Notable Elements of Mr. Duncan's Initial Emergency Department Visit
Thursday night, September 25 – Friday morning, September 26

10:37 p.m. Mr. Duncan arrives in Emergency Department (ED)

- Patients presenting to the ED are treated in order of priority based upon a screening tool used widely around the country.
- Information obtained from Mr. Duncan and his companion during intake was limited to his chief complaint, a date of birth, gender, and first and last name.
- Based on these initial symptoms, Mr. Duncan returned to the waiting room to await triage. 5-10 patients at the time were waiting for beds in the ED treatment area.

11:36 p.m. Triage starts

- A triage nurse again asks Mr. Duncan the reason for his presentation and records Chief complaint identified as "abdominal pain, dizziness, nausea and headache (new onset)."
- She records a temperature of 100.1F.
- His other vital signs were unremarkable.
- Obtaining the patient's travel history was not a part of the triage nurse's process on September 25, 2014.

12:05 a.m. Mr. Duncan is brought back to a room in the ED treatment area

12:27 a.m. First physician interaction with the EHR

- The EHR shows the physician accessed the triage nurse's report, along with other elements of the record, which at this time did not include the travel history. These included:
    - Visit Navigator Template
    - ED Triage [twice]
    - THR Template MD Assessment
    - ED Patient History
    - Flow Sheet ED PTA Home Meds
    - Allergies
    - ED First Provider Contact
- The physician visited the patient but did not begin his examination

12:33 – 12:44 a.m. RN assessment

- The primary ED nurse continues the assessment.
- She identifies his complaints as "sharp, intermittent epigastric/upper abdominal pain; sharp, frontal headache; dizziness; lack of appetite"
- She asks about Mr. Duncan's travel history.
- The nurse documents that Mr. Duncan "came from Africa 9/20/14"
- RN states she recalls the discussion because of how long the plane flight was. (She had personal experience with very long plane fights). Attached no further significance to this travel history.
- This information was not verbally communicated to the physician, as prompted by the EHR.

12:52 – 1:10 a.m. ED physician begins evaluation of Mr. Duncan

- The ED physician accesses the EHR again. A review of the EHR shows that the physician, on several occasions, accessed portions of the EHR where the travel history was now available including:

    - ED Lab Results Screen

- ED Triage [twice]
- ED Rad Results

- The record does not show which information the physician read, only which information was available.
- Additionally, the EHR review shows that the physician gathered personal history and health data directly from Mr. Duncan and his companion.
- These data, as reflected in the EHR, reveal that Mr. Duncan and his companion advised that he was a "local resident", that he had not been in contact with sick people, and that he had not experienced nausea, vomiting or diarrhea.
- The patient's physical examination was remarkable only for nasal congestion and a runny nose along with mild abdominal tenderness.
- The physician views several more locations in the EHR including:

    - ED Lab Results Screen
    - Visit Navigator Template
    - Related Encounters
    - Flow sheet
    - Allergies
    - PTA Home Meds
    - ED Patient History

1:10 – 3:37 a.m. Physician ongoing evaluation and treatment

- Over the next two hours, the physician accesses the EHR several times to review laboratory results, radiology results, response to treatment, review of vital signs, and medications.
- On several occasions, the physician reviewed this information in locations within the EHR that included Mr. Duncan's travel history, as documented by the primary ED nurse. Again, the record does not show which information the physician read, only which information was available.
- The patient is given Extra Strength Tylenol at 0124 and Intravenous Normal Saline is started
- Lab results are reviewed at 0109 and include:

    - WBC – 3.08 L (low end of 'normal range' 3.98)
    - Platelets – 92 L (low end of 'normal range' 130)
    - Glucose – 180 H (high end of 'normal range' 100)
    - Creatinine – 1.41 H (High end of 'normal range' 1.25)
    - AST – 94 H ('normal' <34); can reflect abnormalities in liver function or muscle tissue
- Radiology results reviewed at 0128 and included:
    - CT scans Abdomen & Pelvis- "no acute disease" and Head - "unremarkable"

- The patient's temperature was documented as 103.0F at 3:02 a.m.

- The patient's temperature was documented as 101.2F at 3:32 a.m.

3:37 a.m. Patient discharged

- The discharge diagnosis was sinusitis and abdominal pain. At the time of discharge, the ED physician documented that "patient is feeling better and comfortable with going home."
- Physician makes final views of patient record including:

    - ED Lab Results
    - ED Rad Results
    - Visit Navigator Template
    - Allergies
    - ED Triage
    - ED PTA Home Meds
    - Visit Diagnosis
    - THR Discharge MD ED
    - Discharge Instructions
    - ED Disposition
    - Flow sheet
    - Inpatient DC Instruction Writer
    - Communication Management Section
    - ED AVS PHD RTF
    - ED Orders

- Discharge instructions were recorded in the EHR advising the patient to take medication as directed, return for increased pain, fever, vomiting or other concerns. Follow up with your doctor or the recommended doctor tomorrow for a recheck. Rest and drink plenty of fluids. Specific instructions for abdominal pain, dizziness and sinusitis gave additional instructions and advice when to seek immediate care.