approving Physician(s)/Authorizer(s):	Appendix Attached: ☐ Yes ☒ No Title:

Identify all the relevant approving attending physicians and ensure a signed copy of approvals is maintained with the Medical Directive record.

In addition, ensure there is an accessible and timely means of informing staff of new attendings (e.g. newly privileged physicians, locums, residents).

Signatures may be recorded in this section, either in this section, or in an attached appendix or on designated hospital-specific sign-off forms or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

References	Appendix Attached: ☐ Yes ☒ No Title:

List any references here, as below, attach appendix, or list references in Performance Readiness Assessment form (**Module 1**).

Fitchett, D., Goodman, S., Langer, A. (2001). New Advances in the management of acute coronary syndrome. [electronic version]. CMAJ, 164(9)

Fenton,D. (2005 January 5). Acute Coronary Syndrome, retrieved July 25, 2005 from http:/www.emedicine.com/emerg/topic31.htm

Newberry, L. (Ed.). (1998). /Sheehy's Emergency Nursing. Principles and Practice/. 4^th Ed. .Mosby: Toronto.

Electrocardiogram in Acute Myocardial Infarction new England Journal Med. 2003: 348: 933-940

Guidelines 2006 for cardiopulmonary and Emergency Cardiovascular care: American Heart Association

Tintinelli,j.E Kelen,GD and Stapczynski, J.S Emergency medicine: A Comprehensive Study Guide, 6th Edition 2004.

Appendix
ED Laboratory Test and Diagnostic Procedures Directive

Title and Number of Directive: **ED Laboratory Test and Diagnostic Procedures Directive (record directive number)**

1. Laboratory Test Order Table

This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
Bloodwork		
a) Routine Blood Work – CBC, electrolytes (K, Na, Cl, total CO_2), urea, creatinine & glucose	Signs and symptoms including one or more of the following: • Cardiopulmonary condition (chest pain, SOB, weakness, dizziness, looks unwell), • Neurologic condition (alteration in neurologic status, decreased LOC, confusion, seizure, suspected stroke) • Syncope (>/ = 65 yrs) • Dehydration • Major trauma • Symptoms of significant blood loss/major bleeding • Moderate to severe abdominal pain • Signs and symptoms of infection - fever or hypothermia with tachypnea and tachycardia • Chemotherapy and immunocompromised patients • Chronic, diagnosed disease(s) with change in status or exacerbation in condition • Drug or alcohol ingestion	Customize the orders and procedures for collecting this specimen based on hospital-specific lab protocols

1. Laboratory Test Order Table

This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
b) Liver Profile (LFTs) – Amylase, AST, ALT, T-Bili, Direct Bilirubin, ALP, GGT, Albumin	Signs and symptoms of one or more of the following: • Right upper quadrant or epigastric pain • Blunt abdominal trauma • Acetaminophen overdose (Consider ordering only AST as per hospital policy)	Customize the orders for collecting this specimen based on hospital-specific lab protocols
c) Group and Screen	Signs and symptoms of one or more of the following: • Major trauma patients • Patients with actual or potential hemodynamic instability • Pallor, known or suspected anemia • Recent chemotherapy patient who appears anemic • Patients with suspected major bleed • Female patients abdominal pain and/or vaginal bleeding who may be pregnant	Customize the procedures for collecting this specimen based on hospital-specific lab protocols
d) Serum Quantitative HCG Or e) Urine Qualitative HCG as per hospital policy	Women of childbearing age and capacity with signs and symptoms of one or more of the following: • Abdominal pain • Vaginal bleeding • Hemodynamic instability • Syncopal episode • Major trauma patient • Pregnancy suspected by patient or nurse (e.g. late menses, inexplicable weight gain)	Customize the orders for collecting this specimen based on hospital-specific lab protocols

1. Laboratory Test Order Table

This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
f) Serum Drug and Alcohol Screen as per hospital policy, e.g. • Acetaminophen • ASA • ETOH • Lithium • Digoxin • Carbamazepine • Phenytoin • Valproic Acid	Patients with actual or suspected drug ingestion/overdose with one or more of the following: • Reported ingestion • Alterations in mood, behaviour, and/or motor function suggestive of intoxication • Alteration in LOC • New onset seizure • Major trauma • Concern about non-therapeutic drug levels (carbamazepine, phenytoin, lithium, valproic acid)	Customize the orders for collecting this specimen based on hospital-specific lab protocols
g) (Identify hospital-specific markers)Cardiac Markers: CK, Troponin	Signs and symptoms of Acute Coronary Syndrome	Customize the orders for this specimen collection based on hospital-specific lab protocols.
h) Serum Coagulopathy: INR/PTT	Signs and symptoms including one or more of the following: • Acute coronary syndrome • Current warfarin use • Possible pulmonary embolus (SOB, tachycardia, hypoxia, risk factors such as recent surgery, immobility) • Possible stroke/TIA (weakness, numbness, trouble speaking, vision problems, headache, dizziness) • Actual or potential hemodynamic instability	Customize the procedures for this specimen collection based on hospital-specific lab protocols.

1. Laboratory Test Order Table

This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
i) Blood Cultures	Patients with actual or suspected infection (localized or generalized) with temperature >/= 38 or </= 36 who presents with any of the following signs and symptoms: • Tachypnea > 20 RPM • Tachycardia HR > 90 BPM • Altered LOC • Inmmunocompromised patients • Patients with indwelling vascular access devices	Collection standard: 2 sets of cultures 10 minutes apart Customize the procedures for this specimen collection based on hospital-specific lab protocols.
j) Serum Lactate	Patients with suspected infection who meets SIRS criteria, i.e. looks unwell with 2 or more of the following: • Fever (temperature > 38 C) or hypothermia (temperature < 36 C) • Tachypnea > 20 RPM • Tachycardia HR > 90 BPM • Chemo or immunocompromised patients	• Reference: SIRS Criteria
Urinalysis		
k) Point of Care Test (POCT) Urinalysis (Dipstick or Urinalysis Device as per hospital policy)	Patients presenting with one or more of the following signs and symptoms: • Abdominal pain • UTI symptoms • Patients >/=65 years of age with fever or hypothermia, confusion, delirium, or new onset weakness	

1. Laboratory Test Order Table

This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
l) Urine for R and M	If POCT urinalysis is positive for: • Leukocytes • Proteins • Blood • Nitrates • Glucose	

2. Diagnostic Procedures Order Table

This table This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
a) 12 Lead ECG	Signs and symptoms of, or including one or more of the following: • Respiratory pathology • Cardiac pathology • Cerebrovascular accident • Metabolic imbalance • Trauma to chest wall • Major or multiple trauma • Possible toxic ingestion • Possible adverse reaction to medications or drugs • Weakness or lightheadedness in those > 65 • Electrical injury	Follow applicable hospital policy and procedure

2. Diagnostic Procedures Order Table

This table This table cannot be relied upon in the absence of: ED Laboratory Test and Diagnostic Procedures Directive (record directive number)

Orders	Indications/Contraindications	Guidelines
b) Capillary Blood Glucose	To determine baseline glucose status in patients with a diagnosis of diabetes mellitus and for signs and symptoms suggestive of hypoglycemia or hyperglycemia, including one or more of the following: • Altered LOC • Confusion, agitation, behavioural changes • Recent or active seizure • Suspicion of alcohol ingestion • Syncopal event • Listless, lethargic, fatigued	Follow applicable hospital policy and procedure

Prototype ED Medical Directive - Diagnostic Imaging

Title: **ED Diagnostic Imaging Directive** **Number:** Assign # in accordance with hospital record-keeping policies

Activation Date: **Review due by:**

Sponsoring/Contact Person(s) *(name, position, contact particulars):* Typically chief or physician, and nursing staff member most responsible for developing directive

Orders:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Extremity Plain Film Radiography X-ray Order Table

Orders for diagnostic imaging as identified on the appended order table:

1. **Extremity Plain Film Radiography X-ray Order Table (p. 15)**
   a) Foot x-ray
   b) Ankle x-ray
   c) Knee x-ray
   d) Tibia/Fibula x-ray
   e) Hand x-ray
   f) Finger(s) x-ray
   g) Scaphoid x-ray
   h) Wrist x-ray
   i) Forearm x-ray
   j) Elbow x-ray

Recipient Patients:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Any adult patient (specify age in accordance with hospital policy, e.g. >/= 16) presenting to the ED prior to first contact with the attending physician who meets the conditions identified in this directive.

If patients have plain film radiography studies administered under this directive but leave without being seen by the attending physician:

- Staff will forward the record of studies administered to the attending physician for disposition.

Authorized Implementers:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

All ED nurses and designated staff who have successfully completed the relevant ED Medical Directive orientation program. It is recommended that hospitals maintain a list of authorized implementers as part of the Medical Directive record.

See **Module 2** – Performance Readiness Plan for sample certification forms that may be used if desired to maintain a list of authorized implementers. Such forms may be appended to the directive, identifying them in the 'Appendix Attached' section directly above, or maintain them in accordance with hospital record-keeping policies.

Indications:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Extremity Plain Film Radiography X-ray Order Table

- Plain film radiography x-ray orders will be implemented for the period beginning when a patient arrives in the ED to first contact with the attending physician, unless the attending physician explicitly orders implementation of this directive beyond that period.
- Plain film radiography x-rays will only be ordered under this directive if patients have received trauma to the affected area, and have pain referable to that area.
- Prior to implementation of any directive, a patient assessment is completed in accordance with standards of practice and any applicable hospital policy. Allergies and sensitivities must be documented.
- Prior to a study being requisitioned, ensure:
    - Neurological and orthopedic status are assessed and documented
    - Any jewellery or constricting clothing is atraumatically removed

Specific indications are identified in the appended Order Table.

Contraindications:

1. Known or suspected pregnancy.
2. Unstable patient – physician to be contacted immediately.
3. Signs or symptoms of neurovascular compromise in the affected limb – physician to be contacted immediately.
4. Open fractures will be assessed by the emergency physician directly.
5. Patient is intoxicated or has other distracting injuries and is unable to follow direction, maintain motor control or is uncooperative

See appended Order Table for further specific contraindications.

Consent:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff implementing the directive will obtain consent in accordance with the *Health Care Consent Act* and any relevant hospital policies and procedures (note these).

Guidelines for Implementing the Order / Procedure:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Extremity Plain Film Radiography X-ray Order Table

See appended Order Table.

Documentation and Communication:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Implementing staff document the:

- Specific x-ray order in the order section of the patient record, noting the medical directive name and number, and signing off the order with implementer's name and signature as per the attending physician (when attending physician known). Ensure any requisition contains this information.
- Indications, implementation and patient response in accordance with any hospital record-keeping policies (note these)

Append any designated forms used to document implementation of this directive, identifying them in the 'Appendix Attached' section directly above. See **Module 4** – Sample Prototype Directive Preprinted Orders and ED Record for examples of forms that may be used as desired.

Note: Clear and timely notification, communication and documentation between the nurse and the physician are critical to safe, proper use of a medical directive.

Review and Quality Monitoring Guidelines:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff identifying any untoward or unintended outcomes arising from implementation of orders under this directive, or any issues identified with it will report these to (note to whom) as soon as possible for appropriate disposition. This does not include untoward or unintended outcomes or issues that are possible clinical sequelae regardless of whether a directive or direct order is used.

Additional provisions (e.g. for renewal and re-certification) may be identified here or in Performance Readiness Assessment form (**Module 1**)

Administrative Approvals:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Identify the relevant approval committees and staff members, for example: Unit or Program Administrative Staff and Committees, Educators, Professional Leaders, Professional Councils, Medical Advisory Committee etc.; and ensure a signed copy of approvals is maintained as part of the Medical Directive record.

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

Approving Physician(s)/Authorizer(s):

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Physician Approval Form (Staff); Physician Approval Form (Non-staff**)**

Identify all the relevant approving attending physicians and ensure a signed copy of approvals is maintained with the Medical Directive record.

In addition, ensure there is an accessible and timely means of informing staff of new attendings (e.g. newly privileged physicians, locums, residents).

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

References

Appendix Attached: ☐ Yes ☒ No **Title:**

List any references here as below and attach appendix, or list references in Performance Readiness Assessment form (Module 1).

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21. McRae, R. (1981) Practical Fracture Treatment. Churchill Livingstone: London.

Appendix
Extremity Plain Film Radiography X-Ray Orders Table

Title and Number of Directive: **ED Diagnostic Imaging Directive (record directive number)**

1. Extremity Plain Film Radiography X-Ray Orders Table

This table cannot be relied upon in the absence of ED Diagnostic Imaging Directive (record directive number)

Orders (Specify exam name and views that correspond to hospital-specific policy)	**Indications**	**Contraindications**	**Guidelines**
a) Foot x-ray	Pain in the midfoot zone and one or more of the following findings: 1. Bone tenderness at the base of the 5th metatarsal 2. Bone tenderness at the navicular 3. Inability to bear weight both immediately and in the emergency department	1. Known or suspected pregnancy 2. Unstable patient – physician to be contacted immediately 3. Signs or symptoms of neurovascular compromise in the affected limb physician to be contacted immediately 4. Open fractures will be assessed by the emergency physician directly 5. Patient is intoxicated or has other distracting injuries and is unable to follow direction, maintain motor control or is uncooperative.	
b) Ankle x-ray	Upon palpation of the entire distal 6 cm of the fibula and tibia to assess the malleolar zone, pain in the malleolar zone and one or more of the following: 1. Bone tenderness at the posterior edge or tip of the lateral malleolus 2. Bone tenderness at the posterior edge or the tip of the medial malleolus 3. Inability to bear weight both immediately and in the emergency department	• As above	See Ottawa Ankle Rules Protocol (record version and maintain as part of medical directive record)

1. Extremity Plain Film Radiography X-Ray Orders Table

This table cannot be relied upon in the absence of ED Diagnostic Imaging Directive (record directive number)

Orders (Specify exam name and views that correspond to hospital-specific policy)	**Indications**	**Contraindications**	**Guidelines**
c) Knee x-ray	Knee injury patients with one or more of these findings: 1. Isolated tenderness of the patella (that is, no bone tenderness of the knee other than the patella) 2. Tenderness at the head of the fibula 3. Inability to flex to 90 degrees 4. Inability to bear weight both immediately and in the emergency department (4 steps; unable to transfer weight twice onto each lower limb regardless of limping)	• As above	See Ottawa Knee Rules Protocol (record version and maintain as part of medical directive record)
d) Tibia/Fibula x-ray	Deformity and or swelling in the area	• As above	
e) Hand x-ray	Deformity and or swelling in the area, impaired range of motion and localized bony tenderness	• As above	
f) Finger(s) x-ray	Isolated finger injury distal to the MCP joint	• As above	
g) Scaphoid x-ray	Pain at the anatomic “snuff box” Pain on axial compression of thumb	• As above	
h) Wrist x-ray	Deformity and swelling in the area, impaired range of motion and localized bony tenderness	• As above	
i) Forearm x-ray	Deformity and swelling in the area, localized bony tenderness	• As above	
j) Elbow x-ray	Deformity and or joint effusion or swelling in the area, impaired range of motion and localized bony tenderness.	• As above	

Prototype ED Medical Directive - Medications

Title: **ED Medication Directive** **Number:** **Assign # in accordance with hospital record-keeping policies**

Activation Date: **Review due by:**

Sponsoring/Contact Person(s) *(name, position, contact particulars):* Typically chief or physician, and nursing staff member most responsible for developing directive

Orders:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Medication Order Table

Orders as identified on the appended order table:

1. **Medication Order Table (p. 21)**
   a) Acetaminophen - Pain
   b) Ibuprofen - Pain
   c) Acetaminophen – Fever
   d) Ibuprofen - Fever
   e) Acetylsalicylic Acid (ASA) – Acute Coronary Syndrome
   f) Dextrose 50% IV direct injection
   g) Tetanus and Diptheria Toxoid
   h) Salbutamol
   i) Lidocaine Jelly 2%
   j) Lidocaine, Epinephrine and Tetracaine Compound (LET)
   k) Opthalmic Anaesthetic Eye Drops

Recipient Patients:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Any adult patient (specify age in accordance with hospital policy, e.g. >/= 16) presenting to the ED prior to first contact with the attending physician who meets the conditions identified in this directive.

If patients have medications administered under this directive but leave before being seen by the attending physician:

- Staff will forward the patient record, including the record of administered medications to the attending physician for disposition.

Authorized Implementers:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

All ED nurses and designated staff who have successfully completed the relevant ED Medical Directive orientation program. It is recommended that hospitals maintain a list of authorized implementers as part of the Medical Directive record.

See **Module 2** – Performance Readiness Plan for sample certification forms that may be used if desired to maintain a list of authorized implementers. Such forms may be appended to the directive, identifying them in the 'Appendix Attached' section directly above, or maintain them in accordance with hospital record-keeping policies.

Indications:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Medication Order Table

- Medications will be administered from the period beginning from when a patient arrives in the ED to first contact with the attending physician, unless the attending physician specifically orders implementation of the directive beyond that period.
- Prior to implementation of any directive, a patient assessment is completed in accordance with standards of practice and any applicable hospital policy. Allergies and sensitivities must be documented.
- Specific indications are identified in the appended Order Table.

Definitions for indications used in the table:

1. **Acute Coronary Syndrome (ACS)** –as manifested by discomfort (pressure or pain, radiating or non-radiating, anterior or posterior) from jaw to umbilicus that may include any of the following:
    - Shortness of Breath (SOB)
    - Diaphoresis
    - Pallor
    - Nausea/vomiting
    - Dysrhythmias (palpitations, tachycardia, bradycardia)
    - Syncope
    - Weakness, lightheadedness, pre-syncope
    - Lethargy
2. **Fever** – Temperature >/= 38°C
3. **Hypothermia** – Temperature </= 36°C
4. **Hemodynamic instability** – as manifested by one or more of the following signs of shock:
    - Tachypnic
    - Tachycardia
    - Hypotensive
    - Altered level of consciousness (loc)
    - Pale
    - Diaphoretic
5. **Immunocompromised** - Patients with one or more of the following:
    - On chemotherapy for cancer,
    - On anti-tnf medication – infliximab (e.g. Remicade)
    - Organ transplant(s)
    - Splenectomy
    - Hiv
    - Lupus, rheumatoid arthritis and other chronic inflammatory conditions
    - Diabetes mellitus
    - Chronic alcohol abuse
    - Chronic corticosteroid therapy
6. **Major bleed** – any volume loss that causes hemodynamic instability resulting from possible GI bleed, ruptured aneurysm, ruptured spleen, femur fracture, or ectopic pregnancy
7. **Major trauma** - high risk mechanism of injury

Contraindications:

See appended Order Table.

Consent:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff implementing the directive will obtain consent in accordance with the *Health Care Consent Act* and any relevant hospital policies and procedures (Note these).

Guidelines for Implementing the Order / Procedure:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Medication Order Table

See appended Order Table.

Documentation and Communication:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Implementing staff will document the:

- Medication order (including name of medication, dose, route, time of administration) in the order section of the patient record, noting the medical directive name and number, signing off the order as per the attending physician (when attending physician known)
- Indications, administration, and patient response in accordance with any hospital record-keeping policies (note these)

Append any designated forms used to document implementation of this directive, identifying them in the 'Appendix Attached' section directly above. See **Module 4** – Sample Prototype Directive Pre-printed Orders and ED Record for examples of forms that may be used as desired.

Note: Clear and timely notification, communication and documentation between the nurse and the physician are critical to safe, proper use of a medical directive.

Review and Quality Monitoring Guidelines:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff identifying any untoward or unintended outcomes arising from implementation of orders under this directive, or any issues identified with it will report these to (note to whom) as soon as possible for appropriate disposition. This does not include untoward or unintended outcomes or issues that are possible clinical sequelae regardless of whether a directive or direct order is used.

Additional provisions (e.g. for renewal and re-certification) may be identified here or in Performance Readiness Assessment form (**Module 1**).

Administrative Approvals:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Identify the relevant approval committees and staff members, for example: Unit or Program Administrative Staff and Committees, Educators, Professional Leaders, Professional Councils, Medical Advisory Committee etc., and ensure a signed copy of approvals is maintained as part of the Medical Directive record.

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

Approving Physician(s)/Authorizer(s):	Appendix Attached: ☐ Yes ☒ No Title:

Identify all the relevant approving attending physicians and ensure a signed copy of approvals is maintained with the Medical Directive record.

In addition, ensure there is an accessible and timely means of informing staff of new attendings (e.g. newly privileged physicians, locums, residents).

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

References	Appendix Attached: ☐ Yes ☒ No Title:

List any references here as below and attach appendix or list references in Performance Readiness Assessment form **Module 1**.

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Appendix
Medication Order Table

Title and Number of Directive: **ED Medication Directive MD # …** (assign # as per hospital record-keeping policies)

1. Medication Order Table

This table cannot be relied upon in the absence of ED Medication Directive (record directive number)

Orders	Indications	Contraindications	Guidelines
a) Acetaminophen (975-1000 mg – as per formulary) PO or PR (if unable to take PO) x 1 dose - Pain Or As per patient choice, or hospital formulary b) Ibuprofen 600 mg PO x 1- Pain **If a preceding dose of one of these medications has been taken by the patient, then the other may be administered as indicated under this directive.**	Patients triaged as CTAS 3,4 or 5 with mild-moderate pain (=/< 7/10 on pain scale) as follows: • Headache pain • Dental pain • Ear, nose and/or throat pain • Musculoskeletal pain • Skin pain **Note: Do not give medications by mouth in cases where patient is obviously going to require surgery and consult physician for pain management.**	Acetaminophen: • Abdominal pain • Allergy or sensitivity to acetaminophen, • Ingestion of acetaminophen in last 4 hours • Hepatitis, liver disease, intoxicated patients Ibuprofen: • Abdominal pain • History of liver or renal disease • Allergy or sensitivity to Ibuprofen or Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) • History of Inflammatory Bowel Disease, Peptic ulcer, GI bleed • Ingestion of ibuprofen within last 6 hours • Nursing and pregnancy	Reassess patient and document patient response within 30-60 minutes of administration or as indicated

1. Medication Order Table

This table cannot be relied upon in the absence of ED Medication Directive (record directive number)

Orders	Indications	Contraindications	Guidelines
c) Acetaminophen (975-1000 mg – as per formulary) PO or PR (if unable to take PO) x 1 dose - Fever Or As per patient choice, or hospital formulary d) Ibuprofen 600 mg PO x 1- Fever	• Patients with fever **Note: Do not give PO meds in cases where patient is obviously going to require surgery and consult physician for fever management.**	• As above for Acetaminophen and Ibuprofen – Pain	Reassess patient and document patient response within 30-60 minutes of administration or as indicated.
e) Acetylsalicylic Acid (ASA) chewable 160 mg x1 dose	• Symptoms of acute coronary syndrome	• Allergy to ASA or NSAIDs • Ingestion of ASA in past 4 hours • Active upper GI bleed	
f) Dextrose 50% (25 gms in 50 mLs) IV over 2-3 minutes	• Patient who has an altered LOC with blood sugar </= 4mmol/L • See ED Therapeutic Procedure Medical Directive for order to initiate venous access	• None where indications present	• Patient and blood glucose reassessment and documentation as indicated
g) Tetanus and Diptheria Toxoid (Td) 0.5 mLs IM, deltoid muscle or Identify compound, dosage and administration in accordance with hospital formulary/policy	• Any adult patient presenting with any open injury to the skin or eye who has completed primary immunization and has not had a booster in 10 yrs	• Allergy or sensitivity to Td • Incomplete primary immunization	May consider monitoring for adverse reactions after administration in accordance with hospital policies

1. Medication Order Table

This table cannot be relied upon in the absence of ED Medication Directive (record directive number)

Orders	Indications	Contraindications	Guidelines
h) As per hospital formulary/policy: Salbutamol (Ventolin) 100 mcg/puff; 4-8 puffs by metered dose inhaler x 1 Or Salbutamol (Ventolin) 5 mg/mL; 1 mL in 3 mL of saline via wet nebulizer mask over 10 minutes x1	Patients presenting with SOB and a history of asthma or Chronic Obstructive Pulmonary Disease (COPD) with one or more of the following symptoms: • Cough • Presence of respiratory distress, wheeze, tightness or decreased breath sounds during chest auscultation Carry out febrile respiratory illness screening on all patients. If screen is positive, isolate patient prior to using nebulizer. **Note: For patients with severe respiratory distress, give medication and notify physician STAT**	• Allergy or sensitivity to salbutamol or adrenergic amines (salmeteral, terbutaline, albuterol, fomerterol)	• Reassess and document patient response and vital signs within 15 minutes following administration or as indicated
i) Lidocaine Jelly 2%, 200 mg/10mLs approximately 5 minutes prior to male urinary catheter insertion. May repeat x1 to max of 400 mgs.	Any male requiring urinary catheterization who is not allergic to amide anaesthetics	• Allergy to lidocaine or other amine-type topical anaesthetics (e.g. articaine, bupivacaine, prilocaine, mepivacaine, ropivacaine) • Urethral trauma or known structural abnormality	
j) Lidocaine, Epinephrine and Tetracaine Compound (LET) as topical anaesthetic applied to cover lacerations 30 minutes prior to suturing. (Identify compound, dosage and application technique in accordance with hospital formulary)	Lacerations requiring suturing that do not extend beyond dermis	• Laceration to ear, nose, fingers, toes, penis, no mucous membranes • Significant injury to underlying structure (bone, cartilage, tendons, nerve and vessels) beneath the dermis • Known allergy or hypersensitivity to any compound components	

1. Medication Order Table

This table cannot be relied upon in the absence of ED Medication Directive (record directive number)

Orders	Indications	Contraindications	Guidelines

k) Ophthalmic Anaesthetic Eye Drops to affected eye x 1
 	
Identify anaesthetic eye drops, dosage and application technique in accordance with hospital formulary
	• In anticipation of Morgan Lens insertion
	• For pain caused by any of the following:
	  • Foreign body
	  • Chemical splash
	  • Thermal injury
	  • Corneal abrasion
		• Penetrating injury
		• Known allergy to ester-type agents (amethocaine, benzocaine, proparacaine, chloroprocaine, cocaine, procaine)
		• Known allergy or sensitivity to other eye drop ingredients	

Prototype ED Medical Directive - Therapeutic Procedures

Title: ED Therapeutic Procedures Directive **Number:** Assign # in accordance with hospital record-keeping policies

Activation Date: **Review due by:**

Sponsoring/Contact Person(s) *(name, position, contact particulars):* Typically chief or physician, and nursing staff member most responsible for developing directive

Orders:

Appendix Attached: ☒ Yes ☐ No
Title: Therapeutic Procedures Order Table

Orders for therapeutic procedures as identified on the appended:

1. **Therapeutic Procedures Order Table (p. 29)**
   a) Saline Lock Insertion,
   b) Peripheral IV Access with NS 30 mLs/hour,
   c) Accessing Established Vascular Access Device with NS 30 mLs/hour,
   d) Initiate and Titrate Oxygen by mask or nasal prongs to maintain SaO_2 >/= 95%,
   e) Urinary Catheter Insertion,
   f) Eye irrigation with 1 L NS with or without Insertion of Morgan Lens, or
   g) Spinal Backboard Removal.

Recipient Patients:

Appendix Attached: ☐ Yes ☒ No **Title:**

Any adult patient (specify age in accordance with hospital policy, e.g. >/= 16) presenting to the ED prior to first contact with the attending physician who meets the conditions identified in this directive.

If patients have therapeutic procedures administered under this directive but leave before being seen by the attending physician:

- Staff will forward the patient record, including the record of administered procedures to the attending physician for disposition.

Authorized Implementers:

Appendix Attached: ☐ Yes ☒ No **Title:**

All ED nurses and designated staff who have successfully completed the relevant ED Medical Directive orientation program. It is recommended that hospitals maintain a list of authorized implementers as part of the Medical Directive record.

See **Module 2** – Performance Readiness Plan for sample certification forms to maintain a list of authorized implementers. Such forms may be appended to the directive, identified in the 'Appendix Attached' section directly above and maintained in accordance with hospital record-keeping policies.

Indications:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Therapeutic Procedures Order Table

- Therapeutic procedures will be administered for the period beginning from when a patient arrives in the ED to first contact with the attending physician, unless the attending physician orders implementation of the directive beyond that period.
- Prior to implementation of any directive, a patient assessment is completed in accordance with standards of practice and any applicable hospital policy. Allergies and sensitivities must be documented.
- Specific indications are identified in the appended Order Table.

Definitions for indications used in the table:

1. **Acute Coronary Syndrome (ACS)** – as manifested by discomfort (pressure or pain, radiating or non-radiating, anterior or posterior) from jaw to umbilicus that may include any of the following:
    - SOB
    - Diaphoresis
    - Pallor
    - Nausea/vomiting
    - Dysrhythmias (palpitations, tachycardia, bradycardia)
    - Syncope
    - Weakness, lightheadedness, pre-syncope
    - Lethargy
2. **Fever** – Temperature >/= 38 C
3. **Hypothermia** – Temperature </= 36 C
4. **Hemodynamic instability** – as manifested by one or more of the following:
    - Pale
    - Diaphoretic
    - Tachypneic
    - Tachycardia,
    - Hypotensive
    - Altered LOC
5. **Immunocompromised** - Patients with one or more of the following:
    - On chemotherapy for cancer,
    - On anti-TNF medication – Infliximab (e.g. Remicade)
    - Organ transplant(s)
    - Splenectomy
    - HIV
    - Lupus, rheumatoid arthritis and other chronic inflammatory conditions
    - Diabetes mellitus
    - Chronic alcohol abuse
    - Chronic corticosteroid therapy
6. **Major bleed** – any volume loss that causes hemodynamic instability resulting from possible GI bleed, ruptured aneurysm, ruptured spleen, femur fracture or ectopic pregnancy
7. **Major trauma** - high risk mechanism of injury

Contraindications:

See appended Order Table.

Consent:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff implementing the directive will obtain consent in accordance with the *Health Care Consent Act* and any relevant hospital policies and procedures (note these).

Guidelines for Implementing the Order / Procedure:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Therapeutic Procedures Order Table

See appended Order Table.

Documentation and Communication:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Implementing staff will document the:

- Specific orders in the order section of the patient record, noting the medical directive name and number, and signing off the order with the implementer's name and signature as per the attending physician (when attending physician known)
- Indications, implementation and patient response in accordance with hospital record-keeping policies (note these)

Append any designated forms used to document implementation of this directive, identifying them in the 'Appendix Attached' section directly above. See **Module 4** – Sample Prototype Directive Pre-printed Orders and ED Record for examples of forms that may be used as desired.

NB: Clear and timely notification, communication and documentation between the nurse and the physician are critical to safe, proper use of a medical directive.

Review and Quality Monitoring Guidelines:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff identifying any untoward or unintended outcomes arising from implementation of orders under this directive, or any issues identified with it will report these to (note to whom) as soon as possible for appropriate disposition. This does not include untoward or unintended outcomes or issues that are possible clinical sequelae regardless of whether a directive or direct order is used.

Additional provisions (e.g. for renewal and re-certification) may be identified here or in Performance Readiness Assessment form (**Module 1**).

Administrative Approvals:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Identify the relevant approval committees and staff members, for example: Unit or Program Administrative Staff and Committees, Educators, Professional Leaders, Professional Councils, Medical Advisory Committee etc., and ensure a signed copy of approvals is maintained as part of the Medical Directive record.

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

Approving Physician(s)/Authorizer(s):	Appendix Attached: ☐ Yes ☒ No Title:

Identify all the relevant approving attending physicians and ensure a signed copy of approvals is maintained with the Medical Directive record.

In addition, ensure there is an accessible and timely means of informing staff of new attendings (e.g. newly privileged physicians, locums, residents).

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

References	Appendix Attached: ☐ Yes ☒ No Title:

List any references here as below and attach appendix, or list references in Performance Readiness Assessment form (**Module 1**).

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Appendix
Therapeutic Procedures Order Table

Title and Number of Directive: **ED Therapeutic Procedures Directive (record directive number)**

1. Therapeutic Procedures Order Table

This table cannot be relied upon in the absence of ED Therapeutic Procedures Directive (record directive number)

Order	Indications	Contraindications	Guidelines
a) Saline Lock Insertion, or b) Peripheral IV Access with NS 30 mLs/hour, or c) Accessing Established Vascular Access Device with NS 30 mLs/hour	Signs and symptoms of one or more of the following actual or potential: • Airway compromise • Respiratory distress • Hemodynamic instability / shock, dehydration bleeding • Altered LOC • Severe pain • High risk mechanism of injury • Infection in immunocompromised patients where venous access is not already established • Ingestion of substances or toxins that have or may result in any of the above signs and symptoms In anticipation of one or more of the following: • IV medication administration for pain, symptom control and or/treatment, • Blood product administration, • To provide IV rehydration where dehydration present and oral intake compromised, • To provide fluid resuscitation to improve hemodynamic status	• Hemodialysis lines are not to be accessed for the purposes of this medical directive	Follow applicable hospital policy and procedure

1. Therapeutic Procedures Order Table

This table cannot be relied upon in the absence of ED Therapeutic Procedures Directive (record directive number)

a) Initiate and Titrate Oxygen by mask or nasal prongs to maintain SaO_2 >/= 95%:	Signs and symptoms of one or more of the following actual or potential: • Respiratory distress, • SaO_2 </= 94%, or below established desirable range for the individual patient • Hemodynamic instability • Evidence of suspected hypoxemia (chest pain, tachycardia, hemorrhage, hypovolemia, sickle cell, altered LOC, Trauma, smoke and/or toxin inhalation) If signs and symptoms and/or SaO_2 levels do not improve promptly, notify physician	• **Note: For possible CVA patients,** O_2 administration should only be considered when SaO_2 </= 90%	• Follow applicable hospital policy and procedure
b) Urinary Catheter Insertion: a) Straight in and out Or ii) Indwelling urinary catheter Or iii) 3-way catheter	• For urine specimen collection in immobilized patients where unable to collect by other means Or • To assess and monitor fluid balance in patients with actual or potential signs and symptoms of hemodynamic compromise, and/or • Inability to void or difficulty voiding; Or • Moderate to gross hematuria and inability to void or difficulty voiding • Prior to insertion in males, administer Lidocaine Jelly (See ED Medication Medical Directive for applicable order).	• Pelvic trauma • Recent urethral surgery or bladder reconstruction • Known strictures or previous difficult catheterizations	• Consider using coude tip for all male patients • Follow applicable hospital policy and procedure

1. Therapeutic Procedures Order Table

This table cannot be relied upon in the absence of ED Therapeutic Procedures Directive (record directive number)

c) Eye irrigation with 1 L NS or Ringer's Lactate as per hospital policy with or without insertion of Morgan Lens	• Chemical splash to the eye • Irrigate eye even if patient has flushed prior to arriving at ED • Prior to irrigation, remove any powdered chemical by dry wiping • Prior to insertion of Morgan Lens, topical ophthalmic anaesthetic must be administered (See ED Medication Medical Directive for applicable order)	• Penetrating eye trauma • Foreign body in the eye • Signs and symptoms of ruptured globe (obvious bleeding)	• Follow applicable hospital policy and procedure
d) Spinal Backboard Removal	• Alert and oriented • Prior to removal, ensure: o Team presence - all removals from backboards must be done in a safe team fashion as per standards of practice o Physician presence for any patients suspected of severe injuries - these patients should have the number of logrolls and transfers minimized, making physician presence desirable unless physician directs otherwise	• Focal neurological deficits including parasthesia or loss of sensation in extremities • Vomiting • Altered LOC • Inability to follow direction or verbally communicate symptoms • Suspicion of or ingestion of drugs or alcohol rendering patient unable to cooperate or communicate effectively • High risk mechanism of injury as defined by the following: o Fall from elevation > 3 ft (1 metre/5 stairs) o Axial load to head o MVC high speed (>100km/hr), roll over or ejection o Motorcycle or motorized recreational vehicle collision Note: No patient should be left indefinitely on a backboard; if contraindications exist or nurses are uncomfortable, suggest summoning the ER physician to assess/assist with removal even if definitive medical assessment is delayed until later.	• Follow applicable hospital policy and procedure

Prototype ED Medical Directive - Paediatrics

Title: **ED Paediatric Directive** **Number:** Assign # in accordance with hospital record-keeping policies

Activation Date: **Review due by:**

Sponsoring/Contact Person(s) *(name, position, contact particulars):* Typically chief or physician, and expert nursing staff member most responsible for developing directive

Orders:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Paediatric Order Table

Paediatric orders as identified on the appended order table:

1. **Paediatric Order Table (p. 35)**
   a) Salbutamol and Ipratropium Bromide by Nebulizer
   b) Salbutamol and Ipratropium by Unit Dose Pre-mixed Nebules
   c) Medication by MDI spacer as per hospital policy and practices
   d) Oxygen Administration
   e) Acetaminophen - Pain
   f) Ibuprofen - Pain
   g) Acetaminophen - Fever
   h) Ibuprofen - Fever
   i) Emla®
   j) Oral Rehydration Solution

Recipient Patients:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Any child (specify age in accordance with hospital policy, e.g. </= 15) presenting to the ED who meets the conditions identified in this directive.

If a child has therapeutic procedures administered under this directive but leaves before being seen by the attending physician:

- Staff will forward the patient record, including the record of administered procedures to the attending physician for disposition.

Authorized Implementers:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

All ED nurses and designated staff who have successfully completed the relevant ED Medical Directive orientation program. It is recommended that hospitals maintain a list of authorized implementers as part of the Medical Directive record.

See **Module 2** – Performance Readiness Plan for sample certification forms that may be used if desired to maintain a list of authorized implementers. Such forms may be appended to the directive, identifying them in the 'Appendix Attached' section directly above or maintained in accordance with hospital record-keeping policies.

Indications:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Paediatric Order Table

- Therapeutics will be administered for the period beginning from when a patient arrives in the ED to first contact with the attending physician, unless the attending physician orders implementation of the directive beyond that period. **Exception**: Emla® or Ametop® may be administered throughout a child's visit.
- Prior to implementation of any directive, a patient assessment is completed in accordance with standards of practice and any applicable hospital policy. Allergies and sensitivities must be documented.
- Specific indications are identified in the appended Order Table.

Definitions of Indications used in the order table:

1. **Respiratory distress** is characterized by:
    - Tachypnea
    - Dyspnea reported
    - Nasal flaring
    - Wheezing
    - Indrawing
    - Spasmodic cough
    - Decreased air entry to lung fields on auscultation
    - Cyanosis
2. **Hypoxia** - cyanosis, pallor, decreased level of consciousness, anxiety, or restlessness
3. **Immunocompromised** - Patients with one or more of the following:
    - on chemotherapy for cancer
    - on anti-TNF medication – Infliximab (e.g. Remicade)
    - organ transplant(s)
    - splenectomy
    - HIV
    - lupus, rheumatoid arthritis and other chronic inflammatory conditions
    - diabetes mellitus
    - chronic corticosteroid therapy

Contraindications:

See appended Order Table.

Consent:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff implementing the directive will obtain consent in accordance with the *Health Care Consent Act* and any relevant hospital policies and procedures (note these).

Guidelines for Implementing the Order / Procedure:

Appendix Attached: ☒ **Yes** ☐ **No**
Title: Paediatric Order Table

See appended Order Table.

Documentation and Communication:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Implementing staff document the:

- Specific order in the order section of the patient record, noting the medical directive name and number, signing off the order as per the attending physician (when attending physician known)
- Indications, implementation and patient response in accordance with any hospital record-keeping policies (note these)

Append any designated forms used to document implementation of this directive, identifying them in the 'Appendix Attached' section directly above. See **Module 4** – Sample Prototype Directive Preprinted Orders and ED Record for examples of forms that may be used as desired.

NB: Clear and timely notification, communication and documentation between the nurse and the physician are critical to safe, proper use of a medical directive.

Review and Quality Monitoring Guidelines:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Staff identifying any untoward or unintended outcomes arising from implementation of orders under this directive, or any issues identified with it will report these to (note to whom) as soon as possible for appropriate disposition. This does not include untoward or unintended outcomes or issues that are possible clinical sequelae regardless of whether a directive or direct order is used.

Additional provisions (e.g. for renewal and re-certification) may be identified here or in Performance Readiness Assessment form (**Module 1**).

Administrative Approvals:

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Identify the relevant approval committees and staff members, for example: Unit or Program Administrative Staff and Committees, Educators, Professional Leaders, Professional Councils, Medical Advisory Committee etc., and ensure a signed copy of approvals is maintained as part of the Medical Directive record. See Appendix for sample form.

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

Approving Physician(s)/Authorizer(s):

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

Identify all the relevant approving attending physicians and ensure a signed copy of approvals is maintained with the Medical Directive record. See Appendix for sample form.

In addition, ensure there is an accessible and timely means of informing staff of new attendings (e.g. newly privileged physicians, locums, residents).

Signatures may be recorded either in this section, or in an attached appendix, or on designated hospital-specific sign-off forms, or see **Module 6** – Sample Approval Forms for sign-off forms that may be used as desired.

References

Appendix Attached: ☐ **Yes** ☒ **No** **Title:**

List any references here as below and attach appendix or list references in Performance Readiness Assessment form (**Module 1**).

Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Appendix
Paediatric Order Table

Title and Number of Directive: **ED Paediatric Directive (record directive number)**

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
a) By nebulizer Salbutamol (5 mg/mL) x1 • <6.7 kg = 0.2 mL (1 mg) • 6.7 – 33 kg = 0.03 mL/kg (maximum 1mL {5 mg}) • 33 kg = 1 mL (5 mg) **AND** Ipratropium Bromide (250mcg/mL) • 250 mcg (1mL) **OR** b) **For Unit Dose Pre-mixed Nebules** Salbutamol (5 mg/mL) x 1 • Up to 10 kg = 0.25 mL • 10-20 kg = 0.5 mL • > 20 kg = 1.0mL **AND** Ipratropium Bromide	Child has a history of reactive airway disease (asthma or bronchiolitis) and presents with moderate to severe respiratory distress characterized by one or more of the following: • Audible wheezing • Wheezing with retractions • Spasmodic cough • Dyspnea • Tachypnea • Decreased air entry into lung fields on auscultation Prior to initiating the medical directive, the nurse will assess the patient by obtaining and documenting the following: • Complete set of vital signs, including capillary refill • Respiratory assessment, including chest auscultation, respiratory effort, presence of wheezing, etc.	One or more of the following: • Child presents with sudden onset after a choking episode with a suggestion of foreign body aspiration • Child presents with signs and symptoms of upper airway pathology e.g. stridor, drooling, muffled voice, dysphagia • There is a known allergy to either of the medications (salbutamol or ipratropium bromide)	**Post-Administration Assessment:** • Vital signs, including capillary refill • Oxygen saturation level • Peak flow • Respiratory assessment • Observe patient's response to the inhalation and notify physician. • Document post-treatment assessment as per organizational guidelines (e.g. including vital signs, including capillary refill, oxygen saturation level, peak flow, respiratory assessment)

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
(250mcg/mL) x1 • 250 mcg **OR** c) **If Using MDI spacer,** administer 1 dose as perhospital policy & practices	• Peak flow (in accordance with hospital protocols, if age and ability appropriate [usually over 6 years of age]) • Oxygen saturation • Weight in kilograms • History of presenting illness, current medication history and past medical history • Assessment should be documented prior to initiating the directive • Allergy history		• If there is no improvement or deterioration in the patient's condition, notify the physician immediately and initiate oxygen as outlined below in c).
d) **Oxygen Administration** Initiate and Titrate Oxygen via blow by nasal prongs or mask to maintain SaO_2 >/= 95%:	Signs and symptoms including one or more of the following actual or potential: • Respiratory distress • SaO_2 < 95%, or below established desirable range for the individual patient • Hemodynamic instability / shock • Evidence of suspected hypoxemia (tachycardia, hemorrhage, hypovolemia, sickle cell, altered LOC, trauma, or smoke and/or toxin inhalation) **Note: Notify physician immediately of any child who requires O_2 to maintain SaO_2 >/= 95%**	• No contraindications where indications present	There are few contraindications for oxygen administration in children. Premature infants less than 34 weeks gestation are prone to eye damage. This should never affect the decision to provide short-term emergency oxygen to infants and children of any age.

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
e) Acetaminophen 15-20 mg/kg PO/PR x 1, maximum 975 mg - **Pain** **OR** patient choice or hospital formulary: f) **Ibuprofen** 5-10 mg/kg PO x 1 to maximum of 40mg/kg//24hrs – **Pain** **If a preceding dose of one of these medications has been taken by the patient, then the other may be administered as indicated under this directive** ❖ Form of medication (suspension, tablet, chewable tablet or suppository) should be based on the developmental stage and preference of the child and/or caregiver	Patients triaged as P-CTAS 3,4 or 5 with mild to moderate pain using a developmentally appropriate pain assessment tool with negligible risk of surgical origin and one or more of the following signs and symptoms: • Headache • Dental (e.g. toothache) • Ear, nose and/or throat pain (e.g. possible otitis media) • Musculoskeletal (e.g. minor sprains, possible non-displaced closed fracture) • Skin injuries (e.g. minor burns) Prior to administering the analgesic, the following assessments should be done and documented: • Vital signs including capillary refill • Weight in kilograms • Pain assessment using a developmentally appropriate pain assessment tool • History of presenting illness, past medical history and recent medication history • History of allergies	**Note: Children who are immunocompromised should never receive any medication by the rectal route unless specifically ordered by a physician.** • Child has a known allergy to acetaminophen or ibuprofen • Child has received a therapeutic dose of acetaminophen, ibuprofen or other analgesic within the past 4 hours (acetaminophen) or 6 hours (ibuprofen). If sub-therapeutic dose has been given, calculate the difference and give the remainder of the recommended dose Do not use PO route if: • Child is unable to tolerate oral fluids • There is a risk that surgery or procedural sedation may be required within the next 2 hours and oral administration may interfere with any applicable NPO guidelines and consult physician	**Post-Administration Assessment:** • Reassessment of patient response including vital signs, capillary refill and pain using the same developmentally appropriate pain assessment tool within 30-60 minutes or as indicated

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines

g) **Acetaminophen** 15 –20 mg/kg PO/PR x 1, maximum 975 mg - **Fever**
OR
As per patient choice or hospital formulary:
h) **Ibuprofen** X 1 - **Fever**
• < 6 months - 5 mg/kg PO
• 6-12 yrs, temp <39°C – 5 mg/kg PO
• 6-12 yrs, temp >39°C – 10 mg/kg PO
 	
If a preceding dose of one of these medications has been taken by the patient, then the other may be administered as indicated under this directive
 	
• Form of medication (suspension, tablet, chewable tablet or suppository) should be based on the developmental stage and preference of the child and/or caregiver
	• Child presents at the ED with a temperature of >38.0°C when measured by any route
	• Child must:
	  • Be alert and have an intact gag reflex (if the oral route is to be used)
	  • Be greater than 3 months of age *
	
	Note: Infants under 3 months of age, who present with a fever, are classified as Triage Level 2 (P-CTAS) and should be seen by a physician within 15 minutes.
	
	Prior to initiating the administration of the anti-pyretic, complete the following assessment:
	• Weight in kilograms
	• Vital signs including capillary refill
	• History of antipyretic therapy (adequacy of dose, response) and other current medication history
	• History of presenting illness and past medical history
	• History of allergy to medication
		Note: Children who are immunocompromised should never receive any medication by the rectal route nor should a temperature be taken by the rectal route unless specifically ordered by a physician.
		
		• Child has an allergy to acetaminophen or ibuprofen
		• Infant is less than 3 months of age
		• A therapeutic dose of acetaminophen has been given within the past 4 hours or a therapeutic dose of ibuprofen has been given within the past 6 hours. If a sub-therapeutic dose has been given, calculate the difference between the inadequate dose and the therapeutic dose and administer that amount.
		
		The oral route should not be used if:
		• Child unable to tolerate oral fluids
		• There is a risk that surgery may be required within the next 2 hours and oral administration may interfere with NPO guidelines and consult with physician.
			Post-administration assessment includes:
			• Vital signs including capillary refill
			• Temperature 30 minutes after medication administration

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
i) **Emla®** (Eutectic Mixture of Lidocaine and Prilocaine) or Ametop® (Amethocaine) 1 – 2 gm (about the size of a 25-cent piece) topically to intact skin pre-procedure for pain prevention	Any child who is a candidate for venous or capillary blood sampling, IM or SC injection, IV initiation, subcutaneous implanted port access (or other venous access device) or lumbar puncture who has intact skin	• Child has a known allergy to the active ingredient in the medication(s) - Emla® (Eutectic Mixture of Lidocaine and Prilocaine) or Ametop® (Amethocaine) • The child's skin is not intact, i.e. broken or lacerated skin • There is active eczema or skin rashes	• Cover medicated skin with an occlusive dressing (e.g., Op site®, Tegaderm®) • The area will be anaesthetized after 30 minutes (Ametop®) or 60 minutes (Emla®) and effects will last up to 2 hours • Prior to blood sampling or IV insertion, wipe medication off with a dry gauze or tissue • Perform an aseptic skin preparation prior to needle insertion • Ensure all sites are cleansed and dressings removed prior to discharge from the emergency department
• **Oral rehydration solution** (ORT) 45-60 mmol/L sodium (Pedialyte™, Lytren™, or Gastrolyte™ or as per hospital formulary): • 50 mg/kg over 4 hours for mild dehydration, or	• Child must have vomiting and/or diarrhea and have signs of mild or moderate dehydration as described in the table "Clinical Signs of Dehydration" below. • Prior to initiating the oral rehydration therapy, the following assessment should be done: • Vital signs including blood pressure and	Do not implement directive and notify physician immediately if: • Child appears extremely ill, lethargic or has altered perfusion • Child has bilious or bloody vomiting	**Administration:** • For **mild dehydration,** offer a total of 50mLs/kg ORT by age appropriate method (feeding cup, medication cup, syringe, or regular cup) starting with small sips of 5 mL at a time every 1-2 minutes. Bottle-

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
• 100 mg/kg over 4 hours for moderate dehydration, and • For each subsequent stool, add ORT 10 mg/kg to 4 hr total, and for any subsequent emesis, add ORT volume for volume to 4 hr total ❖ If the patient refuses to drink the solution, may substitute Pediapops™ (frozen form of oral rehydration fluid). ❖ May add sugar-free flavouring powder (Crystal Light™ with Aspartame™) to disguise taste. Permission should be obtained from the parent/guardian prior to giving aspartame-containing fluids. For a summary of orders, see table "Summary of ORT" below	capillary refill • Weight in kilograms • Level of consciousness • Level of dehydration (see table below) • Urine output (can be estimate e.g. number of wet diapers over past 6-8 hours and judgment of small, medium or large volume of urine by parents estimate) • History of oral intake and the number of stools **Note: This directive may only be used for mild-moderate dehydration. If child has severe dehydration, notify physician immediately.**	• Child has vomiting alone (no diarrhea) **and** has signs associated with neurologic/ toxicologic etiology Clear fluids such as fruit juices, soft drinks, popsicles or sports drinks are not appropriate and should not be used for oral rehydration, unless it is the only fluid the child will accept and parents insist.	feeding can be used but fluid should be offered in small amounts to avoid further vomiting resulting from drinking a large amount of fluid. The fluid should be offered over a **4 hour period**. In addition, ongoing losses (stool and emesis, see below) should be replaced by adding to the 50 mL/kg four hour intake total • For **moderate dehydration**, offer a total of 100 mL/kg of ORT, plus replacement of ongoing losses (stool and emesis, see below) **over a four hour** period • For **each subsequent stool,** add 10 mL/kg of ORT to the four hour total • **Emesis** should be replaced on a volume-for-volume basis added to the four-hour total • **Continue to offer ORT even if vomiting continues**

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
			• If infant is breastfed, breastfeeding may be continued in addition to the ORT. The duration of each breastfeeding episode should be kept brief to avoid large amounts of breast milk being ingested at a time, which may induce vomitting • Parents may administer ORT. Explain the process clearly to the parents and ask them to record amounts taken • Patients unable to increase oral intake within 1 – 2 hours should have an IV started. Notify physician. Post–directive Patient Assessment: • Observe the infant/child's response to ORT **at least every 30 minutes,** including frequency of vomiting and stooling

1. Paediatric Order Table

This table cannot be relied upon in the absence of ED Paediatric Directive (record directive number)
Based on: Emergency Medical Directives, Child Health Network for the Greater Toronto Area, December 2002.

Order	Indications	Contraindications	Guidelines
			• Check vital signs including capillary refill and colour **at least every 30 minutes** and more frequently based on assessment • Monitor level of consciousness/ alertness • Urine and stool output (number of wet diapers and volume of fluid). It may be necessary to weigh diapers to determine urine/fluid volume output • Notify physician immediately if deterioration in condition is observed

ORT Table 1 - Summary of ORT		
Assessment	**Mild Dehydration 0-5%**	**Moderate 5-10%**
Over first 4 hours	50 mL/kg Replace each stool loss at 10 mL/kg Replace emesis losses at volume for volume	100 mL/kg Replace each stool loss at 10 mL/kg Replace emesis losses at volume for volume
Reassess intake and patient response every 30 minutes		
If intake poor or condition deteriorates, notify physician immediately		

ORT Table 2 - Clinical Signs of Dehydration			
	Mild	**Moderate**	**Severe**
Weight loss	3-5%	6-10%	9-15%
Vital Signs Heart rate Respiratory rate Blood pressure	Slight⇑ Normal Normal	Increased Normal Normal	Markedly increased Tachypnea Decreased
Skin Capillary refill (abdomen) Elasticity Anterior fontanel (<18 months of age) Mucous membranes	<2 seconds Normal Normal Normal	2-3 seconds Decreased Depressed Dry	>3 seconds Increased(tenting) Depressed Dry
CNS Mental status	Normal	Alerted	Depressed Decreased muscle tone
Eyes Tearing Appearance	Normal/absent Normal	Absent Sunken	Absent Sunken
Urine Volume	Small	Oliguria	Oliguria/anuria

Hospital Logo

MODULE 4

Sample Directive Pre-Printed Order Forms & ED Record

ED Prototype Medical Directives Module 4 of 6

Use these forms as samples of how to document implementation of directives

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Table of Contents

(Insert Hospital Name) **Medical Directive Pre-Printed Orders** **ED Medical Directive #** **Labwork and Diagnostic Procedures** **For Use in Area(s):**	Sample **Patient** **Identification** **Here**

DO NOT use form if expiry date (yyyy/mm) has passed.
May only be filled in by staff authorized to implement directive.

Activate		Orders
Yes	**No**	***Initial "yes" or "no" column. If "no", stroke out orders.***
☐	☐	Routine Blood Work – CBC, electrolytes (K, NA, Cl, total CO_2), urea, creatinine & glucose
☐	☐	Liver Profile (LFTs) – Amylase, AST, ALT, T-Bili, Direct Bili, ALP, GGT, Albumin
☐	☐	Group & Screen
☐	☐	Serum Quantitative HCG
☐	☐	Serum Drug & Alcohol Screen: ❑ Acetaminophen, ❑ ASA ❑ ETOH ❑ Benzodiazepines ❑ Lithium ❑ Digoxin ❑ Tegretol ❑ Dilantin
☐	☐	Cardiac Markers: CK, Troponin (Identify hospital-specific markers)
☐	☐	Serum Coagulopathy: INR/PTT
☐	☐	Blood Cultures
☐	☐	Serum Lactate
☐	☐	Point of Care Test (POCT) Urinalysis
☐	☐	Urine for R&M
☐	☐	12 Lead ECG
☐	☐	Capillary Blood Glucose

Filled in by: _____/_____ _____ _____/_____
Signature, Designation & Printed Name | Initials | (yyyy/mm/dd) (hh:mm)

"Form #" ("Approval Date")
Original: Health Record; Copy: Pharmacy
Place in Orders Section of Health Record

(Insert Hospital Name) **Medical Directive Pre-Printed Orders** **ED Medical Directive #** **Diagnostic Imaging** **For Use in Area(s):**	Sample **Patient** **Identification** **Here**

DO NOT use form if expiry date (yyyy/mm) has passed.
May only be filled in by staff authorized to implement directive.

Activate		Orders *Initial "yes" or "no" column. If "no", stroke out orders.*
Yes	**No**	
☐	☐	Foot x-ray (Specify exam name/views that correspond to hospital-specific policies and procedures)
☐	☐	Ankle x-ray (')
☐	☐	Knee x-ray (")
☐	☐	Tibia/Fibula x-ray (")
☐	☐	Hand x-ray (")
☐	☐	Finger(s) x-ray (")
☐	☐	Scaphoid view x-ray (")
☐	☐	Wrist x-ray (")
☐	☐	Forearm x-ray (")
☐	☐	Elbow x-ray (")

Filled in by: _____/_____ _____ _____/_____
Signature, Designation & Printed Name | Initials | (yyyy/mm/dd) (hh:mm)

"Form #" ("Approval Date")
Original: Health Record; Copy: Pharmacy
Place in Orders Section of Health Record

(Insert Hospital Name) **Medical Directive Pre-Printed Orders** **ED Medical Directive #** **Medications** **For Use in Area(s):**	Sample Patient Identification Here

DO NOT use form if expiry date (yyyy/mm) has passed.
May only be filled in by staff authorized to implement directive.

Activate		**Orders** ***Initial "yes" or "no" column. If "no", stroke out orders.***
Yes	**No**	
☐	☐	Acetaminophen (975-1000 mg – as/formulary) PO or PR (if unable to take PO) x 1 dose - Pain And/Or As/patient choice, or hospital formulary Ibuprofen 600 mg PO x 1- Pain
☐	☐	Acetaminophen (975-1000 mg – as/formulary) PO or PR (if unable to take PO) x 1 dose - Fever And/Or As/patient choice, or hospital formulary Ibuprofen 600 mg PO x1 - Fever
☐	☐	Acetylsalicylic Acid (ASA) chewable 160 mg x1 dose – Symptoms of Acute Coronary Syndrome
☐	☐	Dextrose 50% (25 gms in 50 mLs) IV over 2-3 minutes
☐	☐	As per hospital policy/formulary: Tetanus & Diptheria Toxoid (Td) 0.5 mLs IM, deltoid muscle Or Identify compound, dosage and administration for tetanus immunization in accordance with hospital policy
☐	☐	As per hospital policy/formulary: Salbutamol (Ventolin) 100 mcg/puff; 4-8 puffs by metered dose inhaler x 1 Or Salbutamol (Ventolin) 5 mg/mL; 1 mL in 3 mL of saline via wet nebulizer mask over 10 minutes x1
☐	☐	Lidocaine Jelly 2%, 200 mg/10mLs appr. 5 minutes prior to male urinary catheter insertion. May repeat x1 to max of 400 mgs.
☐	☐	Lidocaine, Epinephrine and Tetracaine Compound (LET) as topical anaesthetic applied to cover lacerations 30 minutes prior to suturing. (Identify compound, dosage and application technique in accordance with hospital formulary)
☐	☐	Opthalmic Anaesthetic Eye Drops to affected eye x 1 (Identify anaesthetic eye drops, dosage and application technique in accordance with hospital formulary)

Filled in by: _____/_____ _____ _____/_____
Signature, Designation & Printed Name | Initials | (yyyy/mm/dd) (hh:mm)

"Form #" ("Approval Date")
Original: Health Record; Copy: Pharmacy
Place in Orders Section of Health Record

(Insert Hospital Name) **Medical Directive Pre-Printed Orders** **ED Medical Directive #** **Therapeutic Procedures** **For Use in Area(s):**	Sample **Patient** **Identification** **Here**

DO NOT use form if expiry date (yyyy/mm) has passed.
May only be filled in by staff authorized to implement directive.

Activate		**Orders** ***Initial "yes" or "no" column. If "no", stroke out orders.***
Yes	**No**	
☐	☐	Saline Lock Insertion or
☐	☐	Peripheral IV Access with NS 30 mLs/hour or
☐	☐	Accessing Established Vascular Access Device with NS 30 mLs/hour
☐	☐	Initiate and Titrate Oxygen by mask or nasal prongs to maintain SaO_2 >/= 95%:
☐	☐	Straight In and Out Urinary Catheter Insertion or
☐	☐	Indwelling Urinary Catheter Insertion or
☐	☐	3 Way Urinary Catheter Insertion
☐	☐	Eye irrigation with 1 L NS or Ringer's Lactate as per hospital policy – ☐ with insertion of Morgan Lens or ☐ without insertion of Morgan Lens

Filled in by: _____/_____ _____ _____/_____
Signature, Designation & Printed Name | Initials | (yyyy/mm/dd) (hh:mm)

"Form #" ("Approval Date")
Original: Health Record; Copy: Pharmacy
Place in Orders Section of Health Record

(Insert Hospital Name) **Medical Directive Pre-Printed Orders** **ED Medical Directive #** **Paediatrics** **For Use in Area(s):**	Sample **Patient** Identification **Here**

DO NOT use form if expiry date (yyyy/mm) has passed.
May only be filled in by staff authorized to implement directive.

Activate		**Orders** ***Initial "yes" or "no" column. If "no", stroke out orders.***
Yes	**No**	
☐	☐	By nebulizer; Salbutamol (5 mg/ml) x1 ☐ <6.7 kg = 0.2 ml (1 mg) _____ mgs ☐ 6.7 – 33 kg = 0.03 mL/kg (maximum 1mL {5 mg}) _____ mgs ☐ 33 kg = 1 ml (5 mg) _____ mgs **AND** Ipratropium Bromide (250mcg/ml) **250 mcg (1mL)** **OR**
☐	☐	**For Unit Dose Pre-mixed Nebules:** Salbutamol (5 mg/ml) x1 ☐ Up to 10 kg = 0.25 ml ☐ 10-20 kg = 0.5 ml ☐ > 20 kg = 1.0ml **AND** Ipratropium Bromide (250mcg/ml), 250 mcg x1 OR
☐	☐	If Using MDI spacer, administer as/hospital policy & practices
☐	☐	Initiate and Titrate Oxygen via blow by nasal prongs or mask to maintain SaO_2 >/= 95%:
☐	☐	Acetaminophen 15-20 mg/kg PO/PR x1, max dose 975 mg) - Pain **And/Or**
☐	☐	**As/patient choice or hospital formulary;** Ibuprofen 5-10 mg/kg PO x1 maximum of 40mg/kg/24hrs – Pain
☐	☐	Acetaminophen 15-20 mg/kg PO/PR x1, max dose 975 mg - Fever **And/Or**
☐	☐	**As/patient choice or hospital formulary;** Ibuprofen - Fever ☐ < 6 months - 5 mg/kg PO _____ mgs. ☐ 6-12 mos, temp <39°C – 5 mg/kg PO _____ mgs. ☐ 6-12 mos, temp >/=39°C – 10 mg/kg PO _____ mgs.
☐	☐	Emla® or Ametop® 1 – 2 gm (~a 25-cent piece) topically to intact skin pre-procedure for pain prevention
☐	☐	Oral rehydration solution 45-60 mmol/L sodium (Pedialyte™, Lytren™, or Gastrolyte™ or as/hospital formulary): ❑ 50 mL/kg over 4 hours for mild dehydration, or ❑ 100 mL/kg over 4 hours for moderate dehydration, and ❑ For each subsequent stool, add ORT 10 mL/kg to 4 hr total, and for any subsequent emesis, add ORT volume for volume to 4 hr total See MAR (*or identify applicable record*) for amount administered

Filled in by: _____/_____ _____ _____/_____
Signature, Designation & Printed Name Initials (yyyy/mm/dd) (hh:mm)

"Form #" ("Approval Date") Original: Health Record; Copy: Pharmacy
Place in Orders Section of Health Record

Emergency Triage Record

(From: Mount Sinai Hospital)

Clearly imprint patient identification

Date: _____ Triage Time: _____ Room #: _____
CEDIS Complaint _____

Canadian Triage and Acuity Scale (CTAS)
1 – Resuscitative 2 – Emergent 3 – Urgent 4 – Less urgent 5 – Non urgent

Subjective Assessment	Objective Assessment	**Past Health History** □ None	Allergies □ None

Respiratory Assessment
□ No Distress
□ Mild
□ Moderate
□ Severe

Haemodynamic Assessment
□ Skin well perfused
□ Skin not well perfused

Radial Pulse Quality
□ Strong □ Weak
□ Regular □ Irregular

Glasgow coma Scale (GCS) Score

Eye opening
□ 1. No eye opening
□ 2. Open in response to pain to limbs
□ 3. Eyes open in response to speech
□ 4. Spontaneous eye opening

Best Verbal Response
□ T. Intubated
□ 1. No verbal response
□ 2. Incomprehensible Speech
□ 3. Inappropriate Speech
□ 4. Confused Conversation
□ 5. Orientated Response

Best Motor Response
□ 1. No response to pain
□ 2. Extensor posturing to pain
□ 3. Abnormal flexor response to pain
□ 4. Withdraws to pain
□ 5. Localizing response to pain
□ 6. Obeys commands

Pain Score
_____/10

□ Acute Pain
□ Chronic Pain

□ Central Pain
□Peripheral Pain

Time (HHMM)	RR	SpO_2	HR	BP	GCS	Pain	Temp	Triage Reassessment and Interventions	RN

Patient Medication List	Dose	Freq.	Patient Medication List	Dose	Freq.

Tetanus Status □ Not known □ < 10 years □ >10 years

Triage RN

Time (HH.MM)	Orders/Dir (Dir=Medical Directive)	Time (HH.MM)	RN	Time (HH.MM)	Order/Dir	Time (HH.MM)	RN	Urine Drip	
					CBC,Lytes,U, Cr,Glucose			Leukocytes	
					G&S			Nitrites	
					INR/Ptt			Protein	
					CK, CK-MB, TropT			Blood	
					LFTs*			Ketones	
					Serum ETOH			Glucose	
					Serum ASA & Acet			Urine Micro	
					Blood Cultures				
					ECG				
	Repeat ECG and Cardiac Markers @ _____				Serum hCG			*LFTs	
Consultation 1	Time Notified (HH.MM)	Arrival time (HH.MM)			Serum Lactate			AST ALT ALP GGT	
Consultation 2					Weight			T-Bili Direct Bili Albumin Amylase	

Emergency Record

Affix Patient Label Here

Time Seen (HH.MM)	Physician

History and Chief Complaint

X-Ray: ECG: Fecal Occult Blood:

Staff Physician Notes	Discharge Time	Discharge Disposition

	Prescriptions	Discharge Instructions
		_____ Info sheet given
		□ Instructed to return if symptoms worsen
		□ Other instructions:

Diagnosis	Fax chart to; □ _____ □ _____	Follow-up □ Family MD □ Other:	
Admit Time (HH.MM)	Housestaff Signature X	Attending Physician's Signature	X

Page 1 of 4

Affix Patient Label

Date: _____ Time: _____
YYYY MM DD HH . MM

Room: _____

Presenting Health Problem	Health History	Smoker ☐Yes ☐No

☐ Brought in by police: Badge #:

☐ Security called to bedside: Time _____
HH . MM

· **Social Situation** Language Spoken _____
- ☐ Interpretation Services contacted
- ☐ Lives with family/friend ☐ Lives alone ☐ Has CCAC
- ☐ Other _____

Clothing/Belongings/Own Medications given to:
- ☐ with patient ☐ Family ☐ Security ☐ Other:_____

· **Airway**
- ☐ Patent ☐ Compromised

· **Airway Interventions**
- ☐ Oral Airway #_____ ☐ Nasal Airway #_____
- ☐ Suctioned ☐ Intubation ET#____ Level at lip =___cm

· **Breathing**
- ☐ No respiratory distress ☐ Mild distress
- ☐ Moderate distress ☐ Severe distress

· **Breath Sounds**
- ☐ Equal, clear bilaterally ☐ Crackles ☐ Wheezes
- ☐ Other_____

· **Circulation**

Skin colour_____ Skin temp_____ Diaphoresis _____

· **Radial Pulse**

☐ Strong ☐ Regular ☐ Weak ☐ Irregular

· **Hydration**
- ☐ Well hydrated ☐ Mild dehydration
- ☐ Moderate dehydration ☐ Severe dehydration

· **Neurologic**
- ☐ Awake, alert and oriented
- ☐ Altered LOC *(see Neuro Vital Sign Record, page 3)*

· **Airway** ☐ N/A

Bowel Sounds _____ Distention _____
Guarding _____ Rigidity _____

· **Genito-Urinary** ☐ N/A

Dysuria _____ Hematuria _____
Frequency_____ Flank pain ☐ Right ☐ Left

· **Gynecologic** ☐ N/A

Last menstrual period_____ Gravida/Para _____
YYYY MM DD

Estimated Date of confinement_____
YYYY MM DD

Vaginal bleeding Amount _____ Duration_____

· **Musculo-Skeletal** ☐ N/A

Limb _____ Tender @ _____
Deformity @ _____ Weight Bearing_____
Distal Pulse _____ Sensation _____
Parasethia _____

· **Pain** ☐ N/A

Location _____ Radiation _____
Quality _____ Time of onset _____
HH . MM

Provoked/Alleviated by _____
Pain Score _____/10

· **Symptoms** ☐ N/A

Nausea _____ Vomiting _____ Diarrhea _____
Last bowel movement _____
YYYY MM DD HH.MM

Initial Assessment by: _____, RN

Signature of Nurse

Page 2 of 4

Affix Patient Label

Interventions

Time	Intravenous Initiation	Gauge	Intravenous Location	Initials
	Site #1			
	Site #1			
	Site #1			
	Site #1			
Time	**Interventions**	**Size**	**Site/Comments/Drainage**	**Initials**
	Urinary Catheter			
	Gastric Tube			
	Central Line			
	Arterial Line			

Intravenous Intake

Time	Site #	Solution	Volume	Rate	Volume Infused	To be Absorbed	End Time (HH:MM)	Initials

Urinary Output

Time (HH:MM)	Urine	Initial	Time (HH:MM)	Urine	Initial

Capillary Glucose Monitoring

Time (HH:MM)	Urine	Initial	Time (HH:MM)	Urine	Initial	Time (HH:MM)	Urine	Initial

Medications

Time (HH:MM)	Medications	Dose	Route	Initials	Time (HH:MM)	Effect	Initials

Page 3 of 4	Affix Patient Label

Vital Signs

Time (HH:MM)	Heart Rate	Cardiac Rhythm	Blood Pressure	Respiratory Rate	SpO_2	Oxygen LPM %	Temperature	Eyes	Verbal	Motor	Glasgow Coma Scale	Pupils				Strength				Initials
												Size mm	React + / -	Size mm	React + / -	Arm		Leg		
																R	L	R	L	

Transfer Summary

Date (YYYY.MM.DD)	Time (HH.MM)	Unit	Report given by	Report given to

Discharge Summary

Date (YYYY.MM.DD)	Time (HH.MM)	Accompanied by	Method of transportation

Follow-up Plan

Written Instructions

Health Teaching

Discharge Nurse

PRINT Name Initials	PRINT Name Initials
PRINT Name Initials	PRINT Name Initials
PRINT Name Initials	PRINT Name Initials

PRINT Name Initials	PRINT Name Initials

Page 4 of 4	Affix Patient Label

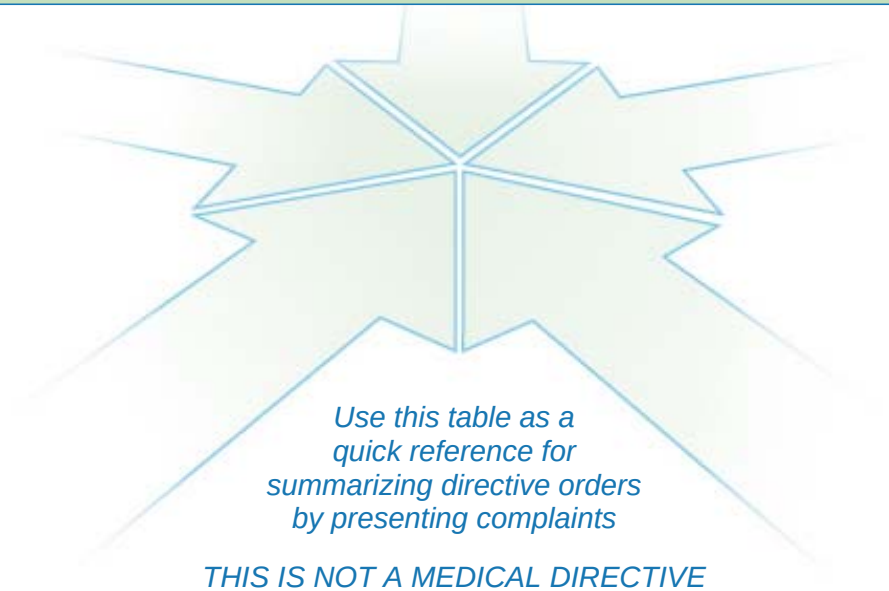
Time (HH:MM)	Progress Notes

Hospital Logo

MODULE 5

CEDIS Presenting Complaints Table

ED Prototype Medical Directives Module 5 of 6



Use this table as a quick reference for summarizing directive orders by presenting complaints

THIS IS NOT A MEDICAL DIRECTIVE

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Draft CEDIS Presenting Complaints Table

April 10, 2008

This table presents a partial CEDIS Presenting Complaint List (Version 1.0, 2007) categorized by ED Prototype Medical Directives. It has been developed:

1. As a practice prompt to guide use of the ED prototype directives, and
2. To facilitate evaluation of the directives' effect on patient flow.

It is not, and may not be used as a medical directive because it lacks mandatory information necessary to qualify as one. Therefore, it cannot be used to authorize performance of procedures identified in it. Refer to Module 3 – Prototype Directives for prototype medical directives.

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
Cardiovascular						
• Chest Pain	• RBW • INR/Ptt • Cardiac Markers	• 12 Lead ECG			• Saline Lock/ IV/Access VAD • O_2	
• Palpitations/ Irregular heartbeat	• RBW • INR/Ptt • Cardiac Markers	• 12 Lead ECG			• Saline Lock/IV/Access VAD • O_2	
• General Weakness	• RBW • Cardiac Markers	• Urinalysis (POCT) • If POCT +tve, then Urine – R&M				

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
		• 12 Lead ECG				
• Syncope/ Pre-syncope	• RBW • Cardiac Markers • INR/PTT • Serum Quantitative HCG as per hospital policy (female patients who may be pregnant)	• 12 Lead ECG • Cap Glucose • Urine Qualitative HCG as per hospital policy (female patients who may be pregnant)		• ASA (signs and symptoms consistent with ACS)		
Environmental						
• Electrical injury		• 12 Lead ECG				
Gastrointestinal						
• Abdominal Pain	• RBW • RBW, Liver Profile (LFTs) (for right upper or epigastric pain) • RBW, Group and Screen, Serum Quantitative HCG as/ hospital policy (female patients who may be pregnant)	• Urinalysis (POCT) • If POCT +tve, then Urine – R&M • 12 Lead ECG (for pain above the umbilicus) • Urine Qualitative HCG as/hospital policy (female patients who may be pregnant)			• Saline Lock/IV/Access VAD	
• Diarrhea	• RBW				• Saline Lock/ IV/Access VAD	• Oral rehydration solution or Pediapop

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
• Nausea and/or vomiting	• RBW				• Saline Lock/IV/Access VAD	• Oral rehydration solution or Pediapop
• Vomiting blood	• RBW • Group and Screen				• Saline Lock/IV/Access VAD • O_2	
• Blood in stool/melena	• RBW • Group and Screen				• Saline Lock/IV/Access VAD • O_2	
Genitourinary						
• Flank pain		• Urinalysis (POCT) • If POCT +ve, th R&M				
• Hematuria		• Urine – R&M		• Lidocaine Jelly (prior to male catheter insertion)	• 3-way urinary catheter	
• Urinary retention		• Urine – R&M		• Lidocaine Jelly (prior to male catheter insertion)	• Indwelling urinary catheter	
• UTI complaints		• Urinalysis (POCT) • If POCT +ve, then Urine – R&M				

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
Neurologic						
• Altered level of consciousness	• RBW	• 12 Lead ECG • Cap. Blood Glucose		• If B.S. <4 mmol/L give Dextrose 50 % IV push	• Saline lock/IV / Access VAD • O_2	
• Seizure		• Cap. Blood Glucose			• Saline lock/IV/ Access VAD	
• Extremity weakness/ symptoms of CVA	• RBW • INR/PTT	• 12 Lead ECG			• Saline lock/IV / Access VAD • O_2	
Ob-Gyn						
• Vaginal bleed	• CBC • Serum Quantitative HCG as/hospital policy • Rh Factor/Group & Screen as/hospital policy	• Urine Qualitative HCG (POCT) as per hosp policy			• Saline lock/IV / Access VAD	
Opthalmology						
• Chemical exposure, eye				• Analgesic eye drops	• Morgan Lens insertion • Eye irrigation	

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
• Foreign body, eye				• Td • Analgesic eye drops		
• Eye pain				• Analgesic eye drops		
Orthopedic						
• Traumatic back/spine injury		• Urinalysis (POCT) • If POCT +ve, then Urine – R&M				
• Upper or lower extremity injury	• Serum Quantitative HCG as per hospital policy	• Urine Qualitative as per hospital policy	Extremity x-rays	• Acetaminophen or Ibuprofen		• Acetaminophen or Ibuprofen
Respiratory						
• Shortness of breath				• Salbutamol	• O_2	• Salbutamol and Ipratropium Bromide • O_2
Skin						
• Abrasion				• Acetaminophen or Ibuprofren • Td		• Acetaminophen or Ibuprofren

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
• Laceration/Puncture				• Acetaminophen or Ibuprofren • LET • Td		• Acetaminophen or Ibuprofen
• Burn				• Td • Acetaminophen or Ibuprofen		• Acetaminophen or Ibuprofen
Substance Misuse						
• Substance misuse/ intoxica-tion	• RBW, Liver Profile (LFTs), Serum alcohol and/or drug screen as per hospital policy • Cap glucose	• 12 Lead ECG			• Saline Lock/ IV/Access VAD O_2	
• Overdose ingestion	• RBW • Liver Profile (LFTs) (For ASA OD, consider AST only as per hospital policy), • Serum alcohol and/or drug screen as per hospital policy • Cap glucose	• 12 Lead ECG			• Saline Lock/ IV/Access VAD • O_2	

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
Trauma						
• Major trauma – penetrating or blunt	• RBW • G&S • INR/Ptt • Serum alcohol and/or drug screen as/hospital policy • Serum Quantitative HCG (female patient who may be pregnant) • Liver Profile (LFTs) for blunt abdominal trauma	• 12 Lead ECG		• Td	• Saline Lock / IV/ Access VAD • O_2	
General & Minor						
• Fever (Note: Patients with sepsis may present with hypothermia, same orders may apply)	• RBW • Blood Cultures • Serum Lactate (patients who meet SIRS criteria) • Urinalysis (POCT) if UTI symptoms or patient ≥ 65 yrs.			• Acetaminophen or Ibuprofen		• Acetaminophen or Ibuprofen
• Hyperglycemia	• Cap Glucose					

CEDIS Presenting Complaint (Version 1.0)	Corresponding Prototype Medical Directives (See Module 3)					
	Adults					Paeds
	Laboratory Tests and Diagnostic Procedures		Diagnostic Imaging	Medications	Therapeutic Procedures	
• Hypoglycemia	• Cap Glucose					
Pain Management[1]						
• Earache • Dental/Gum problem • Facial trauma (minor) • Sore throat • URTI complaints • Headache • Upper Extremity Pain • Lower Extremity Pain • Back Pain • Pre-procedure anaesthetic				• Acetaminophen or Ibuprofen		• Acetaminophen or Ibuprofen • Emla or Ametop

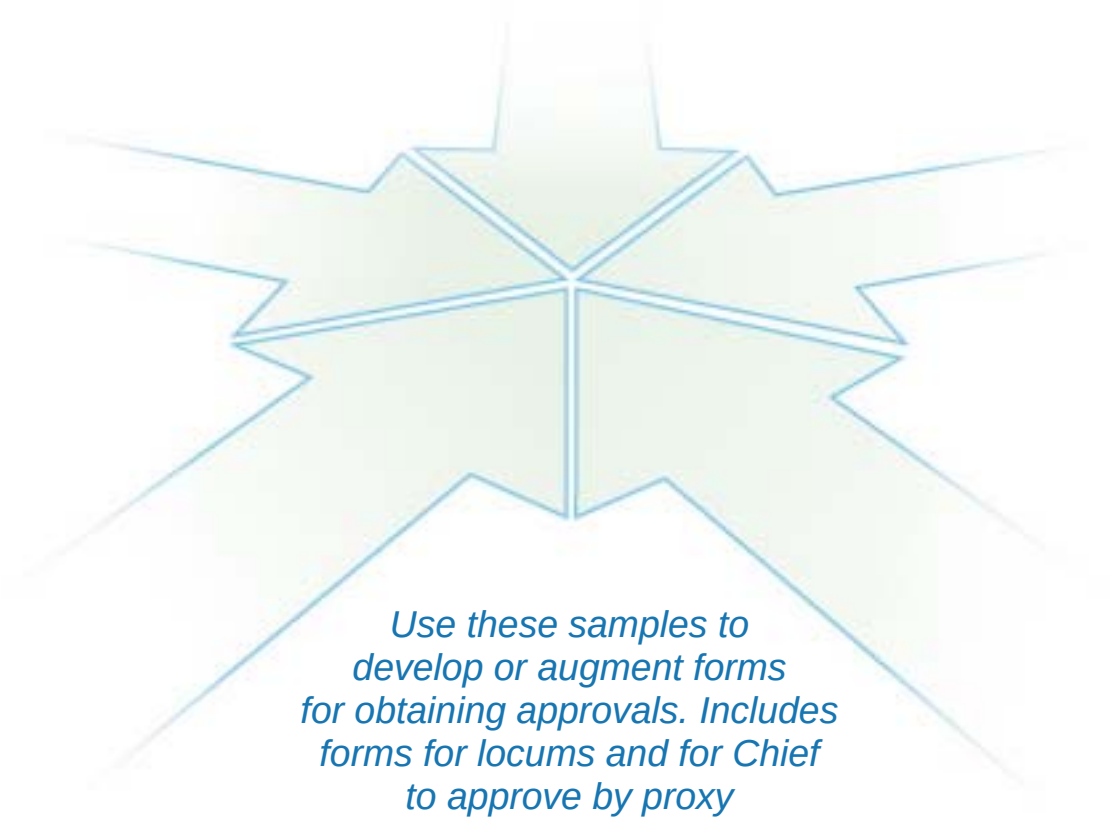
[1] Pain Management is not on the CEDIS list. In the interests of being complete, it appears in the table because the orders and corresponding indications appear in 2 prototype directives: Medication (Adults) and Paediatrics. See Module 3: Prototype Directives.

Hospital Logo

MODULE 6

Sample Approval Forms

ED Prototype Medical Directives Module 6 of 6



Use these samples to develop or augment forms for obtaining approvals. Includes forms for locums and for Chief to approve by proxy

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Table of Contents

Sample Approval Forms:

Acknowledgements:

Physician and Stakeholder/Administrative Approval Form templates from: An Interprofessional Guide on Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Physician Approval Form – Staff Physicians

Title and Number of Directive: _____

Each undersigned physician agrees:

- With the content of the directive and that it is an intervention that can be implemented safely and effectively given the circumstances in the ED as understood by the physician,
- To assume the care of patients who have had an intervention performed as authorized by the directive, and
- S/he knows how the staff will document or communicate when a directive has been implemented so s/he can assume care appropriately.

Name of Physician	Signature	Date

Template from: An Interprofessional Guide on Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Sample Agreement for Chief to Approve Directive(s) on Behalf of ED Physicians

For the Period: _____

Either party may terminate this agreement at any time with notice.

Chief Agreement:

I, _____ (Name of Chief), accept proxy from the undersigned physician(s) and agree to:

- Approve a medical directive that is agreed to by each physician, and
- Ensure each physician is kept informed of the directive.

Signature of Chief	**Date**

ED Physician Agreement:

I, an undersigned physician, give proxy to the Chief named above to approve a medical directive on my behalf under the conditions identified above and agree to:

- Review the directive to fully understand the conditions under which it will be implemented, including knowing how the staff will document or make me aware that the directive has been implemented so I can assume care appropriately, and
- Assume the care of patients who have had an intervention performed as authorized by the directive

Name of Physician	**Signature**	**Date**
Name of Physician	**Signature**	**Date**
Name of Physician	**Signature**	**Date**
Name of Physician	**Signature**	**Date**

Stakeholder/Administrative Approval Form

Title and Number of Directive: _____

In accordance with role responsibilities, the undersigned agree with the use of the directive:

Name and Position	Signature	Date

Template from: An Interprofessional Guide on Orders, Directives and Delegation; Federation of Health Regulatory Colleges of Ontario (January 2007)

Physician Approval Form – Locums and Temporary Physicians

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Each undersigned physician has reviewed each directive above and agrees:

- With the directive, its content, and that it is an intervention that can be implemented safely and effectively given that it has been approved by the ED Chief, physicians and administrative authorities, and given the circumstances in the ED as they understand them
- To assume the care of patients who have had an intervention performed as authorized by the directive
- S/he knows how the staff will document or communicate that a directive has been implemented so s/he can assume care appropriately

Name of Physician	Signature	Date

Physician Approval Form – New Staff

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

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Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Title and Number of Directive/Delegation: _____

Each undersigned physician has reviewed each directive above and agrees:

- With the directive, its content, and that it is an intervention that can be implemented safely and effectively given the circumstances in the ED as they understand them
- To assume the care of patients who have had an intervention performed as authorized by the directive
- S/he knows how the staff will document or communicate that a directive has been implemented so s/he can assume care appropriately

Name of Physician	**Signature**	**Date**
Name of Physician	**Signature**	**Date**