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WELCOME TO THE PEDIATRIC EMERGENCY DEPARTMENT!

PHILOSOPHY

We try to foster a fun learning environment and encourage questions...you should never be afraid to ask for clarification or guidance. We function as a team and respect for all the team members should be a priority! Our nurses love to learn and appreciate anything you can teach.

As part of our commitment to team care of the pediatric patient, we encourage all providers to see the patient initially with the RN. This need not be an exhaustive evaluation but should allow you to get an idea of what can be ordered immediately. This presents a “team approach” to the patient and family and keeps the caregivers “on the same page.”

Our tempo is usually pretty fast. We are an ED and not a clinic. As such we are committed to teaching the principles of emergency medicine and providing excellent medical care. This requires that you learn to triage patients according to severity and learn to recognize the important emergency aspects of pediatric medicine. You never know what is waiting just outside the door and so you must keep patients moving through our system.

We are an academic institution so we do encourage the residents to go to their required conferences unless we are just overwhelmed. This is especially directed to the peds residents and their core conferences.

You should take responsibility for your patient(s). If there are any questions feel free to ask the attending and if there are any concerns about any aspect of the care delivered in the PED (by anyone that works there) please inform the attending.

We have a great opportunity for “cross-fertilization” in the PED since we have residents from Emergency Medicine, Pediatrics and Community Health and Family Medicine. Each discipline brings skills and knowledge that is unique and we all benefit when we share!

Complete the ASAP module prior to coming for your first shift!

<https://elearning2.courses.ufl.edu/portal/site/UFL-23044-10000> use your GatorLink ID

NUTS & BOLTS

If you are not early you are late!! Being on time, with the needed tools and a good attitude is a sign of your professionalism and is expected.

It is your responsibility to come to the PED prior to your first shift to familiarize yourself with the layout and flow. You should speak to a resident that has previously rotated and ask them to “show you the ropes”. As professionals we should always take the initiative to be prepared to work.

Schedule changes should be first worked out between the residents and then sent up the line to the Chiefs of the appropriate service.

Caring for PED patients is not a linear process. It is rare that you will see a patient, do your H&P and entirely write up the chart at one time. Most residents find that if they

write 2-3 sentences in the history and note any pertinent + or - findings in the physical exam that they can return later to complete the chart accurately. A chart is NOT going to be complete before you have to move on to see another patient. You must learn to multitask!

Orders should be entered asap - do not write your chart first!

Documentation is very important and it is expected that all charts are completed within **24 hours**. Charts of patients that are signed out to another resident or that are admitted **MUST** be completed before you leave your shift.

We do have scribes in the PED to help with documentation but there are some specific things you should be aware of:

1. You are ultimately responsible for what is written on the chart so it behooves you to preview their write-up
2. You should document that a scribe was used by adding the **.edscribe** language to the note
3. Scribes usually do not document the MDM or close the chart by completing the clinical impression and the F2 language (emergency condition, status)

On the desktop of every computer is a "One Note" icon that has the Policies and Procedures for the Emergency Medicine department. There is a tab that is Pediatric specific and contains core material that will enrich your PED experience. The information ranges from eBM article (like use of head CT in minor head trauma) to EBM based guidelines (strept throat, AOM, acute sinusitis), to information useful in discharge instructions (miralax cleanout, PACE asthma action plan). We continue to add to this.

There are several ALERTS in ASAP, particularly for weights (in kgs). Do NOT just blindly click through them. They will appear if the weight entered is >95%ile or <5%ile or if it has changed > or < 10% since the previous weight in the system. The greatest source of errors in medications in pediatrics is an accurate weight...please be aware and always check.

Dot phrases for ASAP in the PED

- | | |
|--------------|---|
| .this | lists all lab results, normal and abnormal |
| .edlabslists | abnormal labs only |
| .edcred | name with MD, date, timestamp |
| .vs | last set of vitals (for re-eval notes) |
| .edscribe | scribe attestation, goes at bottom of note |
| pace asthma | (NO dot) pulls in asthma action plan for discharge instructions |

ASAP and Workflow QUICK GUIDE

The longer ASAP introduction is very linear and good for an introduction but clearly does not address how you will work. Seeing a patient in the PED is NOT a linear process. A quick guide summary might be:

From the Trackboard, select the most urgent (lowest triage number) **FIRST**

If a patient has the attending initials in both ATT and R/M column you do not have to see that patient

Select the patient and open the chart

Click on “medical evaluation initiated”

Read the nursing triage note

Briefly see the patient (you may have time to quickly look at PMHx)

Place orders

Write 2-3 sentences for history and pertinent physical findings

It is very important in real time to do REEVAL using the .edcred

MDM is also **VERY** important. In the large box put down your “thoughts” and why you are doing what you are doing. Do **NOT** just copy your HPI

Before dropping in discharge instructions, you must write a few sentences “personalizing” them.

This should include diagnosis, tests and the results and brief treatment plan

At the end after discharge is place, you *must* return to the chart, enter “my note” and “**refresh**” in order to pull in the disposition and clinical impression.

PED - ASAP Condensed Guide

Sign into EPIC using your UF Health credentials. After signing in successfully, you will be prompted to choose your department. The department for the pediatric emergency room is *UF 15ES*.

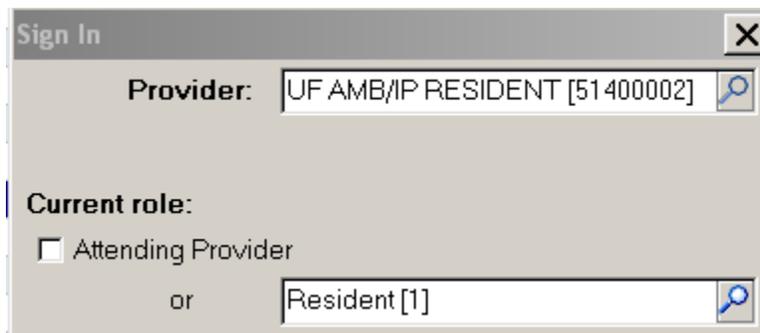


The first thing you will notice is that the ED department home screen is visually very different than the inpatient and ambulatory home screen. The home screen for the pediatric ED is called the *Trackboard*.

The first thing you will want to do after logging into EPIC is to sign in. The *Sign in* button is located in the toolbar of the trackboard, toward the right side of your screen.



Click the *sign in* button and select your role if it does not default.



You can now navigate the trackboard and find your patients. Familiarize yourself with the trackboard column layout. You can see patient information including the chief complaint, initials of the assigned staff treating the patient, acuity as well as pending and resulted lab and imaging orders. The columns are sortable by right clicking on the column header.

ED Track Board (UF SHANDS PEDIATRIC EMERGENCY DEPARTMENT - NT) - Last Refresh Time: 9/20/2013 10:02:13 AM

| Bed | Patient | Age | Complaint | A | TT | MOA | RN | ATT | R/M | SCR | Unack | Lab Stat | Img Stat | Consult Stat | Dispo |
|-----------|---------|---------|------------------------------|---|-------|-----|----|-----|-----|-----|-------|----------|----------|--------------|-------|
| RES-4 | | 18 m.o. | Facial Laceration | 3 | 15... | | | JJK | JR | | | | | | |
| PH-2 | | 6 y.o. | Arm Injury | 2 | 17... | | | LLD | CKH | JR | | | | | |
| PED-9 | | 5 days | Decreased Po | 2 | 17... | | | LLD | JF | FGH | | 1/1/1 | | | |
| PED-8 | | 23 y.o. | Irregular Heart Bea | 2 | 16... | | | JC | CKH | RW | | 1/3/4 | | | |
| PED-7 | | 19 y.o. | Nausea; Abdominal Pain | 2 | 14... | | | LLD | CKH | RW | | 1/5/6 | | | |
| PED-6 | | 12 y.o. | Motor Vehicle Crash | 3 | 15... | | | LLD | CKH | FGH | | | | | |
| PED-5 | | 14 y.o. | Shortness of Breath; Chest | | | | | JC | CKH | JR | | | | | |
| PED-2 | | 10 y.o. | Chest Pain | | | | | KAM | CKH | JR | | | | | |
| PED-13 | | 17 y.o. | sent from clinic for Baker A | | | | | KAM | CKH | JR | | | | | |
| PED-12 | | 9 y.o. | Double Vision | | | | | KAM | CKH | FGH | | | | | |
| PED-11 | | 15 m.o. | Respiratory Distress | | | | | BLD | CKH | CKH | | | | | |
| PED-10 | | 10 y.o. | Headache | | | | | | | | | | | | |
| PED-1 | | 25 y.o. | Hip Pain | 3 | 15... | | | | | | | | | | |
| OTF - PED | | 3 y.o. | | | 22... | | | | | | | | | | |
| OBS-5 | | 11 y.o. | Abdominal Pain | 1 | 16... | | | MNK | | | | | | | |

Depending on the status of the patient, your patient may be found in any one of the patient tabs of the trackboard. After signing in, you can highlight a patient, right click and select the *assign me* button to assign yourself to the patient’s treatment team. The patient will also flow to your *My Patients* tab in the trackboard.



Just prior to physically seeing your patient, or immediately after, you should document that the Medical Evaluation has been initiated. To do this, enter the *My Note* activity and select *New Reading* under the *Medical Evaluation Initiated* header. You can document for the current time just prior to seeing the patient or you can back document the time if you recently saw the patient. Select the appropriate time and make sure to click the *Yes=Medical Evaluation Initiated* button. Once complete, you can click *close* or *next* to move on to documenting the Provider note.

SnapShot

ED CDU Note

Review Visit

My Note

Medical Evaluation Initiated

New Reading | Go to Doc Flowsheets

Medical Evaluation Initiated

Medical Evaluation Initiated:

Medical Evaluation Initiated

New Reading | Go to Doc Flowsheets

ED Provider Notes

My Note | Go to Notes | Refresh

Medical Evaluation Initiated - Medical Evaluation Initiated

Time Taken:

Date: 9/6/2013

Time: 1201

Medical Evaluation Initiated

Medical Evaluation Initiated Yes=Medical Evaluation Initiated

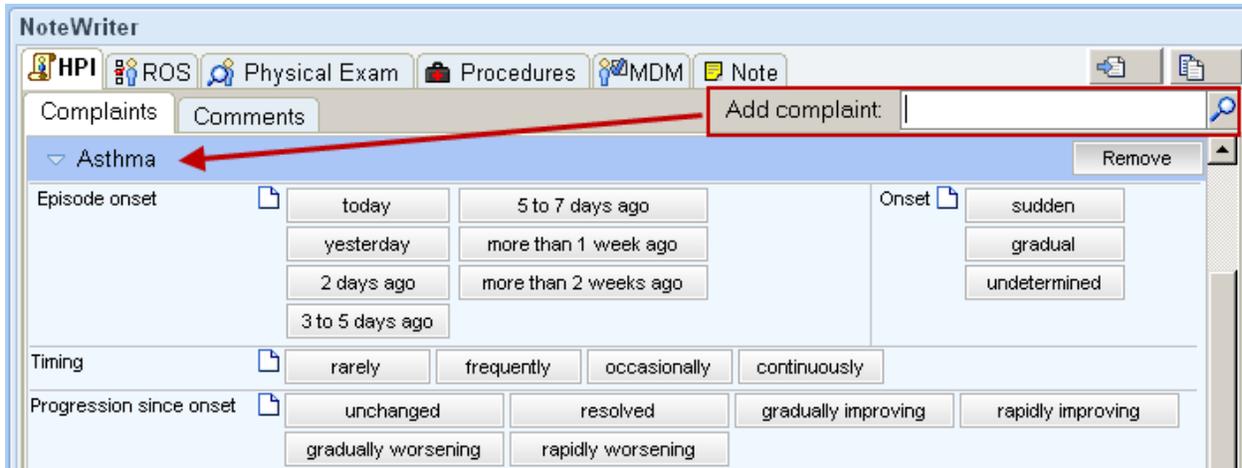
Restore Close F9 Cancel

Another one of the main differences between inpatient/ambulatory Epic workflows and the ED workflows is the provider note. The provider note can be documented and shared amongst the patient’s

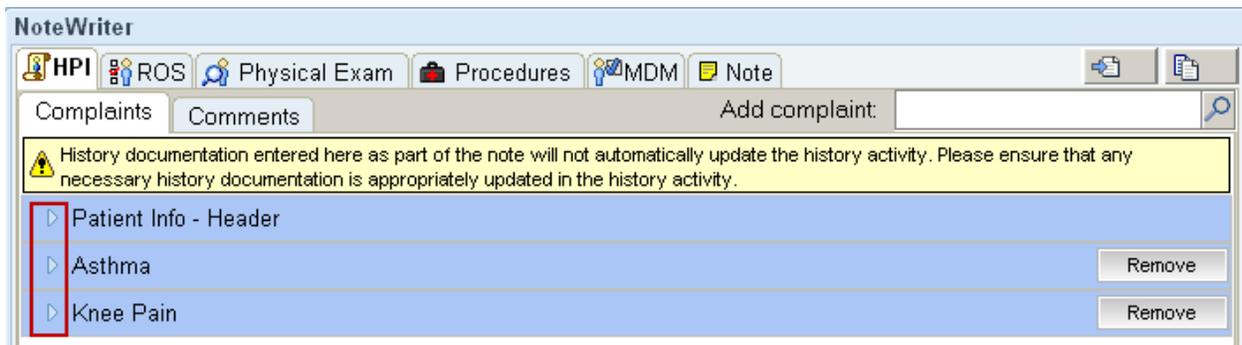
care providers. This allows for ongoing updates and continual documentation throughout the patient's ED encounter by multiple providers.

HPI

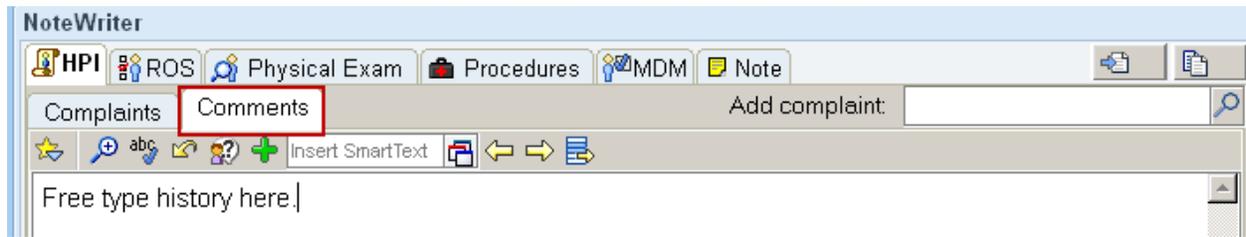
When you are ready to initiate the provider note or update your existing note, click the *My Note* button under the *ED Provider Notes* header. The first tab in NoteWriter is the *HPI* tab. There are 2 ways to document the patient's history in this tab. The first is to add a complaint via the search box.



If you add a complaint here, specific questions will populate to assist you in documenting pertinent information. You may add as many complaints as you wish and you can navigate between them by collapsing each complaint using the small triangle button.

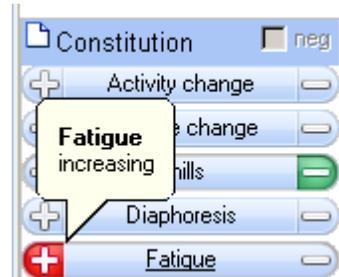


The other way to document the history is to free type it into the comments tab, either way is acceptable. Note that anything you document in the sections above appears into the actual note in the lower half of the window in real time as a preview.

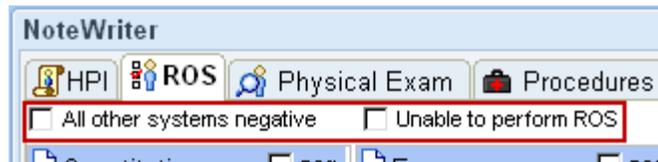


ROS

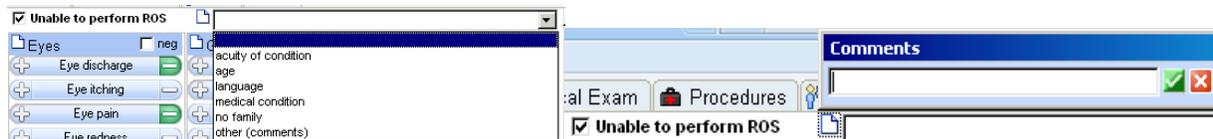
The next tab in *NoteWriter* is the *ROS* (Rule of Systems) tab. You can document pertinent positives and negatives as well as add comments to the individual items by hovering over it with your mouse and simply typing. Epic will catch your typing and you will see comments show up as underlined items.



There are also two important features to point out. Directly underneath the ROS tab, there are two checkboxes.

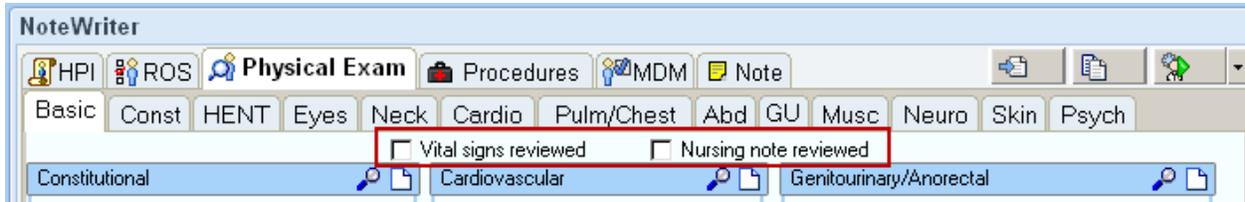


The first is to document *all other systems negative* (**Remember:** to document this checkbox you must actually review all of the other systems.) The other checkbox is to document if you are unable to perform the ROS. If you cannot perform the ROS, you must document the reason why you were unable to perform the ROS. You can do this by selecting one of the items from the drop down box to the right of the checkbox, or by free typing a comment via the paper icon.



PE

The next tab is the *Physical Exam* tab. There are multiple tabs contained in the PE tab. The *Basic* tab will allow you to document everything you need to. However, you may further pursue additional exam options and details via the other tabs. Similar to the ROS tab, there are two checkboxes near the top in which you will specify that you reviewed the patient's vital signs and that you have reviewed the nurse's note.

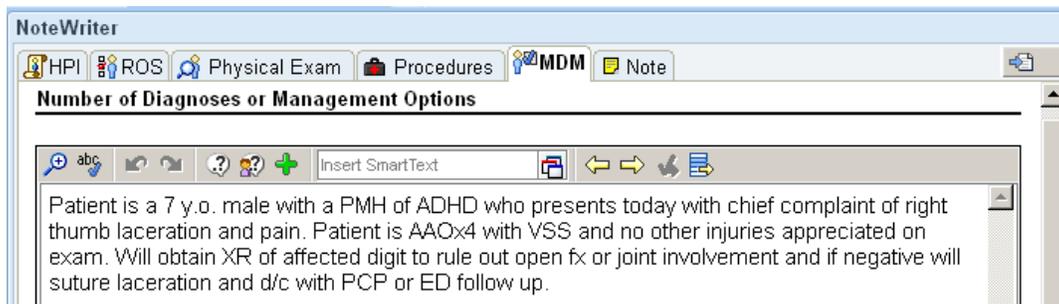


PROCEDURES

The next tab is *Procedures*. This tab is similar in function to adding complaints in the HPI tab. The most common procedures are listed as buttons. There are additional procedures located via the search window. Simply find the procedure in which you want to document and then fill out the corresponding questions that populate the window.

MDM

The second to last tab is the *MDM* (Medical Decision Making) tab. **This is a very important documentation step of the provider note.** Every patient must have a short paragraph that details your plan and assessment of the patient which should include your thought process, chief complaint, DDX, pertinent orders, results, and care plan. **Do not copy the patient's history!** This is the area that most other providers will review to understand what happened in the ED and what the plan of care is.



Once you have completed the paragraph, continue to the questions in the bottom section of the MDM. Answer the questions and add appropriate comments. For example, if you reviewed or ordered clinical lab tests, include your interpretation of the results. Another example is if you obtained history from someone other than the patient, then you should document in the comments which person you obtained it from. You should add a short

comment to nearly every question to provide details to the answer you selected.

Amount and/or Complexity of Data Reviewed

| | | | | | |
|---------------------------------------|--|-----------------------------------|--|--|--|
| Clinical lab tests | <input type="checkbox"/> ordered | <input type="checkbox"/> reviewed | Tests in the radiology section of CPT® | <input type="checkbox"/> ordered | <input type="checkbox"/> reviewed |
| Tests in the medicine section of CPT® | <input type="checkbox"/> CBC, BMP | <input type="checkbox"/> ordered | <input type="checkbox"/> reviewed | Discussion of test results with the performing providers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Decide to obtain | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Obtain history from | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

You do not have to fill out the *Risk of complications, Critical care* or the *progress* sections.

Risk of Significant Complications, Morbidity, and/or Mortality

| | | | | |
|-----------------------|----------------------------------|------------------------------|-----------------------------------|-------------------------------|
| Presenting problems | <input type="checkbox"/> minimal | <input type="checkbox"/> low | <input type="checkbox"/> moderate | <input type="checkbox"/> high |
| Diagnostic procedures | <input type="checkbox"/> minimal | <input type="checkbox"/> low | <input type="checkbox"/> moderate | <input type="checkbox"/> high |
| Management options | <input type="checkbox"/> minimal | <input type="checkbox"/> low | <input type="checkbox"/> moderate | <input type="checkbox"/> high |

Critical Care

Time < 30 minutes 30-74 minutes 75-105 minutes > 105 minutes

Progress

Patient progress improved stable resolved other (comment)

NOTE TAB

Once you have completed the MDM, it is time to review the note itself. In the *Note* tab, you can see the note template with data pulled in from the chart (highlighted in green) as well as the items that you have input from the previous tabs (highlighted in orange.)

History

Chief Complaint
Patient presents with

- Hand Injury

Right hand injury related to falling from bicycle, noted ? open fracture to thumb, also pain to index finger - dressing applied

HPI Comments: Free type history here.

Patient is a 7 y.o. male presenting with asthma and Knee Pain. The history is provided by the patient and the mother.

There are 4 additional items in the body of the note that you will need to document before you can sign the note (you could share the note without all of the variables documented, but eventually you or another provider will have to complete these items to sign the note.)

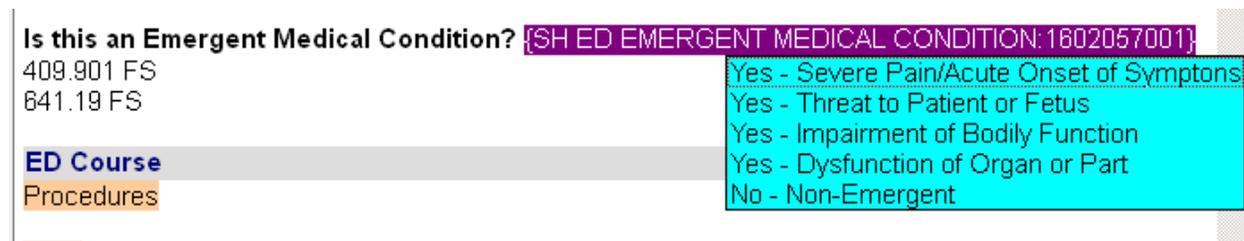
To find these additional items to document, start near the top of the note and click the F2 key on the keyboard or use the yellow arrows in the note's toolbar to navigate.



The first item you should jump to is the *Differential diagnosis* wildcard (***) The DDx should have at least three diagnoses. With the wildcard highlighted, simply start typing to replace the wildcard with your documentation.

Differential DDx: ***

Once you have documented the DDx, the next item for you to navigate to is the SmartList for *Emergent Medical Condition*. If you used the F2 key or the arrow, the list should automatically drop down for you. Do not use the non-emergent value (reason: in Florida, the patient defines the emergency and the majority of patients being seen in the ED consider their situation an emergency. The *non-emergent* condition is not your opinion after a work-up.) Select one or more of the other values by left clicking to select the value and right clicking to confirm. A handy phrase to remember this workflow is “left-click to pick, right-click to stick.”



RE-EVALUATION

The next item to document is your ED Re-Evaluations. This is an item that you will document throughout the patient's ED encounter. This item does not have a wildcard or SmartTool to drive you to the section. You should document any changes and re-evaluations of the patient including responses to treatment, care plan changes, consults and changes in assessment in this area along with the time/date and your name and credentials (easiest way to add this data is to use the SmartPhrases or “dot-phrases” for time and MECRED to insert your name and credentials.) Do not delete any previous re-evaluations and simply continue to add new re-evaluations under the older ones. **It is important to click the refresh button (you may also use the keyboard shortcut CTRL+F11) during your re-eval to refresh all of the SmartLinks in the**

note. Refreshing the SmartLinks will ensure that you have the most recent data, such as vital signs and lab results, populating your note.



The Re-Evaluations section is one of the only ways for other providers to get an accurate account of the patient's care timeline.

The last item to document in the body of the note is the Patient Status SmartList. You can use the F2 or the arrow key to open this list.

ED Patient Status

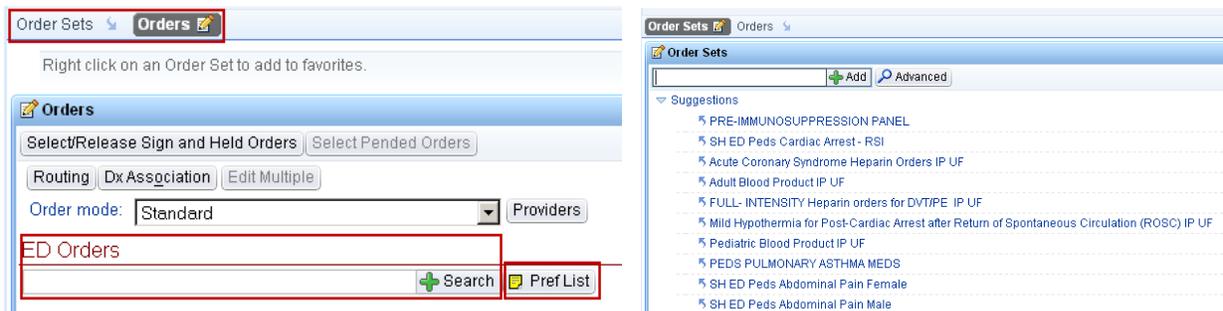
Patient Status:
The patient condition on admission/discharge/transfer is: **SH ED UF PATIENT**
CONDITION:1602057101

- Stable
- Guarded
- Critical
- Other (LWBS, AMA)
- Deceased

You can now share the note so that you can return to it later or other providers may document in it, or sign the note if you are completely finished. (Any subsequent changes after the note is signed will have to be done using an addendum.)

Orders and Order Sets

Navigate to the Orders activity of your patient's chart by choosing it from the vertical navigation toolbar on the left. You may take action on currently active orders, write new individual orders, write orders from the ED preference list, or choose an order set to order from. Change the tab selection from orders to order sets to get to the order set search window, or choose from one of the suggested pediatric ED order sets. ED Specific order sets that often contain EBM guidelines include DKA, Hypoglycemia and IEM, Fever for patients greater than 28 days, Immunocompromised and the Sickle cell order sets.



Discharge

When discharging a patient, use the Discharge activity. This sets up the discharge workflow activities for you in a navigator.

The first item is follow-ups. You may select the patient's PCP or another service or provider by choosing the appropriate buttons. All follow-ups should be completed within 48 hours.

The screenshot shows a 'Follow-Up' form with the following fields and options:

- Follow-Up With:** PEDIATRICS, HORIZON
- Details:** Schedule an appointment as soon as possible for a visit in 2...
- Buttons:** New, Delete, With PCP
- With:** Provider (selected), Department, Location, ER, Other
- How:** Call, Make Appointment (selected)
- When:** 2 (selected), Day(s) (selected), Week(s), Month(s), Date: 9/8/2013
- Comments:** As needed, If symptoms worsen

If you choose to prescribe medications, remember you cannot e-prescribe currently from the ED. Other key points of filling out the script is to make sure you fill in the dispense information correctly including checking the full amount calculations for solutions to be correct. Keep the class set to normal and the script should print to the locked tray prescription printer in the Peds ED.

No Rx Prescribe

acetaminophen 650 MG TABS

Take 650 mg by mouth once for 1 dose.
Disp-30 Tablet, Normal
Given at 9/5/2013 1716. Ordered by: Jones

Previous Sig: As of 9/5/2013: Take 2 Tablets by mouth once. Maximum acetaminophen dose from all sources is 4 grams o
Copy To Patient Sig

Patient Sig: **Take 650 mg by mouth once for 1 dose.**
Edit Add additional information to the patient sig

Product: **ACETAMINOPHEN 650 MG PO TABS** View Available Strengths

Sig Method: Specify Dose, Route, Frequency Use Free Text

Dose: 650 mg 325 mg 650 mg

Route: Oral Oral

Frequency: ONCE NOW Q4H PRN Q6H PRN

Starting: 9/6/2013

Notes to Pharmacy (F6): (300 char max.)

Dispense: 30 Tablet Refill: 0 Days/Fill: Full (1 Days) 30 Days 90 Days

Class: Normal E-Prescribing Print Phone In CLINIC PERFORMED Sample MD to complete Rx



The next item in the Discharge workflow is for Discharge Instructions. In the free text area, you must write **personalized instructions to the patient** that covers the diagnosis, specific tests and results the patient received, and an assessment and plan. After this personalized statement, you may then add additional instructions via the suggested instructions links. (**Remember** to check the formatting of the instructions you add.)

There is a list of discharge instructions for ASAP on the desktop that lists some suggestions you might not think of. Personalized "Asthma Action Plan" is available as a SmartText. In the active selection box, type "PACE asthma."

Discharge Instructions

Go to References/Attachments

Suggested Discharge Instructions:

- [ASPIRIN AND YOUR HEART \(ENGLISH\)](#)
- [CHEST PAIN \(NONSPECIFIC\) \(ENGLISH\)](#)
- [CHEST PAIN \(NONSPECIFIC\)-BRIEF \(ENGLISH\)](#)

Personalized instructions.

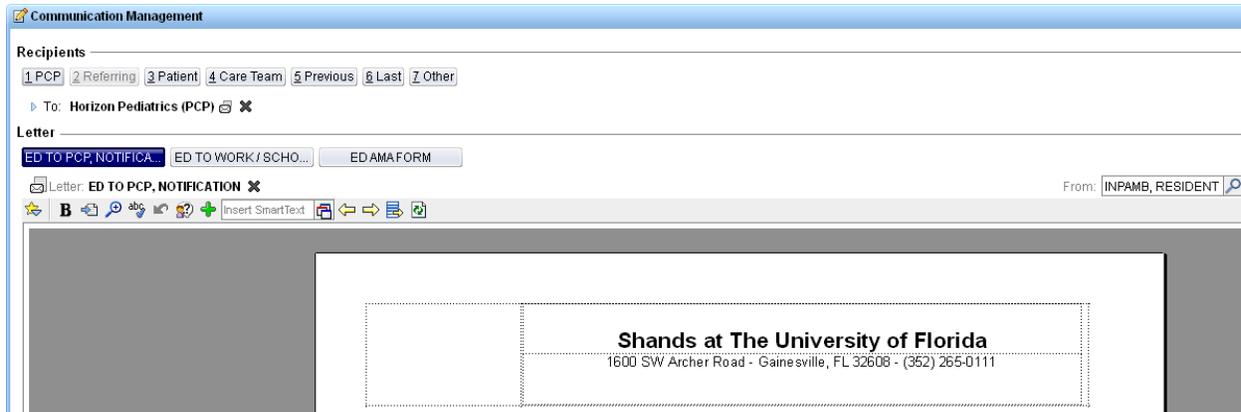
Aspirin and Your Heart

Aspirin affects the way your blood clots and helps "thin" the blood also can be used as a secondary measure to prevent more heart a

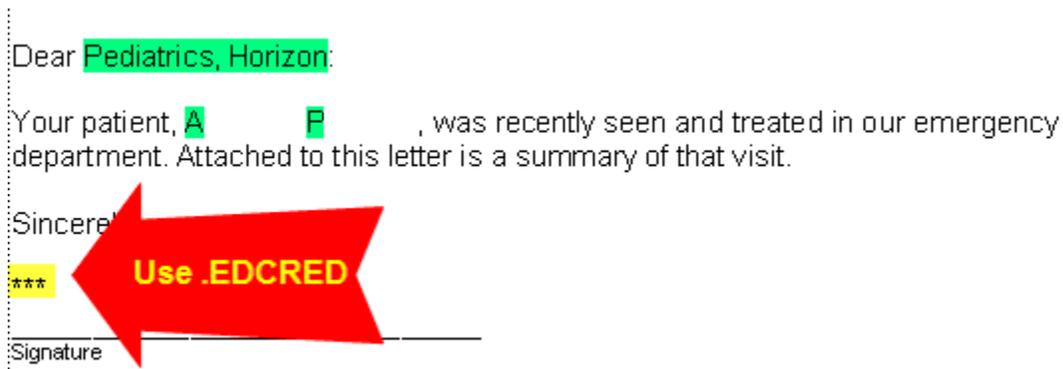
ASPIRIN MAY HELP IF YOU:

Comm Management

One of the last discharge activities to complete is *Comm Mgt* (communication management.) Letters to the PCP as well as returning to school/work letters are to be created and sent via this activity. Select *New Communication* and select the recipient. If the PCP is not listed, you can add one by the *Add field* to the far right or by selecting the *Other* button and filling out the recipient information. Next, select which type of letter to be sent. A preview of the letter will open which is editable.



You will need to review the letter and add your name and credentials in place of the wildcard (similar to the ED provider note, you can use the F2 key to navigate the letter to find the wildcards.)



When you have finished with the letter, you can *Pend* it to come back later and edit it. Most often, you will choose the *Send upon Closing Encounter* option to send the communication after the patient is physically discharged and the encounter is closed.



After you have documented the discharge disposition and finalized the clinical impression, it is best to refresh your note one last time to pull in these details into your note.



ED Disposition

ED Disposition: **Discharge**

ED Clinical Impression

ED Clinical Impression

Diagnosis

Fever

DISCHARGE INSTRUCTIONS IN ASAP YOU MIGHT NOT THINK OF:

TEENAGERS

Alcohol intoxication
Alcohol, FAQs
Amphetamine abuse
Anxiety and panic attacks
Cervicitis
Chemical dependency
Cocaine abuse and chemical dependency
Domestic abuse
Eating disorders
Emotional crisis
Herpes labialis
Marijuana abuse and chemical dependency
Pelvic exam
Pelvic inflammatory disease
Polysubstance abuse
Pregnancy
Safer sex
Sexually transmitted disease

INFANTS

Baby care
Baby – caring for common problems of the infant
Baby, safe sleeping
Birth, Baby care
Fussy babies
Jaundice newborn
Labial adhesions
Neonatal acne
Newborn booklet
Newborn rashes
Rear-facing infant only safety seat

CHILDREN

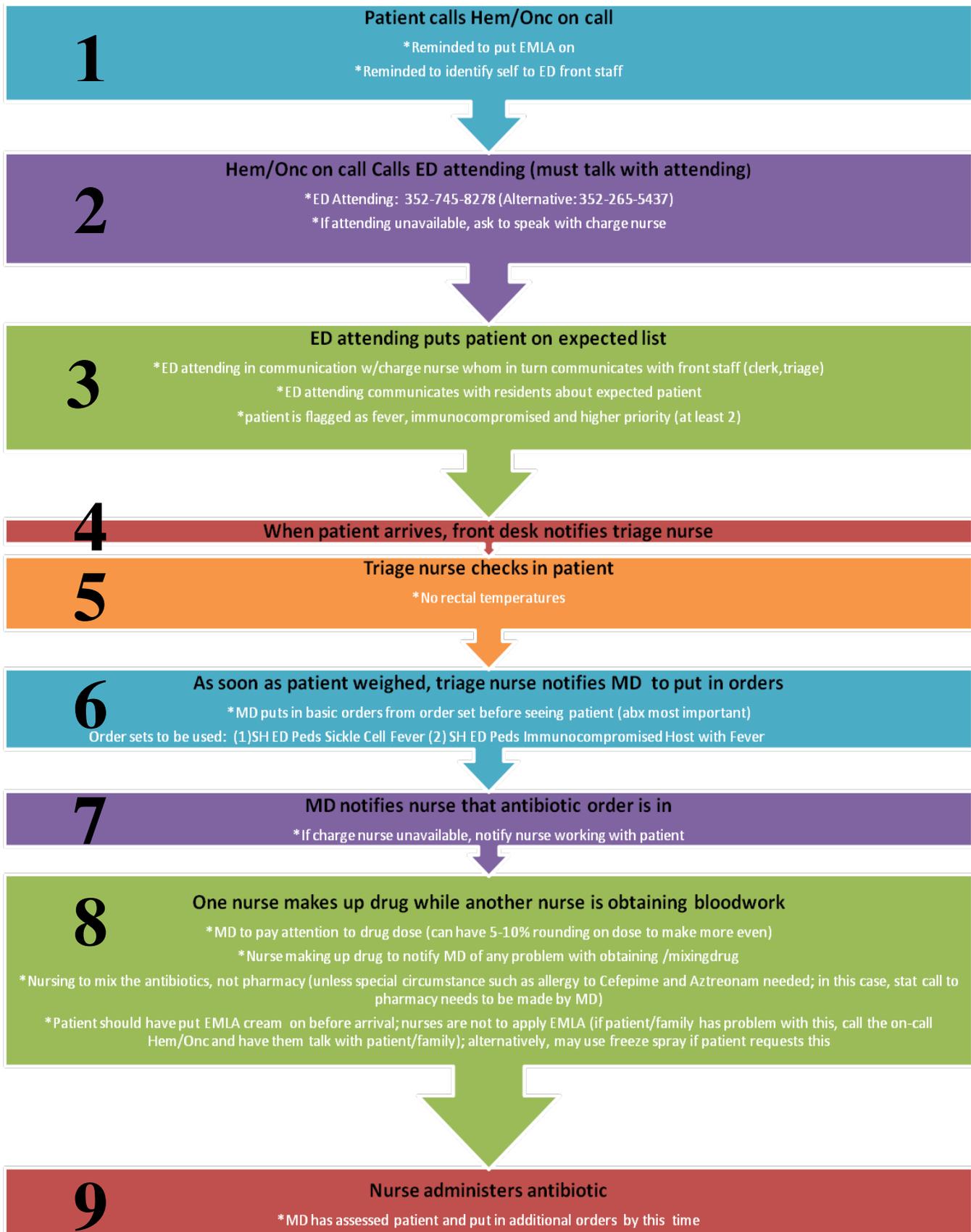
Allergic reaction
EpiPen auto injector instructions
Antibiotic medication
Antibiotic nonuse
Antibiotic treatment and drug resistance
(reason not to use abx)
Child safety seat use chart

Child safety seats
Choking episode
Choking in children
Common cold
Dehydration
Diet of diarrhea
Dosage chart, Tylenol (see also fever, with dosing charts)
Dosage chart, motrin (see also fever, with dosing charts)
Ear infection, easing the pain
First-aid measures in poison ingestions
Fussy babies and children
Keeping your child safe
Non-toxic ingestion
PACE asthma – Asthma action plan
Overdose, accidental
Overdose, pediatric
Poison proofing
Poisoning in children, Easy to read
Poisoning in children – brief
Poisoning prevention, child
Post-concussion syndrome
Safety, making a home safe for children
Sore throat, gargle

TRAUMA

Arm sling use
Cast care
Cast shoe
Cast or splint
Crutches
Head injury, child (included return to sports)
Concussion and brain injury, child
Laceration care
Laceration, after care
Laceration, old, not sutured
Laceration with skin glue
RICE – routine care for injuries
Suture removal
Sutured wound care
Tissue adhesive wound care

TIME TO ANTIBIOTIC FLOW CHART



All febrile Sickle Cell patients receive 75 mg/kg Ceftriaxone

All Infants less than 28 days receive 100 mg/kg Ampicillin and 4mg/kg Gentamicin

All other febrile immunocompromised patients receive 50 mg/kg Cefepim

YOU MUST READ THIS PRIOR TO STARTING YOUR PEDIATRIC ED ROTATION

Quality Control Initiative for the management of FEBRILE IMMUNOCOMPROMISED PATIENTS

Immunocompromised patients are at high risk of developing serious infections and becoming very sick very quickly. It is therefore imperative that you act quickly with these patients and work with other members of the healthcare team to ensure timely antibiotic delivery. (Please see attached flow sheet for the triage process in the ED---Be aware of the steps that are being taken to ensure we streamline the process to get these patients treated QUICKLY—GOAL IS TO RECEIVE ANTIBIOTICS WITHIN 1 HOUR OF ARRIVAL)

Your most important role as a resident, in addition to your assessment of the patient, is prompt ordering.

QUICK TIPS for ordering:

1. Use the following order sets:

(1) SH ED Peds Sickle Cell Fever

(2) SH ED Peds Immunocompromised Host with Fever

Patients included in this group include:

- A. Cancer or leukemia-currently receiving chemo or within 1st 6 months after completion of chemo
- B. Solid organ transplant-within 6 months of transplant or receiving immunosuppressive therapy related to transplant within last 3 months
- C. Patients without spleen
- D. Bone marrow transplant-within last year or taking immunosuppressive therapy within last 6 months
- E. Immune deficiency-congenital or acquired (e.g. AIDS or on meds for prevention of or suspicion of HIV)
- F. Anyone on immunosuppressive therapy

2. Before seeing the patient, use the basic parts of the order sets that are already marked (you can always go back through the order set a second time after antibiotics have been ordered)
*most important is the antibiotics and cultures; the rest can typically wait until after you see the patient
*Do not wait on blood counts to see whether or not the patient is neutropenic----all of these patients will start off getting Cefepime
3. Antibiotic (in the order set)
*Sickle cell patients will get 75 mg/kg Ceftriaxone (max 2g)
*All other patients will get 50mg/kg Cefepime (max 2g)
****See dosing charts that are available in the ED (attached to most resident computers)**
*There are special circumstances, such as when patients are allergic to medications, but these are all listed at the top of the order set, so there is no need to list them here or memorize them
4. Notify nurse that you have ordered the drug and it needs to be made (If charge nurse unavailable, tell bedside nurse or additional nurse helping her out)
5. After you have ordered the antibiotics and told the nurse they are ordered, assess the patient and determine what additional testing/interventions are needed (If patient is crashing on arrival, just ensure someone is caring for the patient while someone else is ordering the antibiotics.

TAKE HOME MESSAGE: WHENEVER YOU SEE IMMUNOCOMPROMISED, FEVER AS CHIEF COMPLAINT OR NURSE TELLS YOU OF THESE PATIENTS, ACT FAST AND MAKE SURE SOMEONE IS WORKING ON ORDERING/MAKING/DELIVERING ANTIBIOTICS TO THEM

All febrile Sickle Cell patients receive 75 mg/kg Ceftriaxone

All Infants less than 28 days receive 100 mg/kg Ampicillin and 4mg/kg Gentamicin

All other febrile immunocompromised patients receive 50 mg/kg Cefepim