Background

The report, Better Care Sooner: the Plan to Improve Emergency Care in Nova Scotia, is the Nova Scotia government’s response to the Dr. John Ross report on Emergency Care released in October, 2010. The report focuses initially on planning and implementing Collaborative Emergency Centres (CEC) within the district health authorities, enhancing access to primary health care, identifying emergency department standards and addressing emergency department access and flow issues. The objectives of the Better Care Sooner plan are to:

1. Improve access to doctors, nurses, and other health care professionals
2. Make emergency care more streamlined and patient-centered
3. Provide better care for seniors, people with mental illness, and others with complex needs
4. Increase public use of the 811 nurse line and 911 in urgent situations and emergencies
5. Fund for Performance and Quality Care

The responsibility for client management in a CEC is a shared responsibility between the registered nurse, the paramedic and the medical oversight EHS on-call physician. Registered nurses have worked for many years as part of interprofessional teams. Staffing models of care in District Health Authorities (DHAs) will be based on the unique needs of the communities they serve and dependent upon the availability of specific personnel. As a result, the group of health care professionals providing primary care to clients may change according to DHA but the same staffing model decision-making process will be applied in each circumstance.

CECs are a new method of delivering team based care to meet the health care needs of communities. The College of Registered Nurses has developed this Q&A document to provide registered nurses with information regarding implementation of the collaborative emergency centres and specifically to provide guidance to registered nurses who will be practising in CECs. This is a living document that will be reviewed and updated regularly by CRNNS as the plan to implement CECs in the province evolves with the Department of Health and Wellness (DHW) and the District Health Authorities (DHAs).

Q1: What is a Collaborative Emergency Centre

A: A Collaborative Emergency Center (CEC) is a model of care that makes access to emergency care a seamless part of primary health care in Nova Scotia by enhancing access to a comprehensive interprofessional primary health care team which is also capable of dealing with unexpected illness or injury. The CEC is located either within or within very close proximity to a rural hospital or health care facility.
Q2: How are services offered within a CEC?

A: CECs have three central components that are formally linked:

- Access to primary health care provided by a team or mix of professionals for extended hours with same day or next day appointment. The team shall have a minimum core mix of physicians, registered nurses and administrative support and have access to other complementary health care providers within the DHA.

- Capacity to provide urgent care. The primary health care team provides urgent care (Canadian Triage and Acuity Scale or CTAS Levels 3-5) either on-site or in a proximate site that is equipped to provide such a service.

- Protocols for emergency care. CECs will have a plan in place for emergency care. The primary health care and urgent care components will be linked with district hospitals, physicians and EHS (Emergency Health Services) for referral of patients that require a level of care that exceeds the capacity of a CEC.

Q3: What elements are needed to support CECs?

A: Having the right people doing the right work collaboratively within an interprofessional team.

- Optimizing the roles of existing staff and introducing other providers as required such as paramedics to meet the health care needs of the community
- Promotion of the 811 tele-nursing service
- Promotion of the 911 emergency services
- Communication and public education on the CEC system
- Full utilization of an electronic health record

Q4: Where will CECs be located in Nova Scotia?

A: CECs are being opened in phases in communities across the province. Seven CECs are currently operational and several more CECs are expected to be up and running by the end of 2014.

CECs operate as part of the 24/7 emergency care system and services are tailored to meet local needs. These needs will be informed by consultation with the community. The specific design in each community will be defined depending on the unique needs of that community, although a consistent level of care will be provided in CECs.

Q5: What standards of care apply in CECs?

A: In determining whether a client has received appropriate care in a CEC, the emergency care standards identified by Dr. John Ross have been adapted and approved for use in CECs by the Department of Health and Wellness. The standards developed by Dr. Ross identify nine different areas of focus including:

- Access
- Triage
- Transfer
- Staffing qualifications
- Site performance
- District health authority performance
- Clinical personnel practice quality review
- Patient satisfaction
- Equipment
Registered nurses are expected to adopt the conduct of a prudent registered nurse with the skills and knowledge necessary to triage emergency clients in accordance with the CTAS scale. They provide nursing care to patients of CTAS levels 3-5 and to more emergent patients in accordance with advanced cardiac life support (ACLS) and pediatric advanced life support (PALS) standards.

Q6: What are the staffing requirements for CECs?

A: The staff mix, competencies, and scope of practice are dependent on the scope of the services and supporting infrastructure available at the CEC.

Q7: How will after hours care during the night differ from care during the day at a CEC?

A: Clients will have access to appropriate care 24/7 including primary, urgent and emergency care. The staffing complement after hours is different than daytime care as there will not be a physician onsite. The night time staffing model includes a medical oversight EHS physician available on call, by telephone, and two other staff members who are onsite. The onsite staffing model could be a paramedic and a registered nurse, or two registered nurses without a paramedic. The paramedic is physically located in the CEC. If the RN is not physically located in the CEC s/he will be called from her/his work unit or area within the facility by the paramedic when the client arrives. It is a requirement that both the RN and the paramedic assess the client in collaboration with the EHS on-call physician.

Q8: What are the responsibilities of the interprofessional team consisting of the registered nurse, paramedic and EHS on-call physician in the afterhours CEC?

A: Physicians and registered nurses are regulated health professionals with a broad definition of their scope of practice identified in their respective legislation. Paramedics are not regulated by statute; however the Emergency Health Services Act provides that paramedics providing services under the Act are registered. Paramedics are authorized to provide care pursuant to medical directives issued by the EHS provincial medical director. Medical directives on medications, procedures and protocols define the parameters for paramedic practice in Nova Scotia.

The responsibility for client or patient assessment is the collaborative responsibility shared between the paramedic and the registered nurse in consultation with the medical oversight EHS on-call physician. Every client contact will result in a mandatory three-way conversation among the paramedic, the registered nurse and the online physician. Communication may take place at any point in the client journey and can occur several times over the client contact. Every decision for the client will be based on the collective assessment, clinical judgment and decision making authority of the paramedic, registered nurse and online physician. If a patient requires a level of care that exceeds the capabilities of the site, the patient will be transferred to the closest, most appropriate facility if there is capacity to safely do so. The care of the patient will then be transferred to the accepting ER physician.

The collective assessment will be an opportunity to integrate the competencies that paramedics and registered nurses already have. The paramedics have specific experience in emergency medicine with interventions based on patient assessment and/or online medical orders and/or medical directives depending of the focus of practice of the paramedic e.g. advanced care paramedic or primary care paramedic.

Based on the paramedics’ education and experience, their area of expertise could include, but is not limited to:

- Conducting thorough acute care assessments with a focus on ‘triage’
- Implementing bedside diagnostics (e.g. ECG)
- Conducting emergency procedures
- Providing acute emergency care (e.g. IV initiation, oxygen)
- Facilitating emergency transfers with EHS
- Documentation

Registered nurses’ education and experience prepare them to provide holistic care of clients throughout the lifespan. Registered nurses assess, identify a working nursing diagnosis, implement, coordinate, monitor and evaluate care.
Based on this, the registered nurses’ area of expertise could include, but is not limited to:

- Conducting thorough acute care assessments with a focus on ‘triage’
- Conducting a comprehensive physical and psychosocial assessment with focus on forming an initial clinical impression
- Implementing bedside diagnostics (e.g. ECG)
- Providing clinical judgment to inform a working diagnosis
- Conducting emergency procedures
- Documentation
- Providing acute emergency care (e.g. IV initiation, oxygen)
- Coordinating client care by:
  - Providing discharge planning, teaching and follow up
  - Ensuring follow up care arrangements are made or delegated to the appropriate individual or service (e.g. CEC day staff, next-day booking, X-ray, lab, etc.)

The on call medical oversight EHS physician brings education and experience in supporting and directing care of emergency patients in many different care settings. Based on this, the on-call EHS physician’s area of expertise could include, but is not limited to:

- Conducting patient assessments in collaboration with the RN and paramedic with focus on disposition (responsible and accountable for transfer and/or discharge)
- Providing concurrent on call medical oversight
- Enabling transport decisions
- Linking with regional hospitals for patient transfers

Each member of the collaborating team in a CEC must have clearly delineated roles and responsibilities. As the role of the paramedic in CECs is new, it is essential that the roles of the RN and the paramedic be clearly defined in each CEC, particularly where the care required falls within a shared area of competence. Each member of the collaborative team - the paramedic, the registered nurse and the EHS on call physician - must have a basic understanding and respect for each other’s roles and confidence that all team members will consult and collaborate based on their expertise.

Q9: What if there is a difference of opinion in the assessment of the client between the paramedic and the RN?

A: The responsibility for client assessment is a shared responsibility between the paramedic and the registered nurse in consultation with the medical oversight EHS on call physician. Assessment findings are based on data collection and analysis of that data including objective data and client observation. The team will come to consensus based on the review and analysis of all of the assessment findings data. The final decision is the responsibility of the medical oversight physician.

Q10: How will the staffing model at the health facility support the RN to meet the Standards of Practice for Registered Nurses when the RN is required in a CEC?

A: The healthcare facility determines the appropriate staffing mix based on a number of factors, including the client population being served in the local community. If the RN in the facility is called to the CEC to work with the paramedic, the facility is responsible to ensure that the clients in the original work unit are covered in the absence of the RN. The facility has to provide clear direction and appropriate staffing to allow RNs to attend to clients in the CEC. RNs have to be assured by their employer that their regular patients and nursing responsibilities will be managed appropriately in their absence from the regular work unit. Nurses use judgment every day regarding patient care priorities and this circumstance is not different. When care exceeds the capacity to respond, each facility should have a plan to support patient care.
If registered nurses have concerns regarding their ability to satisfy their duty of care to clients in CECs and/or an inpatient unit, they are advised to report these concerns to their manager, preferably in writing. It would also be appropriate to seek advice from a practice consultant at CRNNS or the Canadian Nurses Protective Society.

Q11: What education, support and training are put in place to assist registered nurses working after hours in CECs to meet CRNNS’ Standards of Practice for Registered Nurses?

A: All CEC service providers, including registered nurses, must have the appropriate education and training to be able to provide safe, ethical and compassionate care to clients in a CEC setting. The plan for education and training for registered nurses in CECs must be informed by their previous education, work experience and existing competencies. For those RNs with limited experience in acute care, the education plan should be more comprehensive especially in terms of how to meet standards for nursing practice with clients requiring urgent and emergent care. CRNNS recommends that each RN identify her/his specific learning needs related to providing care in the CEC and communicate this in writing to the manager.

The CEC team members who will be providing emergency services must be trained on the Canadian Triage and Acuity Scale (CTAS) as well as provided with ACLS (Advanced Care Life Support) and PALS (Pediatric Advanced Life Support) training or equivalency pediatric emergency education. All team members should have CTAS, ACLS and PALS education and if not, then there needs to be a definitive plan for all team members to acquire this education in a timely manner. It is essential that registered nurses are able to maintain professional continuing competence according to the standards of practice for registered nurses with ongoing educational needs addressed by the employer. For low frequency but high risk interventions, CRNNS recommends a hands on component to continuing competency training.

In preparation for the opening of the first CECs, teams came together for joint education to review the CEC plans, collaborative model, roles and responsibilities, and to foster relationship building. This collaborative education has continued in preparation for the openings of all CECs to date.

As per the Better Care Sooner Plan, additional education regarding mental health disorders, substance use/abuse, rapid risk assessment, the interplay of medical problems, patients with complex conditions as well as the unique needs of the senior’s population will be provided.

Q12: What do I do if I do not feel I have all of the competencies and education required to work in a CEC?

A: Registered nurses are not obligated to provide care beyond their level of competency but can provide care within their individual scope of practice. If an RN believes that s/he does not have the knowledge, skills and judgment to practice in a CEC, the RN must inform the employer of the competencies that s/he possess and those competencies in which the RN feels deficient. However, in emergency situations, registered nurses are ethically obligated to provide the best care they can, given the circumstances and their level of competence. Rather that refusing an assignment, because of lack of required competencies to work in a CEC, the RN should negotiate the work assignment with her/his manager based on the competencies that s/he does possess and inform the CEC team of any competency limitations. If the RN chooses to refuse the assignment, s/he must inform the employer of the reason for the refusal, document the decision-making process and provide the employer with enough time to find a suitable replacement.

Employers have a reciprocal duty to provide registered nurses with adequate orientation, timely education, policies and resources to enable them to achieve and maintain the competencies required to practise in a CEC.

Additional information in relations to Duty to Provide Care can be found on CRNNS website crnns.ca.
Q13: What policies and procedures should an employer have in place before a CEC opens?

A: While the responsibility for client management in CECs is a shared responsibility between RNs, paramedics and on-call physicians, the employer plays a role when it comes to providing and implementing policies and procedures that support RNs to meet their standards of practice. CRNNS recommends that employers develop and maintain policies and procedures that incorporate the following:

1. **Pathways of Care**
   - Primary health care (e.g., return visit next day)
   - Urgent Care (e.g., treat and release)
   - Emergent Care (e.g., transfer out)

2. **CEC shift transition**, which outlines appropriate patient care/disposition during shift changes involving physicians, paramedics and RNs within a CEC.

3. **Contingency plans** for instances when care exceeds capacity within the CEC and/or the inpatient unit (e.g., transfer process when client acuity is greater than can be provided in the CEC.)

4. **CEC closures**

5. **Delegation** - RNs should ask the employer to provide documentation that the paramedic has the necessary education, is competent to carry out the delegated function and that there are processes in place to monitor competence and address any issues and concerns.

6. **Post-entry level competencies** required to work in the CEC

7. **Orientation** – initial and ongoing for new hires.

Q14: What should I do if there is an employer policy which is in conflict with my Standards of Practice?

A: This is a difficult situation, but according to your Standards of Practice (Standard 1, Indicator 1.3) you are obligated to question policies and practices in conflict with the Standards of Practice for Registered Nurses. RNs should utilize the Professional Practice Issues Resolution Framework located in CRNNS’ document entitled, “Resolving Professional Practice Issues”. This framework should help you address the policy in conflict. The Colleges Practice Consultants are always available to advise RNs on how to address and resolve these types of professional practice issues.

In addition, please contact CRNNS’ Practice Consultants if you have any questions. You can reach Trent MacIsaac by email at tmacisaac@crnns.ca and Jennifer Best at jbest@crnns.ca. You may also speak with Trent or Jennifer by calling 1.800.565.9744 for a confidential support.

Q15: Am I, as an RN, at an increased risk of losing my licence to practice nursing because I work in a CEC?

A: No. Registered nurses – regardless of their work environment – practice according to their standards and within their scope of practice. RNs working in CECs have the competencies required of them to use their judgment as they do in any other practice setting/situation. Their practice would be measured according to the prudent practice of a registered nurse in a similar situation. Licence revocation occurs infrequently and only after it has been proven that there have been serious breaches of the Standards of Practice for Registered Nurses and/or the Code of Ethics for Registered Nurses. RNs have been collaborating members of interprofessional healthcare teams for many years and are skilled and experienced at making decisions as an essential member of a collaborating healthcare team.

Q16: Can an RN delegate to a Paramedic?

A: Paramedics are enabled by medical directives to provide emergency care. Delegation is the decision to transfer an intervention that is within the scope of practice of one health care professional that has the authority to perform the intervention to another health care team member for whom this intervention is outside her/his scope of practice.
Delegation takes place only when it is determined to be in a client’s best interest.

The responsibility and accountability for delegation is shared amongst the delegator, the delegatee and the employer.

The nurse (delegator) is accountable and responsible for:
- assessing the client’s needs to inform the appropriateness of delegation
- the decision to delegate
- determining if the delegatee is competent to perform the delegation
- appropriately supervising; supervision entails initial direction, periodic inspections and corrective action when needed
- for the overall outcome and the outcome of the intervention

The paramedic (delegatee) is accountable and responsible for:
- having sufficient knowledge, skills and judgement to accept the delegation
- refusing to accept delegation for those acts which s/he is not competent
- following agency policy and procedure
- performing the intervention safely, effectively and ethically
- documenting the care provided as per agency policy
- reporting observations and client information to the delegator

The employer is accountable and responsible for:
- providing adequate staff
- ensuring there is a process in place to establish competence including adequate education and training
- ensuring paramedic competence
- establishing written policies and procedures which include:
  - who the delegator is
  - paramedics to whom authority has been, or can be, delegated
  - the process for delegation
  - guidelines for care

Medication administration is one example of when an RN may delegate to a paramedic. Both Advanced Care Paramedics (ACP) and Primary Care Paramedics (PCP) receive medication education in their diploma program. Medication administration is within the scope of practice of both the ACP and the PCP. The specific medications that a paramedic can independently administer are dependent upon their education (see table on page 9). All paramedics working in CECs will receive additional education on the competencies required including medication administration. The employer must ensure the paramedic has received the required education and clearly communicate this information to the registered nurse.

There may be unique situations or circumstances in which it is appropriate for the RN to delegate medication administration to the paramedic. If you have specific questions regarding delegation and your current practice or your future practice in a CEC we encourage you to speak with your manager or contact one of CRNNS’ Practice Consultants by calling 902.491.9744 or toll-free 1.800.565.9744. You may also send an email to practice@crnns.ca.

An example of when this delegation may occur could be in an emergency situation in which the RN is unable to immediately give medication to a client because she/he is performing another urgent intervention. It is in the best interest of the patient to receive medication as soon as possible so the RN may make the decision to delegate medication administration to the paramedic. It is important to remember that the RN is always accountable for the
decision to delegate medication administration. The paramedic accepting the delegation has an accountability to clearly indicate her/his competence to accept the delegation of administration of medication to the RN.

While CRNNS anticipates the need for RNs to delegate medication administration to the paramedic quite rare, the decision to do so would be considered appropriate in those unique situations where delegation is in the best interest of the client.

It is the opinion of CRNNS that the needs, safety and quality care of the client are best served if the RN has the ability to delegate medication administration should such circumstances occur. Should the situation arise, CRNNS has created guidelines, Assignment and Delegation Guidelines for Registered Nurses and Licensed Practical Nurses as a resource to support the RN in her/his practice. For more information, please visit: http://crnns.ca/wp-content/uploads/2015/02/AssignmentandDelegationGuidelines.pdf

As is the case with the delegation of any nursing intervention, the RN maintains accountability for the decision to delegate and the outcomes of the decision.

The following table shows medications that can be independently administered by Primary Care and Advanced Care Paramedics.

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<tr>
<th>Primary Care Paramedic (PCP)</th>
<th>Advanced Care Paramedic (ACP)</th>
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<td>Aspirin</td>
<td>Narcan</td>
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<td>Epinephrine</td>
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<td>Glucagon</td>
<td>Oxytocin</td>
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<td>Oxygen</td>
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<td>Tetracaine</td>
<td>Sodium Bicarb</td>
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<td>Ventolin</td>
<td>Valium</td>
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<td>D50W</td>
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<td>Gravol</td>
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<td>Benadry</td>
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<td>Insulin</td>
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<td>Antiplatelets</td>
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Q17: Has the College of Registered Nurses of Nova Scotia been consulted in the development of the plan for the implementation of CECs and, specifically, the plan for after hours care?

A: The College of Registered Nurses has been consulted and has had several meetings with staff of the Department of Health and Wellness, staff at the DHAs, and the Provincial Medical Director for Emergency Health Services. CRNNS is in support of the initiative where registered nurses selected for CECs are provided with the appropriate education, support and direction to enable them to implement this new role. CRNNS will continue to provide support to registered nurses in the form of site visits, phone consultations, and/or one-on-one conversations as requested by leadership teams and members.
Q18: What processes are in place to ensure that registered nurses have regular and ongoing education and training to maintain the necessary competencies required to practice in a CEC?

A: CRNNS has communicated the need to ensure that registered nurses are able to meet and maintain the Standards of Practice for Registered Nurses. The DHW and the DHAs involved in CECs are working on a strategy and plans to ensure that CEC staff will have up to date training and standardized courses delivered in multiple sites around the province. Appropriate training for all providers is part of the mandatory standards for Emergency Care, as adopted by the Province, and will be implemented over the next three years. The CRNNS practice consultants are available for ongoing consultation and support for registered nurses in CECs as well as RNs in all practice areas as necessary. CRNNS’ Practice Consultants are available via the telephone and are available for site visits upon request.

Q19: Are registered nurses permitted to discharge patients from a CEC after hours?

A: Registered nurses cannot discharge patients without a physician’s order. Every patient will receive a physician consultation with the online EHS physician as part of the collaborative team discussion.

Q20: What method of documentation or charting will be used in CECs?

A: The current day time documentation practice should not change. During the after hours, the electronic health record (EHR) currently used by EHS will be used. RNs will be trained on the EHR. Registered nurses will register the patient in Meditech including the chief complaint, initial assessment and the CTAS score. The remainder of the formal charting will be done on the EHR. A copy of the EHR will be retained to attach to the patient’s record to have complete documentation of the patient encounter. The paramedics will be documenting on the EHR as well. In order to not have two separate records, both the paramedic and the RN will document on the EHR.

Q21: What are the types of disposition for patients seen in a CEC after-hours?

A: Every disposition decision will be based on the collective assessment, clinical judgment and decision making authority of the paramedic, registered nurse(s), and the online EHS physician.

There are three possible dispositions:

1. Treat and transfer to another healthcare facility: as per the ER standards, if a patient requires a level of care that exceeds the capabilities of the CEC site the closest, most appropriate facility will accept the patient in transfer as soon as possible if there’s capacity to safely do so. The EHS physician is responsible to coordinate an appropriate transfer for the client.

2. Treat and release.

3. Treat and follow up: the registered nurse will ensure communications with the local primary care team and other local service providers. The registered nurse will also ensure follow-up care arrangements are made or delegated to the appropriate individual or service, for example, x-ray, lab, and next day booking in the day time CEC.

Patients will not be held in a CEC for extended periods of time, or when care requirements exceed the capacity of the care team. CECs are not intended to be in the business of in-patient care provision, but may provide observation or treatment to avoid transfer prior to discharge.
Q22: What is the Canadian Triage Acuity Scale?

A: The Canadian Triage and Acuity Scale (CTAS) attempts to more accurately define patient needs for timely care and to allow Emergency Departments to evaluate their acuity level, resource needs and performance against certain operating “objectives”. Since it is patient access to appropriate care, not simply physician assessment, the time from triage to see a physician is not a strict requirement and may change based on the patient care plan or verbal review with physicians.

CTAS LEVELS

The CTAS levels are designed such that level 1 represents the most ill patients and level 5 represents the least ill group of patients. Explanation and examples of cases which would fall under each category are listed below.

Level 1 - Resuscitation

Conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions. Examples of types of conditions that would be Level 1 are: cardiac/respiratory arrest, major trauma, shock states, unconscious patients, and severe respiratory distress.

Level 2 - Emergent

Conditions that are a potential threat to life, limb or function, requiring rapid medical intervention or delegated acts. Examples of types of conditions which would be Level 2 are: altered mental states, head injury, severe trauma, neonates, myocardial infarction, overdose and CVA.

Level 3 - Urgent

Conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living. Examples of types of conditions which would be Level 3 are: moderate trauma, asthma, GI bleed, vaginal bleeding and pregnancy, acute psychosis and/or suicidal thoughts and acute pain.

Level 4 - Less Urgent (Semi urgent)

Conditions that are related to patient age, distress, or potential for deterioration or complications that would benefit from intervention or reassurance within 1-2 hours. Examples of types of conditions which would be Level 4 are: headache, corneal foreign body and chronic back pain.

Level 5 - Non Urgent

Conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to other areas of the hospital or health care system. Examples of types of conditions which would be Level 5 are: sore throat, UTI, mild abdominal pain which is chronic or recurring, with normal vital signs, vomiting alone and diarrhea alone.
Q23: Can CRNNS provide specific examples of different presentations to a CEC and the appropriate disposition?

A: The following case examples have been provided by the Medical Director of EHS services to illustrate different levels of the CTAS scale as well as the appropriate disposition (presented in the context of emergency cases most commonly addressed in the Parrsboro hospital).

CASE STUDY Laceration Hand, CTAS 5

- 22 year old male presents with simple 2 inch laceration to forearm from home renovation accident.
- Patient discharged home with follow-up 12 days later in daytime CEC for suture removal.

CASE STUDY Dysuria CTAS 4

- 36 year old female presents with dysuria and frequency of 2 days duration.
- Patient discharged home with follow-up in CEC later in same day for prescription and recheck.

CASE STUDY ABD Pain CTAS 3

- 52 year old female presents with right lower quadrant pain of 12 hours duration.
- CEC team assesses patient, establishes care plan. IV established and parenteral pain control initiated. Patient and next of kin educated.
- Arrangements made for urgent patient transfer to Regional Hospital with EHS for further imaging and treatment.

CASE STUDY Chest Pain CTAS 2

- 45 year old female presents with retrosternal chest pain of 45 minutes.
- CEC team assesses patient, establishes care plan. ST-Segment Elevation Myocardial Infarction diagnosed. Arrangements for early reperfusion by administration of tenecteplase and adjunctive therapy and rapid transfer out of CEC.
- Arrangements made for patient emergent transfer to Regional Hospital with EHS for further management.

CASE STUDY Cardiac Arrest CTAS 1

- 19 year old male presents respiratory and cardiac arrest due to overdose in community.
- Chest compressions started, early defibrillation, emergent access to 911 for transfer. Ambulance dispatched lights and siren to CEC. ACLS and BLS protocols provided by RN and Medic.
- Arrangements made for patient emergent transfer to Regional Hospital with EHS for further management.