HospitalMD®
EMERGENCY | HOSPITALIST | HYBRID

insight™

CLINICAL EDITION FOR COMMUNITY HOSPITALS

TRAUMA CARE IN THE COMMUNITY SETTING

How effective is your community hospital in treating and stabilizing all types of trauma patients that come through your ED? Patients that are stable can be moved up the chain to a Level I Trauma Center if necessary. However, unstable patients may need serious trauma care in your facility. That's why it is imperative that your clinical team has the proper trauma training, education and practice to provide excellent care that your local community can trust.

- Consider encouraging regular trauma/mock code training at your facility.
- Consider standard assignments at the beginning of each shift that designate who will perform what role(s) during a trauma alert or patient code.
- Know the criteria that designates a patient as a trauma patient and follow established hospital protocols for optimal care.
- Remember the "golden hour" of trauma.
- If patients require transfer–transfer **EARLY** in the process and do not delay the transfer of a trauma patient in order to perform studies.

From the Editor

Welcome to this installment of HospitalMD **insight™–Clinical Edition**! This publication is aimed to inspire and equip you to advance clinical excellence in your community hospital. I would love to hear your feedback, comments, suggestions and accolades. Please email me with any thoughts at: BNewberry@HospitalMD.com.

BRITTANY NEWBERRY, PhD, MSN, MPH, APRN, FNP-BC, ENP-BC
Board Certified Family and Emergency Nurse Practitioner,
Vice President Education and Provider Development, HospitalMD

Some community hospitals are Designated Level IV Trauma Facilities. With this designation comes expectations for provider education, relationships with definitive care facilities, treatment standards, quality and metric monitoring, and patient care expectations. Even if your facility is not a Designated Level IV Trauma Facility, the guidelines are still excellent for structuring the manner in which trauma patients are handled in your facility.

- Any patient with potential threat to life or limb or patients who have a Mechanism of Injury that *could* cause severe injury should be labeled as a Trauma Alert
- Certain times and quality measures are required to be collected and followed in order to maintain Trauma Level IV Designation
- Trauma patients must be stabilized and transferred in a timely manner

WHO SHOULD BE DESIGNATED AS A TRAUMA ALERT?

- Patients with obvious signs of severe injury
- Any patient with potential threat to life or limb
- Patients who have a severe Mechanism of Injury that *could* cause severe injury
- Severe mechanism of injury includes (but not necessarily limited to)
    - MVC with patient ejection, death of another passenger or rollover
    - Pedestrian or bicyclist without helmet struck by motorized vehicle
    - Fall from greater than 3 feet
    - Head struck by high-impact object
    - Any penetrating trauma to the head or trunk
- Any Trauma Patient that cannot be treated at the current facility

CT scans and lengthy workups are not recommended for Trauma Patients in smaller community facilities. The only recommended imaging prior to transfer (if necessary) are chest and pelvis x-rays. If you have ANY suspicion that a trauma patient might have significant injury, consider transfer to a trauma center for evaluation, work-up and disposition.

The decision to transfer should be made within **15 minutes** of the patient's arrival to the ED. You **DO NOT** need radiology or lab results to facilitate a transfer. All that is needed is the patient presentation and/or mechanism of injury.

IMPORTANT TIMES FOR TRAUMA PATIENTS	
Door to Provider Time	10 MIN
Door to Decision to Transfer	15 MIN
Door to Transfer	45 MIN
Door to Transfer/Admit/ Discharge of Traumatic Injury Patient (not designated as Trauma Alert)	120 MIN

You can learn more about trauma level designations from the American Trauma Society.

HospitalMD *CASE STUDY*

These case studies are based on actual cases that **HospitalMD** providers have seen. Details about the case, patient and outcomes have been modified in order to protect patient privacy.

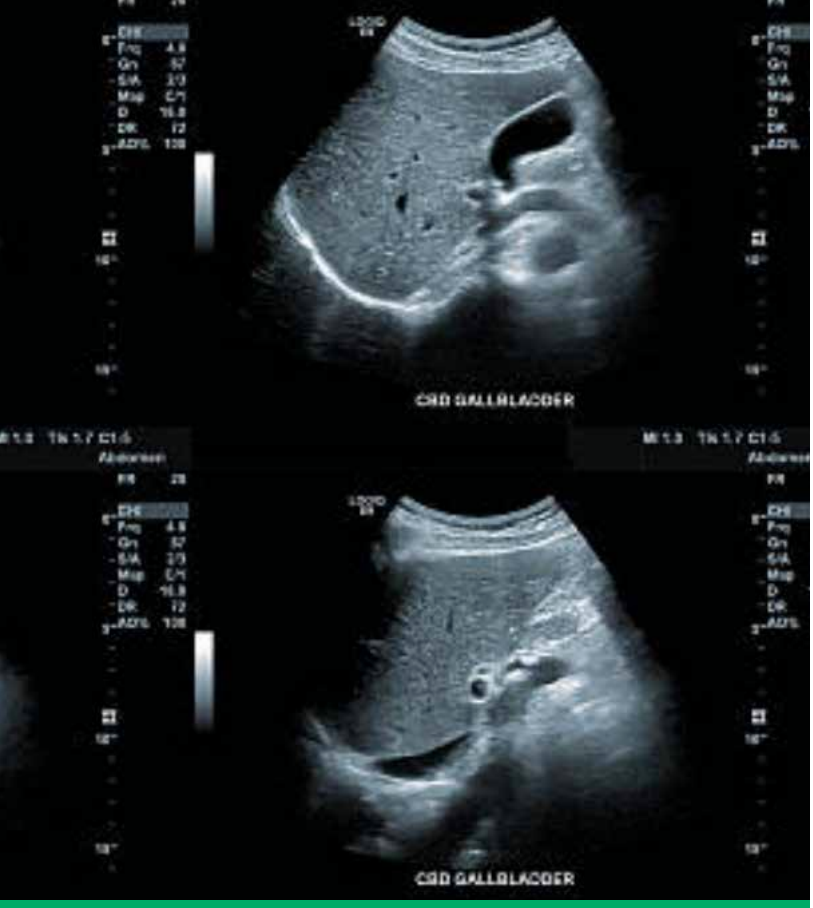
THE CASE: A 47-year-old female presented to the ED for extreme abdominal pain. She described the pain and RUQ that radiates to the back. She stated that the pain has become worse over the past 3 days and that she has never experienced pain like this previously. She reported no other symptoms at the time of presentation.

VS: HR – 68, **BP** – 124/84, **RR** – 18, **T** – 98.4 F, **POx** – 99% on RA

WORKUP: On exam, the patient had RUQ tenderness and no other abnormalities were noted on the exam. CBC, CMP, UA, urine pregnancy and abd/pelvis CT with contrast were ordered. No abnormalities were noted in any of these tests.

DISPOSITION: The patient was discharged to home to follow-up with an established PCP the following day. The patient was informed that no further workup was necessary at that time and that she should return to the ED for any new or worsening symptoms.

THE OUTCOME: The patient was seen 2 days later at a tertiary care facility for an inflamed gallbladder without stones and went to surgery for cholecystectomy.

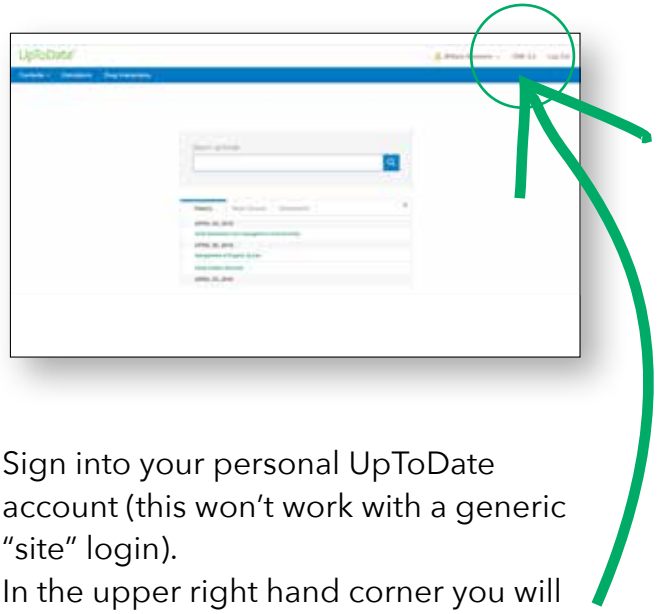


CASE STUDY TAKE AWAYS:

- Be sure to **educate** patients that their symptoms could always be EARLY signs of impending serious illness and that any change in symptomatology or a lack of improvement in symptoms should prompt return to the ED. Many patients do not understand that changing or worsening symptoms may necessitate additional workup that may then show indication of more serious pathology.
- Consider **ultrasound** for patients with potential gallbladder pain in the absence of obvious pathology or gallstones on CT.
- Consider in-hospital **observation** for pain control and serial testing to monitor for any changes in patient condition.
- Remember that lack of **gallstones** does not negate the possibility of gallbladder pathology.

DO YOU KNOW HOW TO ACCESS YOUR UpToDate CME?

Did you know that **UpToDate** gives you CME credit for every subject that you review? It is easy to obtain a record of your completed CME with UpToDate!



- Sign into your personal UpToDate account (this won't work with a generic "site" login).
- In the upper right hand corner you will see a link for "CME".
- Click on this link.
- Click "Redeem" to redeem your CME (credits are available for 2 years).
- Click on "50 Credits".
- Place a checkbox next to the credits you would like to redeem and click "Continue" at the bottom.
- Answer the appropriate questions.
- Click "Next".
- Answer the additional questions.
- Click "Save".
- Click "Download" next to your certificate to view and/or save.

6 DOCUMENTATION *Reminders*

HPI
Strive to always include **FOUR HPI** elements in your charts.

ROS
Document the necessary elements in the ROS and then write or check "**ALL OTHER SYSTEMS REVIEWED AND ARE NEGATIVE**". This statement must be present, and the wording MUST BE PRECISE in order to be considered acceptable by the billing company.

Exam
You must have **EIGHT** exam elements present for a higher level chart.

ECG/Radiology interpretation
If you have ordered either of these, the statement "interpreted by me" must be present in the chart. **An ECG must have 3 elements and an interpretation documented and a radiology result must have an interpretation documented**.

Critical Care Time
If your patient qualifies for critical care, BE SURE to document this on the chart.

Procedures
Be sure to include all pertinent details regarding procedures so that any more complex procedures (ie intermediate vs simple suture repair) can be billed at the rate that matches the true complexity of the procedure.

Wound Repair

DOCUMENTATION REMINDERS

Document repaired wounds *accurately. Avoid documenting "approximate lengths."*

- Measure and record in centimeters, whether curved, angular or stellate
- Include materials used to close (sutures / staples / adhesives) either singly or in combination with each other, or in combination with adhesive strips
- Note: Wounds closed utilizing adhesive strips as sole repair are billed as EM code only

Document if the wound is *superficial* – Simple repair

- e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one-layer closure;
  - This includes local anesthesia and chemical or electro cauterization of wounds not closed

***Intermediate repair procedure* notes in addition to documentation listed in #2 above, requires:**

- Documentation of layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure.

Second scenario for intermediate wound repairs:

- **Document a single layer closure of heavily contaminated wound if it requires "extensive" cleaning and/or removal of particulate matter as it qualifies for intermediate repair.**
  - Include specific language: Heavily contaminated plus extensive cleaning and/or removal or particulate matter/foreign bodies.
  - Examples: Dog bites and motorcycle/bicycle accidents often qualify if documented.

Events and Clinical Resources

ANNUAL HEALTHSTREAM EDUCATION DEADLINE HAS PASSED!

Have you completed your HealthStream annual education? This education was due on April 30th. If you have not completed this, please get this done ASAP. It is very important that we have documentation of annual training on compliance topics such as EMTALA, restraint use and corporate compliance.

GET ACEP NOW

ACEP Now is a great publication that works to keep all of us working in Emergency Medicine up to date on clinical and political topics. Go to this link to look at the latest issue and subscribe!

UPCOMING CONFERENCES

ACEP Calendar of Emergency Medicine Conferences

Calendar of Hospital Medicine Conferences

AAENP Conference Events

ONLINE EDUCATION

Emergency Medicine Boot Camp

Hospital Medicine Boot Camp

PROCEDURE TRAINING

Global Training Institute

Emergency Procedures Course

CERTIFICATION REVIEWS

Fitzgerald ENP Certification Review

Rosh ENP Certification Review

JOURNALS AND PROFESSIONAL ORGANIZATIONS

FREE! Emergency Medicine News

FREE! ACEP Now

Emergency Medicine Practice

Advanced Emergency Nursing Journal

Annals of Emergency Medicine

Journal of Hospital Medicine

Society of Hospital Medicine

American College of Emergency Physicians

American Academy of Nurse Practitioners

American Academy of Emergency Nurse Practitioners

American Academy of Physician Assistants

PODCASTS

EM: Rap

EMCRIT

FOAMCast

REBELEM

EMplify

Hospital and Internal Medicine Podcast

The Hospitalist Podcast

If you have a great resource you would like added to this list, let us know!

Facebook.com/HospitalMD

Linkedin/HospitalMD

HospitalMD.com
DELIVERING EXCELLENCE. EVERY TIME.