EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

Position Statement

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USE OF PROTOCOLS IN THE EMERGENCY SETTING

Description

The use of protocols — also known as standing orders, preprinted order sets, advanced nursing interventions, advanced triage protocols, and computerized order sets — has been recognized as a method of enhancing safety while expediting patient care.[1–4] Protocols are institution-based guidelines, developed for specific disease conditions or chief complaints, that allow the emergency nurse to initiate diagnostic tests and interventions before the patient is evaluated by a provider.[2] Early implementation of protocols has been reported to decrease patient length of stay in the emergency department by making diagnostic test results available early, improving patient time to care, and bed availability.[1,2] Using protocols has also been shown to facilitate the early treatment of pain[5] and decrease delays in critical interventions, such as antibiotic administration for patients with pneumonia[6] and thrombolytic therapy for patients with acute myocardial infarction.[7]

ENA Position

It is the position of the Emergency Nurses Association that:

1. The use of protocols is an important strategy to expedite care, improve patient flow, and increase patient safety.
2. Emergency nurses collaborate with interprofessional colleagues to develop, approve, and evaluate evidence-based protocols within the emergency nursing scope of practice to assure they are consistent with current best practices.
3. Emergency nurses, as licensed healthcare providers, are among those who qualify under CMS regulations to use computerized provider order entry (CPOE) programs to enter orders directly into the medical record.

Background

Meaningful Use[9] of the electronic health record (EHR) is part of a Centers for Medicare and Medicaid Services (CMS) 19-billion-dollar incentive program originating from the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.[10] Meaningful Use Stage 2 has 16 sections, with the first being specific to CPOE and requiring that, in order to qualify for the incentive, hospitals must use CPOE for 60% of all medication orders, 30% of all lab orders, and 30% of all radiology orders.[11] To qualify for inclusion, an order must have been entered into the computer the first time it appears in the medical record; in other words, a written record cannot be transcribed into the EHR and qualify as meaningful use of CPOE.[11]

The HITECH Act of 2009 created ambiguity as to who was allowed to enter orders into the computerized EHR technology (CEHRT), and many facilities and practitioners interpreted the regulatory language as prohibiting order entry by nurses.[12] In 2012, CMS held hearings reported in the Federal Register and, as a result of "many comments," issued the following statement: “We clarify that nurses who are licensed and can enter orders into the medical record per state, local and professional guidelines may enter the order into CEHRT and have it count as CPOE.”[8]

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Developed: 2015.

Approved by the ENA Board of Directors: January, 2014
Revised and Approved by the ENA Board of Directors: July 2015