EMP/EPMG

Emergency Medicine Physicians/Emergency Physicians' Medical Group

Department: Legal; Risk Management; Clinical Quality	**Policy and Procedure Title:** Fever in the Infant 0-90 days
Effective Date: February 1, 2006	**Replaces Policy Dated:** June 1, 2004
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Scope: EMP & EPMG Physicians	

PURPOSE: Children less than three months old who have a fever on presentation to the Emergency Department represent a significant liability risk if they are discharged without definitive identification of a fever source for which outpatient treatment is appropriate and close outpatient follow-up assured, or if they are admitted without antibiotic treatment. In order to minimize the liability risk created in these situations, this policy is intended to provide an additional layer of both consultation and oversight in the disposition decision-making involved in caring for such patients. The final disposition decision still rests with the physician treating the patient.

POLICY:

1. Applicability.

   a. This policy applies to patients meeting criteria i, ii & iii; if one of the scenarios in part iv occurs:

      i. Children under 90 days of age (Note: age to be determined from date of delivery; not EDC); and

      ii. Rectal temperature 100.4° F. or greater in the Emergency Department, OR a report of a fever at home by a caregiver (Note: A fever at home can either be a measured temperature by a caregiver OR a subjective temperature); and

      iii. The patient has NOT had ALL of the following:

         (1) A Complete Blood Count and differential;

         (2) A Blood Culture;

         (3) A urinalysis and urine culture from a specimen obtained by catheter or suprapubic tap;

         (4) A Lumbar Puncture; and

(5) A Chest X-ray if the patient exhibits signs of a lower respiratory tract infection, respiratory distress, abnormal breath sounds or a pulse ox of <95%.

iv. Triggering Scenarios

(1) Child is 28 days or younger with fever, not admitted to the hospital in consultation with the primary care provider or the pediatrician on call.

(2) Child is 29-90 days old with fever, found to have abnormal test results and is therefore considered high risk for sepsis, but not admitted to the hospital. Abnormal test results may be any one or more of the following:

(a.) A WBC count <5,000 >15,000; or

(b.) Greater than 1,500 bans on the WBC differential; or

(c.) Greater than 8 WBC's in the CSF or a positive gram stain of the CSF; or

(d.) Abnormal urinalysis (positive leukocyte esterase or nitrate or >5 WBC/HPF) or a positive gram stain of unspun urine (preferred test);

(3) Child 0-90 days old who appears "toxic" or "ill" and is not admitted to the hospital after a full septic work-up;

(4) Child 0-28 days old not started on antibiotics in the ED after all cultures obtained;

(5) Child 28-90 days old not given Rocephin (50mg/kg IV or IM) after all cultures obtained.

b. Example 1: Mother brings 4 week old infant to the Emergency Department because he was crying continuously and she was worried the child had "colic". She also reports the child felt warm, as if the child had a fever, but she did not have a thermometer to measure the temperature. By the time the child is seen by the physician, the child has stopped crying and is now feeding normally. Mother states she thinks the visit was a "false alarm" and wants to take the child home. The rectal temperature is 99.2° F. and the exam is reassuring. The physician agrees that the child does not need further evaluation and may be taken home. Policy applies.

c. Example 2: Mother bring 4 week old infant to the Emergency Department because he "felt warm, like he had a fever." The child appears well, and rectal temperature is 99.2° F. No rash, no lethargy. Child is feeding, crying and moving well. The physician concludes the child is well, the mother's history probably did not accurately reflect the existence of a fever, and the child may be discharged without further evaluation. Policy applies.

d. Example 3: Same as in Example 2, but physician obtains blood cultures, gets a chest x-ray which is negative, obtains a urinalysis which is negative, and performs a lumbar puncture which is negative. The physician concludes the child has no evidence of infection, the mother's history probably did not accurately reflect the existence of a fever, and the child may be discharged. Policy applies.

2. Exclusions. This policy does not apply to the following cases:

a. The emergency physician begins empirical antibiotic treatment and arranges for the patient to be admitted to the hospital, admitted to another facility or transferred to another facility for further treatment and evaluation.

b. Diagnostic studies reveal a source of fever which can appropriately be treated in the outpatient setting, and a visit for re-evaluation by a physician within 8 hours after discharge has been arranged.

PROCEDURE:

1. Before dispositioning a patient who meets the criteria specified in Policy Section 1, "Applicability," the emergency physician must contact the Regional Director on call to receive FailSafe reports. The emergency physician must present sufficient clinical information to support the disposition decision. The Regional Director will advise the emergency physician whether or not he or she agrees that the disposition is appropriate. The ultimate disposition decision shall be the prerogative of the treating emergency physician, even if the emergency physician elects to disposition the patient contrary to the Regional Director's advice.

2. In any case where the Regional Director has been called pursuant to this policy and the patient is not admitted, unless the case falls under one of the exceptions listed under Policy Section 2, the Regional Director and the treating emergency physician shall assure appropriate follow-up has been achieved. This may be accomplished by arranging for the emergency physician (or ED Director, or Regional Director) to contact the patient or follow-up physician, or any other mechanism which assures the follow-up desired. Any such follow-up activities shall be documented as addenda to the patient's ED medical record.

3. In any case where the Regional Director has been called pursuant to this policy, the calling emergency physician shall document the call in the ED medical record.

4. In any case where the Regional Director has been called pursuant to this policy, the Regional Director will obtain patient data and will file a written or e-mail report of the call with the Risk Manager or his designee within

48 hours. The report shall be on a form provided by the Risk Manager for this purpose.

5. In the event no Regional Director has been assigned to be on call for FailSafe reports, or the physician is unable to reach the Regional Director on call for FailSafe reports, the physician should contact any of the following physicians:

   a. Any other EMP Regional Director

   b. Director of Clinical Quality (Dr. Klauer)

   c. Risk Manager (Dr. Frank)

   d. EMP Chief Medical Officer (Dr. Gage)

Policy History:
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