Screening Questions at Triage

[Ann Emerg Med. 2017;70:115.]

Triage is a rapid evaluation of patient acuity for the purpose of establishing the order or the location in which the patient should be treated by an emergency care provider and may be bypassed when patient care space and staff are immediately available. Optimal patient care occurs when the time between the patient’s presentation and treatment by an emergency care provider is as short as possible.

Delays can occur when regulatory questions are routinely asked of patients during initial triage. Although screening for depression, substance abuse, and domestic violence can provide important information about the care some patients may require, the routine inclusion of general screening questions in the initial triage process creates a preventable delay in caring for patients. Screening information should be obtained after the initial prioritization process is complete and should not interfere with timely access to needed care.

The American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) support initial triage processes that limit the focus and content of questions to information pertinent to the patient’s condition to determine the priority in which patients should be treated by an emergency care provider.

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Urgent Care Centers


An urgent care center is a walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department (ED). Other names for similar types of facilities include, but are not limited to, after-hours walk-in clinics, minute clinics, quick care clinics, minor emergency centers, and minor care clinics. In some instances, facilities have used the term “emergency” in their name or advertisements; for example, “Minor Emergency Clinic” or “We Treat Emergencies.”

Emergency Department Nurse Staffing

[Ann Emerg Med. 2017;70:115.]

The American College of Emergency Physicians (ACEP) supports emergency department (ED) nurse staffing systems that provide adequate numbers of registered nurses who are trained and experienced in the practice of emergency nursing. Adequate nurse staffing levels should account for patient volume and acuity, the increased time demands of electronic medical record documentation, the number of patients boarding in the ED, patient and family education, and care coordination. Nurse staffing should be evaluated on these factors, in addition to experience and skill mix of the ED staff.

Maintaining ED nurse staffing at levels comparable to those for inpatient and observation units is prudent to provide the same standard of care, treatment, and services to meet patient care and safety expectations. Contingency plans should provide additional nurse staffing for unanticipated emergency patient volume or acuity, and boarding of emergency patients awaiting community psychiatric, observation, or inpatient bed placement. These plans should include the assignment of medical, surgical, and ICU nurses, in addition to behavioral health personnel to the ED, as needed to care for patients boarded in the ED.

ED staffing models should account for experience in emergency nursing, as well as the proportion of ancillary personnel available to support the emergency nursing staff.

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This policy statement was originally approved as a Board Motion titled “Nursing Shortage” in June 1988 and was approved as a policy statement in June 1999.

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Although the Urgent Care Association of America and the American Academy of Urgent Care Medicine have criteria for urgent care clinics, there are limited regulations or state licensing requirements. Criteria may include that the facility be open 7 days a week, contain multiple examination rooms, have on-site diagnostic equipment, have a licensed physician as a medical director, accept walk-in patients during business hours, treat a broad spectrum of illnesses and injuries, and perform minor medical procedures.

Urgent care clinics across the country offer a wide range of care. Some provide levels of care similar to the level of care of an emergency department (ED), including a board certified emergency physician, advanced diagnostic equipment, including CT scan, X-ray, and many onsite laboratory services.

The majority of these facilities; however, are staffed by primary care physicians, advanced practice registered nurses and physician assistants, and have limited diagnostic equipment, often only including point-of-care testing and limited medications. Unlike EDs associated with a hospital, urgent care facilities do not have state or federal mandates to see, treat, or stabilize patients without regard for the patient’s ability to pay.

The American College of Emergency Physicians (ACEP) believes that any facility that does not meet the definition of an ED or freestanding ED as defined by ACEP, and that advertises itself as providing unscheduled care, should:

- not use the word “emergency” or “ER” in its name in any way;
- not use the word “emergency” or “ER” in any advertisements or claims of service, or to describe the type or level of care provided, or as an alternative to an ED because doing so may be considered a deceptive trade practice, as defined by federal or applicable state law; and
- be required to comply with appropriate state or federal licensing requirements that specify staffing and equipment criteria to provide clear information to patients accessing medical care.

ACEP believes that urgent care centers do hold a place in appropriate unscheduled care, but the lack of regulation of facilities has caused confusion for patients and has put the prudent layperson definition of an emergency at risk. Therefore, ACEP encourages all states to have regulations in regard to urgent care centers and the use of the word “emergency” that are developed to be consistent with this policy and with input from ACEP chapters in the state.

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Alternative Methods to Vascular Access in the Emergency Department


There are situations in the emergency department in which intravenous access procedures fail or are insufficient to meet the clinical needs of the patient. Alternative access methods must be available under such circumstances, and their usage should be a part of the emergency medicine practice privileges. These alternate access modalities include, but are not limited to, intravenous lines, external jugular lines, central lines, and peripheral lines placed under the guidance of ultrasonographic or illumination devices. Facility policies and procedures for nonphysician practitioners, including but not limited to nurses, allied health professionals, advanced practice providers, and technicians performing these procedures in accordance with their scope of practice, should allow expeditious establishment of intravenous access through alternate routes when indicated. These policies should include a discussion of the initial and recurrent training requirements and provisions for periodic physician oversight, such as orders or protocols.

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Electronic Prescription Drug Monitoring Program


The diversion of controlled substances from medical to nonmedical purposes has become a significant public health problem. The American College of Emergency Physicians (ACEP) supports the use of electronic prescription drug monitoring programs (PDMPs) and believes these systems should:

- protect patient privacy;
- not discourage a patient with a medical condition from seeking care;
- support access to legitimate medical use of controlled substances;
- ensure accurate, timely, and complete data;
- facilitate seamless data flow from the PDMP into the electronic health record for easy access by the provider (ideally, for example, push systems);
- be voluntary;