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Inside

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New pain management standards: 4 questions surveyors are asking

Joint Commission surveyors want to know your plan to manage pain

Are you ready to answer questions about how pain is assessed and treated for patients in your ED? Can you produce documentation that shows how pain was managed for any given patient? You'll need to do both these things to comply with new pain management standards from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations. **(For information on how to view the standards, see resource box, p. 75.)**

The new standards address six broad areas, says **Emory Petrack**, MD, MPH, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland. These are assessment, continuum of care, improving organization performance, patient rights, care of patients, and education. **(See related stories on assessment of pain, p. 77; four steps to manage severe pain, p. 80; and follow-up for pain management, p. 79.)**

You must be ready to answer questions in the following four areas, according to Petrack:

1. Are the tools used for pain assessment developmentally appropriate for different age groups?

HCFA delays outpatient PPS by one month

ED managers have been given a break — but it's a short one. The Health Care Financing Administration (HCFA) has delayed implementation of the hospital outpatient prospective payment system (OPPS) by one month, to Aug. 1.

"I have made this decision because I believe that it is virtually impossible for HCFA or the hospital industry to implement [the change] on July 1," HCFA administrator **Nancy-Ann DeParle** wrote in a letter sent to the American Hospital Association (AHA) and other hospital associations.

(Continued on page 84)

2. Have appropriate policies and procedures for pain assessment and management been established? Are they being followed? How are staff being trained, and how are competencies being demonstrated?

3. Are patients and families educated in issues related to pain management?

4. Do patients know their rights? How do they know them? **(See story for more information about questions surveyors are asking, p. 76.)**

There is tremendous variability in how patients presenting with painful conditions are assessed and managed, notes Petrack. "A major goal of these standards is to ensure that a patient's pain is appropriately and consistently addressed throughout the hospital," he says.

Spotlight on the ED

The ED will be a major area of focus for surveyors, predicts **Anne Llewellyn**, RNC, BPSHSA, CCM, CRRN, CEAC, owner of Professional Resources In Management Education, a health care educational and consulting company in Miramar, FL.

"The ED is a key area where many patients come to seek treatment for pain," Llewellyn says.

The new standards create special challenges for EDs, notes **Susie McBeth**, associate director of the Joint Commission's Department of Standards. "Unlike other departments, EDs handle all sorts of pain, both acute and chronic," McBeth says. "They also see all types of patients, including infants, children, and the elderly. All of those are handled differently, with different screening tools used."

Executive Summary

New standards for pain management from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations will be scored for compliance in 2001.

- Surveyors are already asking ED managers about plans to comply with the standards.
- Every patient needs to be assessed for pain, treated if necessary, and reassessed.
- You need to assess pain differently for children, the elderly, and developmentally disabled individuals.

Complying with the new standards will take significant work and leadership by the ED management team, says Petrack. "That said, there is great potential to improve our management of painful illnesses and injuries, and in so doing, yield better emergency care to the patients we serve," he says.

Here are ways to comply with the new pain management standards:

PAIN ASSESSMENT GUIDE

TELL ME ABOUT YOUR PAIN

W ords to describe pain

aching	throbbing	shooting
stabbing	gnawing	sharp
tender	burning	exhausting
tiring	penetrating	nagging
numb	miserable	unbearable
dull	radiating	squeezing
crampy	deep	pressure

Pain in other languages

itami	Japanese	dolor	Spanish
tong	Chinese	douleur	French
dau	Vietnamese	bolno	Russian

I ntensity (0-10)
If 0 is no pain and 10 is the worst pain imaginable, what is your pain now? ... in the last 24 hours?

L ocation
Where is your pain?

D uration
Is the pain always there?
Does the pain come and go? (Breakthrough Pain)
Do you have both types of pain?

A ggravating and Alleviating Factors
What makes the pain better?
What makes the pain worse?

How does pain affect

sleep	energy	relationships
appetite	activity	mood

Are you experiencing any other symptoms?

nausea/vomiting	itching	urinary retention
constipation	sleepiness/confusion	weakness

Things to check
vital signs, past medication history, knowledge of pain, and use of noninvasive techniques

REFERENCES: Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service, March 1994. — Wong, D, and Whaley, L. Clinical Handbook of Pediatric Nursing, ed. 2, The C.V. Mosby Company, St. Louis, 1986, p. 373.

Source: University of Colorado Hospital, Denver.

COMING IN FUTURE MONTHS

- Controversy over ambulance restocking
- Algorithm to avoid EMTALA violations
- New restraint standards from the Joint Commission
- Motivate floor nurses to accept ED patients without delay

• Implement a quality improvement program.

Develop a quality improvement component for pain management, advises Petrack. "The successes and failures of pain assessment and management will need to be formally examined and opportunities for improvement identified," he says.

• Have physicians participate in the planning process.

Involve ED physicians in the overall planning of your pain management process, says **Stuart Shikora**, MD, FACEP, a surveyor with the Joint Commission and an ED physician at Mount Diablo Medical Center in Concord, CA.

A pain management strategy cannot be created for the ED by consultants, administrators, or nursing staff, says Shikora. Physicians need to help develop protocols for interventions and tools to use for specific types of pain, he explains.

• Tie pain management in with ORYX.

If your hospital chooses pain management as a parameter to measure for the Joint Commission's ORYX initiative, that presents an opportunity for your ED, says Shikora. "The ED contribution could be a simple three-point study looking at whether the patient's painful condition was assessed, measures were taken, and results were reassessed." **(For more information about ORYX, see *ED Management*, April 2000, p. 37.)**

• Consider alternative ways to manage the pain of substance abusers.

ED patients with substance-related disorders may request medication to manage their pain, notes McBeth. "This creates an ethical dilemma, since even if a patient is a drug seeker, that doesn't preclude them from having pain. Their pain still needs to be treated," she says.

If you suspect a patient is a drug seeker, explore nonpharmacological interventions such as distraction, massage, heat, acupuncture, physical therapy, or behavioral therapies, she suggests.

• Form a process improvement team.

Have a multidisciplinary team look at issues and address standards to improve consistency of pain management facilitywide, stresses **Regina Fink**, RN, PhD, AOCN, research nurse scientist at the University of Colorado Hospital in Denver. At the hospital, a team of physicians, nurses, and pharmacists has formed five subcommittees to address pain assessment, staff education, patient outcomes, patient education, and policies and procedures, she reports.

• Use protocols.

Collaborate with ED staff to set policy and standards that delineate specifically how pain will be assessed, treated, and reassessed, advises Petrack. **(See protocols for EMLA Cream in the ED and Renal Colic Pain, inserted in this issue.)**

"I would highly recommend that EDs use protocols to comply with the new standards," says McBeth. The American Pain Society and the American Academy of Pain Medicine, both based in Glenview, IL, have developed pain management guidelines that can be used to develop ED protocols, she notes. **(See resources box, below, for information on how to obtain copies of the guidelines.)**

• Use cards for pain management.

At the University of Colorado Hospital's ED, double-sided cards with information on pain assessment and analgesic use are handed out to nurses at orientation. **(See Pain Assessment Guide, p. 74, and Analgesic Reference Guide, enclosed in this issue.)** The cards help nurses know which medications to use and assess pain consistently, says Fink. The guide includes a 0-10 Numeric Pain Intensity Scale (0 = no pain, 10 = worst

Resources

- The complete new pain management standards of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations are currently available on the Joint Commission's Web site (www.jcaho.org). Double-click on "For Health Care Organizations and Professionals" on the main page. On the next page, click on "Standards" in the top bar. This will take you to the standards page, which includes a link to the pain management standards. Manuals that include the standards can be purchased by calling the Joint Commission's Customer Service Center at (630) 792-5800 between 8 a.m. and 5 p.m. central time on weekdays.
- Single copies of pain management guidelines titled *Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer* are available from the American Pain Society at no cost. To request a copy, contact: American Pain Society, 4700 W. Lake Ave., Glenview, IL 60025. Telephone: (847) 375-4715. Fax: (847) 375-4777. E-mail: info@ampainsoc.org. Web site: www.ampainsoc.org.
- Single copies of consensus statements on the *Basic Principles of Ethics for the Practice of Pain Medicine, The Necessity of Early Evaluation of the Chronic Pain Patient*, and *Use of Opioids for Treatment of Chronic Pain* are available at no charge from the American Academy of Pain Medicine. Brochures on *Acute Pain and Cancer Pain, A Brief Guide to Pain Medicine*, and *A Patient's Guide to Pain Medicines* are available in packs of 50 for $20 plus $3 shipping and handling per order. Single copies of brochures are available at no charge. For more information, contact: American Academy of Pain Medicine, 4700 W. Lake Ave., Glenview, IL 60025. Telephone: (847) 375-4731. Fax: (847) 375-6331. E-mail: aapm@ amctec.com. Web: www.painmed.org.

Sources

For more information on the new pain management standards, contact:

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possible) and a Wong-Baker Faces Pain Rating Scale that ranges from a smiling face (0, no hurt) to a crying face (5, hurts worst).

• Educate yourself and your staff about new approaches.

You need to conduct appropriate training of nurses and physicians so the standards can be implemented, says Petrack.

A good first step is to perform a literature search in order to share research on current philosophies and techniques of pain management with medical and nursing staff, suggests **Ann Kobs**, MS, RN, president and CEO of Type 1 Solutions, a Fort Myers, FL-based compliance consulting firm specializing in preparation for Joint Commission surveys.

Education of medical staff is key, she emphasizes. "Until they understand current methodologies, no significant changes can be made, and physicians will still be prescribing Demerol every three hours," Kobs says.

Many of the pharmaceutical companies that specialize in pain medications will be conducting CE programs to help health care professionals better understand this issue, Llewellyn notes. "This will be a way that professionals can learn about the newer techniques that are now available to treat pain effectively," she says. ■

Here's what surveyors want to know

Although new pain management standards won't be scored until 2001, surveyors are already asking about them and want to see that your ED has a plan in place to comply, reports **Stuart Shikora**, MD, FACEP, a surveyor with the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and an ED physician at Mount Diablo Medical Center in Concord, CA.

"They want to see that there is thought being given to the new standards and that some model of pain assessment is being followed," says Shikora.

Surveyors are asking about both your current pain management and plans for changes, says **Susie McBeth**, associate director of the Joint Commission's department of standards. "We are asking about what you have implemented and what you plan to implement to comply with the new standards."

Most EDs are already treating pain, says McBeth. "The trouble is the consistency with which they do it. You need to re-examine the processes you have now and be sure that pain is assessed and managed for every single patient," she explains.

Surveyors may ask to see the following, according to McBeth:

• protocols and practice guidelines for use of pain management;

• the educational materials about pain management given to patients;

• how pain assessment and interventions are documented in the patient's medical record. This doesn't need to be a special documentation form and can just be part of the comprehensive nursing assessment tool, says McBeth. "Some EDs have special forms if they have a pain management team, but surveyors won't expect to see that."

4 questions to answer now

Surveyors are currently using a four-question survey to ask about the new pain management standards, says McBeth. The results will be taken to the board on Jan. 2, 2001, so they can decide whether the standards will be implemented immediately or in the second quarter of 2001, she explains.

Here are the questions surveyors are currently asking:

1. Do you use a standardized method for documenting pain assessment? If so, how long have you been using it?

Most organizations don't use a standardized tool to measure pain, says McBeth. "The standards have forced them to go back and reassess how they managing pain across the entire organization, not just each unit."

2. How do you document the measurement of pain?

Most respondents document pain assessment in progress notes and not with a separate form. "There are different ways of doing this. We're not looking for a separate pain assessment form. For example, a pain scale might be printed on the form used for the initial assessment," says McBeth.

3. Have you done any special projects on pain management using a performance improvement process?

About one-fourth of organizations are currently doing this, says McBeth. "One hospital had a large number of psychiatric patients, so they undertook a major effort to educate their staff on how agitated behavior may be caused by pain. Now they evaluate for pain before ordering a psychotropic medication," she reports.

4. Have the new pain standards changed the way you handle pain treatment?

Most respondents are reassessing the way they currently manage pain but haven't implemented planned changes yet, notes McBeth.

Time line for scoring

The new pain management standards and examples of compliance will be included in the 2000-2001 standards manuals for affected Joint Commission accreditation programs, and they will be first scored in 2001, according to Shikora.

However, when the standards are first scored, there will be a cap system used for a year or two, Shikora reports. "Although scoring ranges from 1 to 5, 5 being no compliance at all, there will be a cap used. So even if you got a score of 5, its effect on the grid would be negligible, because it will be capped at a score of 1 or 2. This will give you a chance to get up to speed on the new standards."

In 2001, compliance will be determined by the presence of a functioning system to manage patients' pain, protocols that direct staff to use the system, and chart review that shows the system is being used, says Shikora.

Surveyors will not ask about whether you gave the right medication or the right amount, Shikora says. "A lot of people worry that we're going to be looking at whether or not they are using enough dilaudid, or if they are giving a weight-appropriate dose of Demerol, but it's not going to be that detailed at this point. Those practices will be looked at when we fine-tune the system, approximately three years from now."

In 2001, surveyors will do random chart reviews of patients with specific diagnoses to see how well they were assessed, says Shikora. "We will pull the charts of patients with certain target discharge diagnosis or chief complaints which are unequivocally painful and would call for the use of analgesics. Those include kidney stones, renal colic, earaches in children, and fractures." ■

You must assess every patient for pain

You'll need to assess every patient for pain to comply with new pain management standards, stresses **Emory Petrack**, MD, MPH, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland.

"For example, a patient who presents with a fall and a radial fracture will generally have their pain managed if a reduction is required," he says. "However, if a patient is not in obvious pain initially, that patient may not have his or her pain assessed and managed."

The new standards from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations will require that a formal pain assessment be performed for all patients, ideally using a specific pain scale, says Petrack. "The pain will then need to be managed and reassessed during the ED stay," he says.

Surveyors are already asking ED staff whether they have a rating system in mind and if they have already started to use one, says **Stuart Shikora**, MD, FACEP, a surveyor with the Joint Commission and an ED physician at Mount Diablo Medical Center in Concord, CA. "That shows a plan to take this seriously," he says.

Here are some ways to improve assessment of pain:

• **Assess pain at discharge.**

Most EDs have a space on their forms to document pain during triage, initial assessment, and prior to discharge, says **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a Marblehead, MA-based health care consulting firm in specializing in regulatory compliance. "The problem is that many fail to document pain at discharge," Catalano says. "The patient may have had a pain score of 10, which is certainly worthy of a comment at discharge."

• **Ask for specific information about the patient's pain.**

When pain is assessed, the following items should be documented, according to Catalano:

- pain quality;
- location;
- duration;
- frequency;
- measures patient has used before to relieve pain.

• **Assess for other symptoms.**

The new standards require you to assess for all symptoms that might be associated with a disease, condition, or treatment, notes **Ann Kobs**, MS, RN, president and CEO of Type 1 Solutions, a Fort Myers, FL-based compliance consulting firm specializing in preparation for Joint Commission surveys. "It isn't just pain," Kobs emphasizes. The standards also include nausea and dyspnea, she says.

• **Use a variety of pain assessment tools.**

Staff must be familiar with a variety of pain tools to meet the needs of all ED patients, Shikora says. "Children and the elderly are both groups where age-appropriate assessment becomes important," he says.

Developmental concerns will need to be taken into account, with different pain scales used for young children, the elderly, and developmentally disabled individuals, notes Petrack. **(See the Wong-Baker FACES scale for use with children and developmentally disabled individuals, inserted in this issue.)**

How to ask elderly, children

With children, you might need to use certain words when asking about pain, says Petrack. "If you ask a 3-year-old, 'does that hurt?' it may mean nothing. Ask the parents what word they use to describe pain. You may need to ask, 'is that an ouchie?'" Elderly patients may respond more accurately with verbal descriptor scales than numeric rating scales, he adds.

You might need to spend extra time when assessing pain in elderly patients, says **Regina Fink**, RN, PhD, AOCN, research nurse scientist at the University of Colorado Hospital in Denver. "You also may need to rely on family members to help you interpret the patient's pain," she says.

• **Address the needs of non-English speaking patients.**

You'll need a way to assess pain in patients who don't speak English, says Shikora. "A savvy surveyor would not only look at a plan for pain management, but would also ask you, 'How would you communicate this to a patient who doesn't speak your language?'" he explains. "Find ways to assess pain in patients who speak in different languages."

To adequately assess pain in patients who speak a different language, you will need a translator, says Petrack. "You can use a visual tool such as the FACES scale, but you will still need to have someone explain to the patient how to use it," he says.

• **Assess pain for all patients.**

Surveyors are asking staff whether each patient is assessed for pain. At this point, having no documentation of pain assessment and no pain scale would lead to problems if the same were true everywhere in the hospital, says notes Catalano.

Make pain a "fifth vital sign," suggests **Susie McBeth**, associate director of the Joint Commission's department of standards. "When you take the patient's blood pressure and temperature, that is a good time to ask about pain," McBeth suggests.

Unless you have a separate pain assessment form, you'll need to have a box or space for this documentation on the nursing assessment form, says Shikora. "You need to record the patient's response to the questions, 'Do you have pain?' and 'If so, how much?'" she says.

Triage and staff nurses need to ask this question routinely and manage pain consistently, he stresses. Pain must be assessed the same way, with the same treatment, for the same condition, every time, says Shikora.

• **Document reassessment of pain.**

In addition to initial assessment and treatment of pain, you'll also need to show surveyors evidence of reassessment, Shikora says. "For example, if a patient comes in with a pain score of 8 on a scale of 1 to 10 and is given an analgesic, the nurse needs to go back after a reasonable period of time and reassess the pain," he says.

The need to reassess is not based on whether the patient asks for more medicine, Shikora stresses. "You need to take a proactive stance and determine with what frequency you reassess," he says. "Do you go back to assess the patient's pain every 15 minutes or every hour? Maybe the pain has decreased, but the patient is still uncomfortable, so you need to continue treating the pain." ■

Source

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You need to follow up with patients in pain

To comply with new pain management standards, you'll need to address follow-up management to show continuity of care, warns **Anne Llewellyn**, RNC, BPSHSA, CCM, CRRN, CEAC, owner of Professional Resources In Management Education, a health care educational and consulting company in Miramar, FL, and an ED nurse at Imperial Point Medical Center in Fort Lauderdale, FL.

"The fact that a patient with pain has been treated will not be enough," she warns.

According to Llewellyn, surveyors from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations will look for the next step: How is the ED team ensuring effective follow-up care in order to address ongoing problems?

After relieving pain, give patients discharge instructions about pain management along with a referral for who/when/where to follow up if the pain persists, says Llewellyn. For many patients in pain, the ED is the entry point to the health care system, she notes. "Follow-up with the discharged patient will need to be done and documented to ensure that follow-up treatment did occur," Llewellyn says.

Many patients don't follow up due to an inability to pay or an inability to get into primary health centers due to long waits, says Llewellyn. "Instead, they begin the rounds of various EDs in order to get pain medication due to continued pain," she says. "In doing this, they begin the downward spiral of ineffective care. That leads to increased cost to the health care system as well as poor quality of life for the patient."

In Imperial Point's ED, the triage nurse makes a telephone call the next day to see how the patient is doing, Llewellyn explains. "The nurse asks if they got their prescriptions filled, if they had any problems getting a follow-up appointment, or need further explanation regarding their visits," she says. "We also ask how the care was for their ED visit."

This call allows the nurse to assist patients who need help with referrals for follow-up care, she explains. "If a patient tells us they tried to follow up but cannot get in for a two-week period, the triage nurse will place a call to the referring clinic or physician and expedite that visit," Llewellyn says.

Occasionally, patients don't get prescriptions filled due to the cost of the drug, Llewellyn notes. "If we see this, then we let the ED physician know," she says. "Many times, they will write for a less expensive drug."

Here are key points of new standards

According to new pain management standards developed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, you must do the following:

1. Recognize the right of patients to appropriate assessment and management of their pain.
2. Assess pain in all patients.
3. Record the results of the assessment in a way that facilitates regular reassessment and follow-up.
4. Educate relevant providers in pain assessment and management.
5. Determine competency in pain assessment and management during the orientation of all new staff.
6. Establish policies and procedures that support appropriate prescribing or ordering of pain medications.
7. Ensure that pain does not interfere with participation in rehabilitation.
8. Educate patients and their families about the importance of effective pain management.
9. Include patient needs for symptom management in the discharge planning process.
10. Collect data to monitor the appropriateness and effectiveness of pain management.

If a patient says he or she is worse or still in pain, you can instruct the patient to call his or her referral doctor or return to the ED to be re-evaluated, says Llewellyn. "This helps prevent the patient from falling through the cracks," she says.

Staff document all follow-up calls and record any problems in a log. If they give any advice, a record of that advice is attached to the patient's permanent record. "If there are issues that arise, then a copy also goes to the nurse manager," says Llewellyn. "That way, he or she is prepared if a call comes in regarding treatment issues."

Every ED should give patients written instructions on how to care for themselves and how to follow up, says Llewellyn. "We give these instructions to each patient and keep a copy on the permanent record," she says.

This practice also allows the triage nurse to know what the patient was supposed to do, including follow-up visits and medications, says Llewellyn. "Many times, this information is reviewed and clarified during the follow-up phone call," she says. "The patients are very grateful for this information and the follow-up call." ■

4 steps to follow for severe pain

There are four key steps to take when treating severe pain in the ED, according to **Robert S. Hockberger**, MD, FACEP, chair of the department of emergency medicine at Harbor-University of California at Los Angeles Medical Center in Torrance.

"Implementation of a protocol like this one can remarkably improve care for most patients," he says. Here are the four steps to take:

1. Assess the patient's pain.

For children or patients with whom you cannot communicate with because of language problems, use a scale of 1-10 or a series of faces showing an increasing degree of distress, recommends Hockberger.

2. Tell the patient you will treat his or her pain.

This expression of caring increases patient's perception of your empathy and overall satisfaction with the care you provide, says Hockberger.

3. Start an IV and administer 1-2 mg of morphine sulfate per minute until the patient's pain is significantly diminished.

The goal is changing severe pain (a score of 7-10) to mild pain (a score of 2-3). This change can almost always be accomplished within 10 to 15 minutes of presentation for most patients, Hockberger explains.

4. Assess your ED's success in pain management by conducting a quality improvement project.

Measure the time from presentation to pain relief for a selected disorder (for example, fractures or burns) or for all patients who present with a pain score over 6 or 7 during a preset time period, Hockberger suggests.

"Comparing times before and after implementation of a protocol will almost always show a significant improvement," he says. ■

Source

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ED The Cutting Edge

Use 'internal-disaster' mode to move patients upstairs

How to address 'turn-down tactics'

By **Colleen-Bock-Laudenslager**, RN, MSN
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Every ED bed is full, and additional critical care bays have been created in the hallways. The EMS radio is quiet for a moment because your ED is on diversion, but the walk-ins keep coming in. ED resources have been exhausted, and the team is experiencing intense fray. You are attempting to mobilize patients to their inpatient beds when you are told the following: *The bed is not clean. The nurse is on break. We are in the middle of report. We don't have a nurse for that patient.*

These turn-down tactics are the moment of truth for every ED nurse. It is a time to question the profession entirely: How can one unit of the hospital enjoy a pristine existence while the other is bulging at the seams in sheer terror? What ever happened to the days when inpatient nurses pulled beds into the hallways with a portable white screen? What about the bed-cleaning bucket pulled out when housekeeping couldn't move fast enough? (I know; I was one of those inpatient nurses!)

Of all conflicts arising in the ED, situations with floor nurses are the most difficult to resolve. This is the No. 1 conflict EDs have, and the most emotionally embroiling. It's extremely frustrating when the ED nurse might have four monitored patients at one time, and a phone call to the critical care unit creates an obstacle for immediate transfer of the patient to the unit.

Encouraging floor nurses to be open and receptive to ED patients is very difficult, and the problem affects patient flow in the ED. The conflict between nurses overflows into the physician's schedule, because patients are not getting moved out in a timely fashion.

How have health care financing, managed care, and "doing more with less" created such barriers to being team players? Don't get me wrong; I spent years in critical care, and I admire my colleagues who value control

and calm and tout the laws of nurse/patient ratio. But don't they care about the ED critically ill patient who is on an RN list of five to seven monitored patients?

When conflict exists within the hospital setting, I encourage staff to ask: What is best for the patient? If this were considered, many delays would never exist. Is it fair for inpatient nurses to harbor the attitude, "their problem should not be our problem?"

I believe a plausible solution to this ongoing dilemma is to develop a Staffing Internal Disaster Plan. A team of nurses could be corralled in a continuous quality improvement format to develop objective scoring guidelines/criteria for internal disaster on their particular unit. Critical care units and the ED could agree on an appropriate nurse/patient ratio. In addition, each area could establish points for intense procedures like resuscitation, administration of thrombolytics, placement of hemodynamic lines, admission to the unit, etc.

If both departments agreed on internal disaster criteria, the point system could drive which unit needs to accept or keep the patient. For example, the ICU or ED would get five points if a nurse was in the process of placing an IV line and four points if a nurse was admitting a patient or titrating medications every five minutes. If the point total in the ED was 12 and only 9 in the ICU, then ICU would have to take the patient immediately. A systematic point system for internal disaster would lend objectivity during chaotic times.

The plan could be reasonable and fair for all units. The unit with the highest score or the one most obviously under the greatest disaster condition would receive resources mobilized from the other units. In the situation of the critical care units, they may be forced to immediately accept the ED patient(s) and/or attend patients in the ED.

By calling it an internal disaster, critical care would not be violating laws against having more than two patients at once. Under internal disaster-like conditions, they can briefly have three patients at once. Critical care nurses are vigilant and hate to violate rules, but if they knew they were on internal disaster, they would have to move in that mode for a legitimate reason.

A team working together at this level of collaboration has many benefits:

• **It allows team members to understand the needs/values of all the nursing units.** What a fabulous team-building exercise that would foster better working relationships!

• **It gives nurses practice at prioritizing and mobilizing resources under disaster-like conditions.** How many of you are thrilled with your current disaster planning?

• **It equalizes the playing field between the ED and the nursing units.** The ED will not be the only unit bulging at the seams . . . when only *we* can't put a "closed" sign up!

• **It provides a more systematic approach to resource allocation and makes decision-making less emotional.**

• **It would allow nurses to work briefly on different units to round out their experiences.** Nurses would benefit from this form of cross-training.

There is no question health care has recently presented challenges never experienced before. I believe in the power of teams, and I hope professional nurses can collaborate on an internal disaster project such as this.

[Editor's note: Colleen Bock-Laudenslager is a consultant who specializes in staffing and workplace issues in the ED. For more information on creating an internal disaster mode, contact Bock-Laudenslager at P.O. Box 7303, Redlands, CA 92375. Telephone: (909) 798-4969. Fax: (909) 797-2768. E-mail: cblrn@aol.com.] ■

Kapur AK, Tenenbein M. **Vaccination of emergency department patients at high risk for influenza**. *Acad Emerg Med* 2000; 7:354-358.

More than half of ED patients at risk for increased morbidity from influenza had not been vaccinated, and over half of these were willing to be vaccinated during an ED visit, reports this study from the University of Manitoba in Winnipeg, Canada. Here are key findings:

• Of 231 patients who met the high-risk criteria, 123 (53.2%) had not received the vaccine.

• 73 (59.3%) were willing to be vaccinated during an ED visit.

• Of the 50 high-risk patients unwilling to be vaccinated, 36 believed they did not need the vaccine, 30 were concerned about side effects, and 11 wanted to discuss the vaccine with their own physicians.

Even patients who refused vaccination could be educated during the ED visit, according to the researchers, who note that most of the high-risk patients who were not willing to be vaccinated believed that they did not need it. "It is unknown how many of these people would agree to vaccination if informed that it is recommended for them," they add.

Although most emergency physicians rarely or never offer influenza vaccinations, 76% of them were willing to do this during an ED visit, according to a survey of 54 ED physicians. ED physicians can increase the proportion of high-risk ED patients who are vaccinated by more than two-thirds, the study found.

The study's results are evidence that ED vaccination for influenza would be considered as a strategy to increase vaccination among high-risk groups, say the researchers. **(For more information about successful ED vaccine programs, see *ED Management,* February 2000, p. 13.)** ▼

Sun BC, Adams J, Orav EJ, et al. **Determinants of patient satisfaction and willingness to return with emergency care.** *Ann Emerg Med* 2000; 35:426-434.

Communication and education are critical factors that determine how satisfied patients are with ED care and how willing they are to return to an ED, according to this study from Brigham and Women's Hospital, Harvard Medical School, and Beth Israel Deaconess Medical Center, all based in Boston.

A total of 2,899 patients were surveyed on-site, and 2,333 patients were interviewed via telephone. The following problems were reported by patients, which affected their willingness to return to the ED:

• help not received when needed;
• poor explanation for potential causes of problem;
• not told about potential wait time;
• not told when to resume normal activity;
• poor explanation of test results;
• not told when to return to the ED;
• unable to leave a message for family.

The study also found that the actual wait time to see a physician and total length of stay are not significant predictors of patient satisfaction. "Managing the perception of waiting time, by communicating an expected wait time to patients, seems to be more important for satisfaction than the actual wait time," they say.

Improvements in communication must be systems-based, the researchers recommend, and suggest the following:

• Develop systems that build patient communication and education into the process of care.

• Don't rely solely on the individual efforts of busy physicians and nurses, who are distracted by a constant demands and tasks.

• Give caregivers time to communicate with patients.

• Redesign the process of care to reduce distractions to the patient-physician relationship. ▼

Arslanian-Engoren C. **Gender and age bias in triage decisions.** *J Emerg Nurs* 2000; 26:117-124.

ED nurses fail to associate middle-aged women's symptoms with myocardial infarction (MI), which might contribute to increased morbidity and mortality in these patients, according to this study from the University of Michigan in Ann Arbor. The study looked at whether triage nurses made different decisions for men and women with symptoms that suggested MI.

Four focus groups were conducted with 12 ED nurses about the way they handled triage of patients with MI symptoms. Nurses acknowledged they were less likely to suspect MI in middle-aged women and admitted that MI wasn't the first diagnosis considered for middle-aged women, even if the patients had symptoms consistent with MI.

Women are less likely than men to be diagnosed with an MI and to receive early or aggressive treatment, and are more likely than men to die of an MI, the researcher notes.

"In the event that a young woman has an MI and it is missed, the outcome may be deadly," she writes. "Even though young women may not be having a coronary

event, this possibility must be excluded before non-coronary causes are considered for the symptoms, because of the potential seriousness of missing this event."

The following solutions are offered:

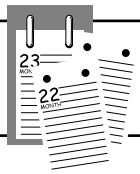
• ED nurses must critically assess their own triage practices for the influence of gender bias.

• Nurses should watch for gender bias regarding patient signs and symptoms, suspected cause, and the need for emergent triage.

• ED nurses should be current with literature on women with heart disease to better understand how the disease presents in women.

• Clinical preparation of ED nurses should include gender bias recognition strategies. ■

CALENDAR



• **Hot Topics in Emergency Medicine** — Aug. 1-3, Brainerd, MN. Sponsored by the Minnesota chapter of the American College of Emergency Physicians. Cost: $125-$295. For more information, contact Shari Augustin, Minnesota Chapter of the American College of Emergency Physicians, 701 Park Ave. S., Minneapolis, MN 55415-1623. Telephone: (612) 347-5645.

• **Wilderness and Travel Medicine** — Aug. 2-6, Big Sky, MT. Sponsored by the California chapter of the American College of Emergency Physicians and Wilderness & Travel Medical Seminars. Cost: $345-$575. For more information, contact Eugene Alfred, MD, Wilderness & Travel Medical Seminars, 1822 W. Lincoln St., Bozeman, MT 59715. Telephone: (800) 522-8747.

• **Domestic Preparedness: Improving Hospital and Provider Response to a Bioterrorist Event** — Aug. 4 and Aug. 30, Glenview, IL. Sponsored by the Illinois chapter of the American College of Emergency Physicians. Cost: $25-$50. For more information, contact Sonja Kulseng-Hansen, Illinois Department of Public Health, 1 S. 280 Summit Ave., Court B-2, Oakbrook Terrace, IL 60181. Telephone: (630) 495-6400.

• **13th Annual Olive View-University of California, Los Angeles (UCLA) Advances in Emergency Medicine** — Sept. 15-17, Boston. Sponsored by the California Chapter of the American College of Emergency Physicians and Olive View-UCLA School of Medicine. The fee is $185-$290. For more information, contact: Olive View National Conference, P.O. Box 600, Creamery, PA 19430. Telephone: (800) 458-4779.

• **Bedside Ultrasound in the Emergency Department** — Sept. 22-23, Redondo Beach, CA. Sponsored by the California Chapter of the American College of Emergency Physicians and Miller Radiology. Cost: $400-$600. For more information, contact Julie Miller, MD, Miller Radiology, 12 Saddleback Road, Rolling Hills, CA 90274. Telephone: (310) 377-1177. ■

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CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *You must assess every patient for pain* and *Journal Reviews* in this issue.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *New pain management standards: 4 questions surveyors are asking* and *You need to follow up with patients in pain.)*
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.

HCFA delays outpatient PPS

(Continued from page 73)

"In particular, I am aware that the unavoidable delays on our part in meeting certain milestones — such as the delay of nine weeks from the original target date of April 1 to release the Claims Expansion and Line Item Processing (CELIP), the expanded claim form necessary for the new system — have also limited the ability of the hospital industry to prepare."

DeParle asked that hospitals not collect deductibles or co-insurance from Medicare beneficiaries beginning Aug. 1 until HCFA can notify the beneficiaries of the correct amount. This step will ensure beneficiaries are charged the correct co-insurance amount, she explained. In July, HCFA will work with hospitals to inform beneficiaries that the OPPS-triggered changes in Medicare payments could mean changes in the amount of coinsurance — usually less — that beneficiaries will need to pay, DeParle wrote.

"We will provide all hospitals with a 'plain English' flier to distribute to beneficiaries," she said in the letter.

HCFA is intensifying its efforts to provide clear and accurate training to fiscal intermediaries and hospitals, DeParle said. "Unfortunately, this one-month postponement is critical to ensure that HCFA and the hospital industry are ready for this significant change," she wrote. ". . . By continuing to work together, I am confident that we will overcome the challenges posed by the implementation."

And what are those challenges? According to the AHA, they include fiscal intermediary staff who can't answer coding questions, incorrect information from intermediaries — even from an intermediary that has led training — and contradictory instructions from HCFA to fiscal intermediaries. The AHA and several other groups had asked HCFA to delay implementation of the outpatient PPS.

In a May 24 letter requesting a delay for the hospital outpatient PPS, the groups said they wanted assurance from officials at the Department of Justice that they would not pursue billing and claims mistakes that might occur during a reasonable period of time after implementation.

"Moreover, we need their assurances in writing," the letter said. ■

EMLA CREAM IN THE ED PROTOCOL

Purpose:
To provide a standing order for the use of EMLA cream for pediatric patients more than 1 month of age for non-emergent venipuncture and IV insertions in the emergency department.

Supportive Data:
• Pediatric patients assessed for non-emergent venipuncture and IV insertions require adequate pain control for the procedure based on their emotional and cognitive developmental levels.
• EMLA cream is a topical anesthetic that provides surface analgesia for venipuncture.
• EMLA cream can ease anxiety and pain of needlesticks in children.

Expected Outcomes:
• Patients receiving EMLA cream will experience significantly less pain during venipuncture or IV insertion, following the recommended applications.
• Use of EMLA cream will improve patients' perceptions of the health care provider.

Assessment:
• EMLA cream should be utilized whenever possible in all pediatric patients more than 1 month old and for all non-emergent venipuncture and IV insertions.
• Patients seen at triage who meet any of the criteria should have EMLA cream placed at triage.
• Application at triage will help allow sufficient time for EMLA cream to become effective.
• Patients who bypass triage, are stable, and may potentially need an IV or venipuncture may have EMLA cream implemented by the primary nurse. Examples may include any of the following conditions:
— dehydration/vomiting/diarrhea;
— febris;
— alterations in respiratory status;
— symptoms of systemic infection/FUO requiring conscious sedation or IV pain medications;
— potential for lab draw;
— spinal taps.

Categories of Care:
• Under treatment/meds/IVs, document application sites of EMLA cream. ED physician's signature is required prior to patient discharge from the unit.

• Place a dollop of EMLA cream (½ of 5 g tube) over each of two selected sites and cover with a Tegaderm dressing. Label corner of Tegaderm dressing with time of application.
• EMLA cream must be applied for at least 45 minutes prior to the start of the procedure. It may be left in place for up to three hours without decreased effectiveness.
• Educate the patient and parents on the indication and use of EMLA cream.
• A tube of EMLA cream, along with two Tegaderms, will be kept at the triage desk for easy access. The patient will be charted for the use of each tube (containing two applications). It will be replaced when used by accessing the Pyxis system and obtaining a new tube.
• Should EMLA cream be utilized by the primary RN, it can be obtained via the Pyxis.
• At the end of the recommended application time, gently remove the EMLA cream from the area and proceed with routine prep for venipuncture or IV insertion.
• When utilizing two sites for EMLA preparation, discontinue both sites at procedure completion time.

Reportable Conditions:
• EMLA cream should be used with caution in patients with congenital or idiopathic methemoglobinemia.
• It is contraindicated in patients with a known history of sensitivity to local anesthetics of the amide type or to any components of the product.
• Use with caution in those patients receiving Class I antiarrhythmic drugs.
• Accidental ingestion.
• Avoid application to open cuts/wounds.

Documentation:
• RNs will record date, time, and application site on the ED record.
• If initiated by the triage RN, a verbal report also will be given.

References:
• Farrington E. Pediatric drug information. Lidocaine 2.5%/prilocaine, 2.5% EMLA cream. *Pediatric Nursing* 1993; 19:484-486.
• Gajraj N, Pennat J, Watch M. Eutectic mixture of local anesthetics (EMLA) cream. *Anesthetic Analog* 1994; 78:574-593.
• Pediatric pain management procedure. *Pediatric Specialty Manual* 1995.

Approved:
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R. Kucewicz, RN, BSN, ED Director_____
Emergency Department Practice Council; May 1999

Review Date: May 2001 **Revision Date:** May 1999

Initiated:
Paula Tanabe, RN, PhD, Clinical Nurse Specialist, May 1996

Distribution:
Emergency Department Specialty Manual

Source: Northwest Community Hospital, Arlington Heights, IL.

RENAL COLIC PAIN PROTOCOL

Purpose:
To provide prompt pain relief for patients presenting with renal colic pain in a busy environment.

Exclusion Criteria:

- pain radiating to back
- absent pulses
- pulsatile abdominal mass
- history of renal insufficiency
- patients older than 50 years
- syncope
- hypotension

Inclusion Criteria:

- severe flank pain with possible radiation to the groin
- sudden onset
- possible past history of renal calculi

Analgesic Interventions:

• Administer:

1. Toradol 30 mg IV unless the following is present:
   - allergy or hypersensitivity to nonsteroidals

   AND

2. Dilaudid 1 mg IV push unless the following is present:
   - allergy to morphine or dilaudid

• Notify emergency physician after administration of pain medications.

Approved:
N. Ryan, MD, ED Medical Director_____
R. Kucewicz, RN, BSN, ED Director_____
Emergency Department Joint Practice Council; September 1999

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