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ED Management®

The monthly update on Emergency Department Management

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August 2000

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Use guidelines to prepare for children with special needs, or risk tragedy

Develop plan to care for rising numbers of children with rare conditions

When a child with muscular dystrophy was rushed to the ED at Children's Medical Center of Dallas in acute respiratory distress, he was immediately given oxygen. That turned out to be the wrong move.

"This was one of the rare occurrences when oxygen can be an enemy rather than a friend," says **Robert Wiebe**, MD, FAAP, director of the ED. Because the ED staff lacked information about the child's condition, he developed respiratory failure and died, Wiebe reports.

In another frightening incident, a woman brought her 5-week-old infant, who had gone into shock, to the ED at Our Lady of Lourdes Medical Center in Camden, NJ. She told the staff the child had a hypoplastic right heart with a central shunt.

"We did the routine thing and put the child on 100% oxygen, intubated the child, and hyperventilated. But things just kept getting worse," says **Alfred Sacchetti**, MD, FACEP, the attending ED physician who treated the child.

When the child's cardiologist was contacted, he instructed Sacchetti to take the child off oxygen and hypoventilate, which allowed the child to become hypoxic. Suddenly, the pulse rate increased, and the child became pink, recalls Sacchetti.

The infant had chronic pulmonary hypertension, which was the result of the underlying hypoxia she had at baseline and unrelated to the other medical

Executive Summary

New guidelines for children with special needs and an Emergency Information Form (EIF) were developed jointly by the American Academy of Pediatrics and the American College of Emergency Physicians.

- The guidelines explain how to create an emergency plan for children with unique medical needs or chronic physical, developmental, or behavioral conditions.
- The EIF includes the name of the child's pediatrician, telephone numbers, and specific instructions for interventions.
- If no EIF is on file, create an internal file for children with special needs using the EIF as a template.

Resource

A copy of the American Academy of Pediatrics (AAP) policy statement, *Emergency Preparedness for Children with Special Health Care Needs* (published in the October 1999 *Pediatrics*) is available. AAP policy statements can be downloaded free from the Web (www.aap.org). Also, the policy statements can be purchased for $1.95 each, including shipping and handling. Emergency Information Forms are available for purchase in packets of 100 for $19.95 plus $5.50 shipping and handling. The form can be downloaded from both the American College of Emergency Physicians' Web site (www.acep.org) and the AAP Web site.

To order, contact the American Academy of Pediatrics, Publications Department, P.O. Box 747, Elk Grove Village, IL 60009-0747. Telephone: (888) 227-1770. Fax: (847) 228-1281. ■

condition. "So when we put the child on oxygen, it made it worse," Sacchetti says. "When we intubated and hyperventilated, it made it worse still."

In that case, the information came in the nick of time, but it could have been obtained too late to save the child's life, says Sacchetti.

'No one can keep up with all the changes'

There is a rapidly growing population of children with rare diseases and medical conditions, due to high-tech devices and medical advances, notes Sacchetti. Ten years ago, these children never survived infancy, he says. "Now they're growing up and going to college. It's not that we're incompetent in the ED, but things evolve so quickly that no one can keep up with all the changes in every specialty."

A new form and guidelines were developed jointly by the Elk Grove Village, IL-based American Academy of Pediatrics (AAP) and the American College of Emergency Physicians in Dallas to arm ED managers with a solid plan to avoid unnecessary tragedies. "The form makes it instantly easier to take care of these kids," says Sacchetti.

The guidelines **(see excerpt, p. 87)** address children with unique medical needs or chronic physical, developmental, and behavioral conditions. Here are ways to comply:

❑ **Use the Emergency Information Form (EIF).** The EIF gives you accurate medical information when it can't be readily obtained from a parent or physician, says Sacchetti, who helped develop the EIF and guidelines for children with special health care needs. **(See stories on the benefits of the EIF, p. 88, and caregiver medical knowledge, p. 89. A copy of the form is inserted in this issue.)**

The EIF should be on file for every child with a rare or unique medical condition, stresses Wiebe. "We have set up agreements with some of our specialists to complete the form for every one of our special-needs kids. That should be done around the country." **(See box at left to obtain copies of the EIF.)**

❑ **Create an internal file for children with special needs.** If a child with an unusual disease or presentation comes to your ED, and there is no EIF on file, create a file on the child using the EIF template, Sacchetti recommends. "That way, the ED is prepared for the second time the child shows up," he says. The internal memo won't be as thorough as an EIF completed by the specialist, but it is the next best thing, he explains.

❑ **Send children home with an emergency care plan.** At Hasbro Children's Hospital in Providence, RI, every child with special needs is sent home with an emergency care plan written by a physician, either the pediatric intensivist or the child's attending physician, reports **Thomas Lawrence**, NREMT-P, program director for Rhode Island Emergency Medical Services for Children in Providence.

The importance of these care plans can't be overemphasized, stresses Lawrence. "Providers treating children with special needs depend on this resource in order to deal with the child's complex medical problems. Care plans provide the care provider with a concise algorithm to follow during the medical emergency."

The emergency care plans are useful throughout the continuum of care, he says. "With the plan at the child's bedside, at-home care providers can have it

(Continued on page 88)

COMING IN FUTURE MONTHS

- Effective ways to reduce admission cycle times
- Collaborate with paramedics to improve care of children
- Update on HCFA documentation guidelines
- New rules for restocking ambulances

Emergency Preparedness for Children with Special Health Care Needs

Excerpt

The American Academy of Pediatrics (AAP) in Elk Grove Village, IL, offers these recommendations:

1. A brief, comprehensive summary of information important for hospital or prehospital emergency management of a child with special health care needs should be formulated by the child's caregivers, health care professionals, and all subspecialty providers.

2. The summary, or emergency medical data set, should be updated regularly and maintained in an accessible and usable format.

3. Parents, other caregivers, and health care professionals should be educated to optimize use of the summary. Parents and other caregivers should be encouraged to take the summary with them for all health care encounters.

4. Mechanisms to quickly identify children with special health care needs in an emergency should be established and should be available to local EMS and hospital personnel.

5. A universally accepted, standardized form should be used for summaries. See suggested form titled "Emergency Information Form for Children with Special Health Care Needs." **(Editor's note: The form is enclosed in this issue of *ED Management.*)** Essential data elements include the patient's name, birth date, date of last summary update, weight, guardian's name, emergency contacts, pediatricians and other health care professionals, primary emergency department, major chronic illnesses and disabilities, baseline physical and mental status, baseline vital signs and laboratory studies, immunization history, medications, medication allergies, food allergies, and advance directives.* The AAP and its chapters should encourage local adoption of the American College of Emergency Physicians/AAP form.

6. Rapid 24-hour access to the summary should be ensured. Copies should be accessible at home, school, during transportation, and in the emergency department, in addition to a copy in the records of treating physicians. Linkage to an emergency telephone number such as 911 dispatch or some other method of ensuring rapid access is desirable. Especially important is identification of the most appropriate EMS squad to be called in areas without a 911 dispatch. Schools and child-care facilities should be encouraged to include the emergency summary as part of a child's individual health plan.

7. Confidentiality of the form should be carefully maintained. Parental permission to establish the emergency information form and distribute it to appropriate agencies should be obtained and kept on file with the originator of the form or at a central repository.

* Most states have a standard advance directive form, which is required for EMS to honor the advance directive to withhold emergency life-saving measures; however, the emergency data set or summary can identify a need to look for the standard form.

Source: Used with permission of the American Academy of Pediatrics. Committee on Pediatric Emergency Medicine. Emergency preparedness for children with special health care needs. *Pediatrics* 1999; 104:1-6.

available as a reference for when to contact EMS, as well as what care to provide until help arrives," he says. ED physicians and paramedics use the plan as a resource.

The care plan tells what makes each patient different from all other children with a similar presentation, says Lawrence. "It may be that this child's seizures are resolved with Dilantin instead of benzodiazepines, or that this child's O_2 saturation on four liters of oxygen is 82%, so no amount of work is going to make it 100%."

❑ **Create an Internet record for children with special needs.** At Hasbro Children's Hospital, an electronic medical record of children's complex conditions is being implemented so other EDs and emergency medical service providers can access the information via the Internet, says Lawrence. It will contain the following information:

- examples of common presenting problems and their management;
- medications to avoid and why;
- procedures to avoid and why;
- food or medication allergies;
- baseline respiratory and mental status;
- baseline vital signs;
- emergency contact numbers for family members, school, and the child's primary and specialty care physicians.

Access to that information is protected by passwords to ensure confidentiality, Lawrence explains.

❑ **Maintain a database.** Consider maintaining a database of information on special-needs children for all EDs in your community, suggests Wiebe. "Our large tertiary care pediatrics center is a referral base for 30 or 40 hospitals in the area," he explains. "When they get kids with rare problems, they call us for advice so we can fax or e-mail information."

A larger ED could provide after-hours information on what kind of emergencies each child might present with and how to treat them, he says. "If there are only 20 cases of a rare organic acid metabolic disorder in the reported literature, but one happens to live near a rural ED, it's highly unlikely that they will know that IV carnitine is going to save a comatose child." ■

Sources

- **Thomas Lawrence**, NREMT-P, Hasbro Children's Hospital, Rhode Island Emergency Medical Services for Children, Grads 209, 593 Eddy St., Providence, RI 02903. Telephone: (401) 444-8210. Fax: (401) 444-7030. E-mail: TLawrence@Lifespan.org.
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This emergency form can save children's lives

The ED will benefit greatly from the Emergency Information Form (EIF), which can put life-saving medical information about children with special needs at your fingertips, says **Alfred Sacchetti**, MD, FACEP, an ED attending physician at Our Lady of Lourdes Medical Center in Camden, NJ.

The form was developed jointly by the Elk Grove Village, IL-based American Academy of Pediatrics (AAP) and the Dallas-based American College of Emergency Physicians.

For the form to help, it must be on file, stresses **Robert Wiebe,** MD, director of the ED at Children's Medical Center of Dallas. "The child's pediatrician or specialist will need to do the work of putting it together, so the most important thing is to distribute the form to the parents," he says. "The parents need to push from the consumer end and make sure the doctor fills it out."

Here are some benefits of having an EIF on file:

❑ **You are alerted to "invisible" conditions.** The form can alert you to rare pediatric diseases that have no obvious symptoms or solutions, says Sacchetti. "Often, there is absolutely no physical way to tell what is going on with these kids," he notes.

The form also alerts you to individual care needs. "For example, children with generalized grand mal seizures aren't responsive to benzodiazepine and need to be treated with lidocaine," Sacchetti says.

❑ **You are alerted to breakthroughs in therapy.** ED clinicians may not immediately be aware of cutting-edge changes in medicine, notes Sacchetti. "A lot of subspecialists are very parochial, and they circulate their advances only within their unique area," he adds.

The form might list specific medications that are newly approved, he says. "You know what the textbooks say to treat the child with, but there may be a brand new treatment which cardiologists have been using for the last three months." For example, the standard treatment for tetralogy of Fallot, a congenital heart defect, is a morphine-neosynephrine combination, but a newer treatment is available, says Sacchetti. "Esmolol is

a short-acting beta blocker which can be used for hypercyanotic spells in these children," he notes.

High-tech devices such as activity sensitive pacemakers require specialized knowledge, he says. "This device senses when the child is active and speeds up the heart rate. If the child is only examined in a supine position, the physician would not be able to detect this function."

❑ **You can anticipate complications in advance.** The form can help you prepare for specific problems that will occur in certain children, says Wiebe. For example, a sickle cell patient with a history of previous stroke who is on hypertransfusion therapy is likely to have complications that can be anticipated, he says.

❑ **The forms can be accessed 24 hours a day.** MedicAlert Foundation in Turlock, CA, acts as a universal repository for information on children with special needs, says Sacchetti. ED staff can call the MedicAlert 24-Hour Emergency Call Center to find out if a child has an EIF on file, and the form can be faxed immediately within minutes, he explains. [The hotline number is (800) 625-3780, and the collect call number is (209) 634-4917.]

❑ **The information allows you to treat the child in a short period of time.** The form may include instructions that can save a child's life while you are waiting to hear from the specialist, explains Sacchetti. "They may not call back for 15 minutes," he says.

In the ED, that 15 minutes may be a matter of life or death, Sacchetti stresses. Other physicians refer children with special needs to specialists, he points out. "In emergency medicine, we don't have that luxury. If a child shows up blue, you have to intervene and don't have time to refer to a subspecialty. You've got to do something now." ■

Parents can't give enough information, study says

Even if parents are there when a child with special needs comes to your ED, they might not know enough to help you save the child's life, notes **Carol Carraccio**, MD, FAAP, professor of pediatrics at University of Maryland Hospital in Baltimore.

"Even the family members may not have a handle on what the problem is or an understanding of the disease process. That could clearly impact on the treatment the child receives," she says.

In one study, researchers interviewed 49 caretakers about their child's chronic medical problem.[1] "The results were concerning," reports Carraccio, the study's principal investigator. Here are key findings:

• About half of caretakers were unable to give their child's specific diagnosis. Of those, about half could provide a lay diagnosis, but the remaining half could only identify an organ system, with statements such as "my child has a heart problem," Carraccio says.

• Twenty-nine percent of caregivers could not provide an accurate list of medications the child was taking. "That is significant in the ED, because we have to worry about drug interactions," she explains. "It's important to know what they are already on, so a drug doesn't exacerbate the child's condition."

• About a quarter of caregivers didn't know the name or phone number of a specialist able to provide information about the child's condition.

• None of the children in the group was wearing medical ID jewelry.

Parents can improve children's care

The findings are only the tip of the iceberg, says Carraccio. "These were people compliant in coming to a subspecialty clinic setting, so it makes you very concerned about the group who didn't come to [the] clinic," she notes. "This makes a valid case that we need something above and beyond just information from the parent to do our best to take care of children with special needs."

Even if parents are knowledgeable about the child's problem, they might be unaware of rare emergency complications that might happen once or twice in a childhood, says Sacchetti. Here are some ways to work with parents of special-needs children:

❑ **Encourage parents to set up a visit in your ED.** Offer to meet with parents to discuss the emergency care of their child, suggests Sacchetti.

❑ **Suggest ways for parents to improve ED care of special-needs children.** Here are some ways that parents can help you ensure their children receive emergency care promptly, according to Sacchetti:

— Contact the police and prehospital care squad to let them know they have a child with special health care needs.

— Put a blue light outside so paramedics can find the house quickly.

— Keep an Emergency Information Form (EIF) on a shelf in the refrigerator with a ribbon around it, so it's readily accessible if a baby sitter or relative is at home when paramedics arrive.

❑ **Encourage parents to obtain medical ID jewelry.** Physicians don't recommend medical ID jewelry to parents as often as they should, says Carraccio. "We could do a better job of saying to families, 'This would be helpful for your child,' and providing the number to call." **(To obtain jewelry, see source box, p. 90.)**

Parents might not realize the need for medical ID jewelry and might mistakenly believe ED staff will know what to do in every situation, says Carraccio.

❑ **Create a continuum of care.** At VNA of Rhode Island/Hasbro Children's Hospital, the Max's All Star Kids Program identifies children with multiple complex health and rehabilitative needs who require repeated services across the health care system, says **Nancy Bowering**, the program's director. The program was developed to address parents' concerns about getting consistent care for their children, she explains. "We assign a care coordinator to assist the family in obtaining quality services and resources to care for their child at home," she explains.

The program also affects care in the ED, where a "Frequent Fliers" file is created for each child discharged from the hospital. The file contains emergency medical information and common presenting problems and their management, says Bowering.

"Emergency care plans are developed in the pediatric intensive care unit upon discharge by the team of intensivists, nurses, and discharge planners," she explains. "The goal is to inform the ED about the child's unique needs and care preferences."

Reference

1. Carraccio CL, Dettmer KS, duPont ML, et al. Family member knowledge of children's medical problems: The need for universal application of an emergency data set. *Pediatrics* 1998; 102:367-370. ■

Sources

For more information about family members' knowledge of children's medical problems, contact:

- **Nancy Bowering**, VNA of Rhode Island/Hasbro Children's Hospital, 593 Eddy St., Providence, RI 02903. Telephone: (401) 444-3201. Fax: (401) 444-7030. E-mail: NBowering@Lifespan.org.
- **Carol Carraccio**, MD, FAAP, University of Maryland Hospital, Department of Pediatrics, 22 S. Greene St., Room N5W56, Baltimore, MD 21201. Telephone: (410) 328-5213. Fax: (410) 328-0646. E-mail: ccarracc@peds.umaryland.edu.

To obtain an application for medical identification jewelry, contact:

- **MedicAlert Foundation**, 2323 Colorado Ave., Turlock, CA 95382. Telephone: (800) 432-5378 or (209) 669-2436. Fax: (209) 669-2495. E-mail: customer_service@medicalert.org. Web: www.medicalert.org.

Point/Counterpoint

VIP patients should be treated differently

By **Larry Mellick**, MD, FACEP
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We in emergency medicine have become experts at managing unique sets of patients with special needs. It is my opinion that VIPs and celebrities comprise just another set of those patients with special needs. Organizational rank, positions of authority, and celebrity status bring with them certain risks and social and cultural demands. It is impossible to deny the fact that VIPs have special needs.

In fact, dangers exist in not carefully managing the emergency medical care of VIPs or celebrities. Besides the obvious dangers and risks that presidents and other national leaders may experience, there are issues of privacy, comfort, and confidentiality that must not be ignored. It is common sense to protect a celebrity from exposure to the paparazzi or news media, autograph seekers, and the curious. By treating them differently, we care for them as valued patients with special needs.

Recently, when there was some disagreement on this issue in my own department, we asked a discerning question. "What if Tiger Woods presented to our ED with a medical condition during the week of The Master's golf tournament? Would his presence in our waiting room put him at any special risks? By not treating Mr. Woods differently, would there be disruptions to the care of others?" The answer was obvious.

What if the patient is the CEO of your hospital? Is it practical to not act or respond differently to such patients? We can't deny the fact that the unique needs of these patients require us to treat them differently.

Everyone would agree that the president, a senator or congressman, the city mayor, local professional sports team members, or your hospital CEO could be considered VIPs at some level. Do your family members qualify as VIPs? Perspectives seem to transition when

(Continued on page 92)

Policy/Procedure for Celebrities/VIPs Who Present for Evaluation or Treatment in Emergency and Express Care Services

PURPOSE: To provide a policy and procedure that addresses those situations when a celebrity or VIP presents requesting evaluation or treatment to the Emergency and Express Care Services. The intent of this policy and procedure is to ensure that these individuals are secure and that their personal comfort and patient rights are not compromised. Some individuals are placed at increased risk for being approached by the general public and/or hospital staff for reasons unrelated to their medical care. These individuals include politicians (local, state, and national), famous religious leaders, sports figures, and others. The intent of this policy is not necessarily to move these individuals to "the head of the line," but rather to ensure their security and anonymity. Nevertheless, there are individuals who, for reasons of security and safety, should have confidential and expedited care.

POLICY: In the event a celebrity or VIP presents for evaluation or treatment, this procedure will be followed:

I. Arrival by EMS:

1. Patient to be placed in the appropriate exam room.
2. Draw curtains and/or close doors to room.
3. Notify patient care coordinator (PCC) immediately.
    a. PCC to notify the following:
        i. attending emergency services (ES) physician
        ii. public safety trauma officer
        iii. registration staff (bedside registration to occur)
        iv. director of clinical operations or designee
        v. director of emergency services or chairman
4. DO NOT place patient's name on tracking board.
5. Access to patient is to be limited to practitioners with a "need-to-know" status (e.g., primary nurse, ES resident, ES attending, applicable ancillary services). NOTE: Members of the hospital administration may arrive in the department to welcome or meet some patients. Please refer them to the PCC.
6. Staff members are to honor the patient's privacy.
7. ES staff have the responsibility to keep any curious onlookers out of the area. Contact the PCC and/or the public safety trauma officer about individuals who are not complying with requests to move out of the area.

II. Ambulatory arrival: (Note: Individuals may present at triage OR at the trauma officer desk.)

1. The patient should be placed in an exam room if available. NOTE: These individuals are not necessarily to be evaluated or treated before other ES patients with a higher triage score or greater need. Nevertheless, these individuals should be treated in the most expeditious manner possible.
2. If no exam room is available, the following areas are potential optional "waiting rooms":
    a. MCG ED family grief/consultation room
    b. CMC ED family grief/consultation room
    c. CMC ED conference room
    d. CMC exam room.
3. Follow items I, 1-7.

III. Patient care coordinator will:

Document the specifics of the visit (name of person; chief complaint; disposition; any issues, positive or negative) on the 24-hour report and submit to the emergency services manager.

IV. Special security issues: Because of heightened security status for some celebrities/VIPs who are important to national security, (e.g., the president), it will be necessary to place them immediately in an examination room (regardless of the minor nature of their illness or injury). In these cases, the individual needs to be taken immediately to the appropriate and designated examination room. The room selected must allow minimal access or visibility and allow maximal security and protection. Any security instructions given by a protective agency (e.g., the Secret Service) should be followed. Additionally, these individuals should receive expedited care.

Source: Medical College of Georgia, Augusta.

opponents to special treatment for VIPs are given specific examples. One young physician opposed to a policy for VIP patients stated, "To the waiting room with them all." However, when asked how he would like to have his wife treated, his perspective faltered.

Why do we resist? Let's admit it. The reasons some of us resist treating celebrities or VIPs differently are based more on our disdain for the social elite than on altruistic feelings for the common folk, the poor, and socially disenfranchised. Or perhaps, we harbor vestiges of an "anti-establishment" outlook left over from an era past. Others might think this is an ethical issue based on Judeo-Christian tenets that discourage treating the privileged differently. Here are my suggestions:

❑ **Show deference, but don't practice bad medicine.** What's wrong with showing a degree of honor and deference to those who have been vested with positions of honor? Isn't this part of social structure that gives some degree of community cohesion and order? On the other hand, we cannot compromise the medical care of the celebrity or other patients in the process of showing special respect to the VIP or while meeting their unique needs.

❑ **Shouldn't everyone be a VIP?** Let's consider the possibility that if we aren't treating everyone like a VIP, then our system might need some operational improvements. The very fact that we have to treat patients differently should be a bellwether that our service needs to be overhauled. Why not move all of our patients immediately out of the waiting area and into a treatment room using bedside registration? Why isn't timely turnaround of laboratory and radiology tests and patient throughput a priority for everyone? Are confidentiality and patient safety aggressively safeguarded for all of our patients?

"To the waiting room with them all" is not the correct attitude and is unfair to all of our patients, VIP or not. Let's treat everyone just as we would like to be treated. There has to be a happy medium. Of course, we can't compromise medical care of other patients in the ED during the process of caring for a celebrity. However, the confidentiality, safety, and comfort of the celebrity should not be placed at risk, either. Policies for the management of VIPs must be developed. **(See policy, p. 91.)**

Like it or not, the potential for disruption will always be present when a VIP presents for medical care in your ED. It is our responsibility to have an adequate plan for meeting the needs of the celebrity patient as well as the needs of our other patients.

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It's wrong to treat VIPs better than other patients

By **Douglas S. Diekema**, MD, MPH
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Many VIPs expect to be treated differently. That expectation is not restricted to restaurant reservations and first-class air travel. A VIP requiring a visit to the ED also will often expect special treatment upon arrival. Treating VIPs differently, however, might not always be the best medical or ethical course of action.

Although a VIP coming to an ED might think that special treatment will mean better medical care, that's not always the case. For example, if the chief of staff comes into the ED with abdominal pain, there might be a tendency not to subject him or her to a rectal exam. Assuming that a rectal exam is needed, you are depriving that person of the best possible care. One study has shown that the spouses of physicians are less likely to get pelvic exams than other patients would be. When you break out of protocols to try to deliver "better" care, there's always the risk that, in reality, you deliver inferior care.

All patients need confidentiality

Many ED physicians would prefer not to know if they were treating a celebrity. We find ourselves second-guessing what we're doing for a given chief complaint by asking, "Is this really necessary?" Sometimes those questions can be good, but not if the answer is different when the patient is a celebrity. Most of us deliver our best care when we're not trying to practice differently simply because someone is a VIP.

There still might be some things we ought to do differently for celebrities in order to provide them with the same protections we would provide to all patients. All patients can expect confidentiality regarding their ED visit, and a celebrity is no different. You can make a good argument that easily recognizable celebrities shouldn't be made to sit in the waiting room where others will notice them. Rather, they might be offered a more private location where they could wait their turn. It is important to recognize that the justification is to provide them with confidentiality similar to that of others, not to provide them with preferential care.

Special care given to celebrities can fall into two categories: It might mean trying to deliver a different level of medical care, or it might mean providing the celebrity with amenities that other patients don't get. For example, celebrities might be seen in the ED immediately regardless of their triage level, or a nurse might be assigned to pay constant attention to a celebrity rather than seeing two or three other patients. In a teaching hospital, the celebrity is likely to see only the attending physician or a consultant, while everyone else gets evaluated by a house officer.

Consider ethical implications

This leads us to the question: Is it ethically appropriate for some patients to be treated differently with regard to emergency care? It's difficult to mount an ethical argument for giving better care based on celebrity status.

Emergency medicine traditionally has used the triage system to determine which patients will be seen first. Triage emphasizes medical need as the criterion by which we distribute the fastest medical care. When you change the system by taking a celebrity out of order or by focusing the attention of the attending physician on the celebrity and away from the other patients, there is no question that you are being unfair to others. Other patients are getting less attention and waiting longer because the VIP has been treated preferentially.

Money and potential donations are the driving forces behind the desire of many institutional administrators to provide celebrities with a good experience during their hospital visit. It's not unusual for an ED manager to get a phone call from the CEO of the hospital saying a local celebrity or a board member is coming to the ED. Institutions feel they have an interest in providing special care to such people because they hold the power to help financially and will be more disposed to giving a donation if they have a good experience.

Management might say all patients will benefit in the future if a celebrity makes a donation. I would counter that argument by saying that in reality, most patients would benefit more if the celebrity had the same kind of experience provided to all patients. If you want to improve the system for everybody, then those who wield the most power should be subjected to the same system. If a three-hour wait is considered tolerable for other patients with a nonemergent problem, it ought to be as tolerable for a VIP as well. If the VIP complains about the wait, administrators are much more likely to change the system than if John Doe has made the same complaint. If financial donors have an optimal experience that no one else has, management might overlook problems of overcrowding and understaffing.

There also might be some risk management issues related to a VIP in the ED. If a patient had a bad outcome as the result of a longer wait or received less attention because there was a celebrity in the ED attracting all the resources, you would have a potential risk management problem.

Our society tends to feel egalitarian about medical care. There is no question that in the minds of most people, emergency care is not something that should be distributed based upon social status. Imagine a case in which a patient was harmed because he or she wasn't seen quickly enough because a celebrity was in the ED. The jury almost certainly would sympathize with the harmed patient. Such a case would also present a public relations nightmare.

Celebrity status might warrant a special parking place or reservation in a restaurant, but it shouldn't be relevant to emergency care.

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Joint Commission UPDATE

New restraint standards will change your practice

ED staff are at high risk for placing patients in unnecessary restraints, according to **Robert Wise**, MD, vice president of standards for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL.

"If things are very busy, ED staff might be tempted to use restraints to resolve an issue quickly. If patients are restrained because there is low staffing, it would be seen as abuse," he warns.

New restraint standards require you to use restraints or seclusion only for emergency situations when there is imminent risk that patients will harm themselves or others, according to Wise. "Even then, restraints are only to be used as a last resort," he says. **(See key changes in the standards, p. 95.)**

You'll need to demonstrate that a patient is in restraints for specific reasons, stresses Wise.

"You will then have to document the severity of the presenting problem to show it reaches the level of imminent danger. You need to show that it's not just

Executive Summary

New restraints and seclusion standards from Joint Commission on Accreditation of Healthcare Organizations require you to use restraints or seclusion only for emergency situations when there is imminent risk of physical harm to a patient or others.

- The standards will be scored for compliance in January 2001 and will not be capped (a sliding scale scoring system usually used for several months after new standards are introduced).
- Document that alternative measures, such as trying to contact family members, were considered before restraints were used.
- The need for restraint must be described by behavior, not diagnosis.

HCFA, Joint Commission standards are different

The new standards for restraint and seclusion from the Joint Commission on Accreditation of Healthcare Organizations differ from those of the Health Care Financing Administration (HCFA), notes **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, specializing in regulatory compliance.

The HCFA rule says a physician's order must be obtained within one hour for restraints applied for behavioral reasons. The Joint Commission says the order must be obtained within four hours for adults, two hours for adolescents, and one hour for children under age 9, she explains.

HCFA's "one-hour rule" is considered onerous by a lot of clinicians, so it has generated a lot of controversy, she says. "Generally, the most stringent standard applies. Let that be your guide, and go with the HCFA one-hour rule." ■

being done for staffing reasons or convenience."

The standards will be scored for compliance in January 2001, Wise reports. Type 1 recommendations are usually built on information gathered across the facility, notes **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, specializing in regulatory compliance. "However, with restraints, just one order could do it," she says. "Follow policy and procedure to the letter."

The two basic issues are patient safety and respecting patients' rights. Because of safety issues and the known deaths associated with restraint use, the general feeling is that the new standards will not be capped for scoring, which means there won't be a sliding scale scoring system that's typically used for several months after standards are introduced, he says. "You'll need to check your policies for holes and see if anything needs to be changed." **(See how the standards differ from those of the Health Care Financing Administration, below left.)**

Here are ways to ensure compliance with JCAHO's new restraint and seclusion standards:

❑ **Provide staff with training.** Staff need ongoing training in restraint use, says Wise. The training should address the following, he advises:

— understanding how underlying causes such as medical conditions and staff interventions can cause aggressive behavior;

— de-escalating patients' agitation;

— recognizing readiness for discontinuation of restraint or seclusion;

— recognizing signs of physical distress.

❑ **Continuously monitor patients.** Continuous monitoring is accomplished through continuous in-person observation by an assigned staff member, says Wise. "We left it pretty open so an ED can figure out how to do this," he adds. "It requires some creative thinking about how somebody in restraints would be continuously monitored." It could be a drain on staffing, Wise notes. "However, that would be an impetus to facilitate the appropriate transfer or remove the individual from restraints as quickly as possible," he says. "In a busy ED, it's possible that someone in restraints could be left alone for significant periods of time, which would be viewed as a serious issue."

❑ **Know when to use medical/surgical or behavioral health standards.** You don't have to use the more stringent behavioral health standards until you have ruled out a medical condition, says Wise. "If a patient in your ED is acting strangely or bizarrely, and it's not clear whether it's for a psychiatric or medical reason, the triage nurse will have leeway if you need to restrain the person for a medical exam," he explains.

At that point, you might reasonably think that a medical problem might be present, says Wise. "So you could use the medical/surgical standards, until it becomes clear that it is a behavioral health problem," he notes. At that point, the behavioral health standards would apply. "It's up to the careful judgment of the triage person to determine initially what standards are being used and to use the appropriate standard as the work-up progresses."

❑ **Realize that a diagnosis is no longer adequate to justify restraints.** Many hospitals use diagnoses such as "altered consciousness," "psychiatric hold,"

"demented," or "overdose" as criteria for restraint use, but those criteria are insufficient, says **Stuart Shikora**, MD, FACEP, a JCAHO surveyor and an ED physician at Mount Diablo Medical Center in Concord, CA.

"Just because a patient is demented, that doesn't immediately justify use of restraints," he stresses. "That is not satisfactory."

The need for restraint has to be described by behavior, not diagnosis, says Shikora. "For example, you can have a patient coming out of anesthesia who is combative but is not demented," he says. In that case, document that "restraints are needed to prevent dislodging of tubes," he suggests.

Formulate specific criteria to justify restraint use, he says. "Look at behaviors which are dangerous to the patient or staff and write those down as a reason to use restraint, not the diagnosis. That implies the need for restraint but doesn't clearly state it."

❑ **Consider alternative measures for restraint**. Document that alternative measures were considered before restraints were used, says Shikora. For example, the nurse might check off "family at bedside, unable to calm patient," he suggests. "Document that 'we tried this, but it didn't work,' or 'resources weren't available,' or 'an out-of-control patient might be calmed by a family member, but none were available.'"

If the patient wants someone there, the effort to contact that person must be made and documented, Catalano says. "If several options are given, call several people until you find one of them at home. Document all attempts."

[The new restraint and seclusion standards are available on the Joint Commission's Web site: www.jcaho.org. Double-click on "For Health Care Organizations and Professionals." On the next page, click on "Standards" in the top bar. That will take you to the standards page, which includes a link to the restraint and seclusion standards. The manuals including the standards can be purchased by calling the Joint Commission at (630) 792-5800, 8 a.m. to 5 p.m. Central time on weekdays.] ■

Sources

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Here are key changes in restraint standards

New restraint and seclusion standards from the Joint Commission on Accreditation of Healthcare Organizations include the following changes:

• Staff are trained and competent to minimize the use of restraints and seclusion, and in their safe use. Staff must demonstrate an understanding of the factors that influence behavior and may result in the need for restraints and seclusion.

• All individuals placed in restraints or seclusion, regardless of age, must have an order for restraints and

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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 *Use guidelines to prepare for children with special needs, or risk tragedy*, p. 85, and *Parents can't give enough information*, p. 89.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *Joint Commission Update: New restraint standards will change your practice*, p. 93, and *HCFA, Joint Commission standards are different*, p. 94.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

seclusion issued by a licensed independent practitioner within one hour of the initiation of the restraints or seclusion.

• The length of the initial and any subsequent order for restraints and seclusion cannot exceed one hour for children under age 9 and four hours for adults.

• Upon expiration of an order for restraints or seclusion, a new order — written or verbal — must be issued by a licensed independent practitioner within every hour for children under age 9 and within every four hours for adults. ■

Site focuses on ED issues

Are you looking for information on legislative and regulatory issues, coding and reimbursement, and managed care? If so, log onto the Abaris Group's Web site at www.theabaris.com.

"We wanted to create a site where ED managers could go to find the background research they need to operate a contemporary ED," says **Michael Williams**, president of the Abaris Group, a consulting firm specializing in emergency services in Walnut Creek, CA.

The site contains ED visit data, data on ED visits by age groups, and utilization rates. "You will also find a series of articles I wrote on managed care strategies," he says. Topics include updates on ambulatory patient classifications (APCs), the Emergency Medical Treatment and Active Labor Act advisory issued by the Health Care Financing Administration (HCFA), clarification of CPT critical care codes, and the patient bill of rights. There also are links to other sites for updates on breaking news issues such as HCFA's APC rules and the latest on the Office of the Inspector General's opinion on paramedic stocking, notes Williams. Recent news articles include steps for implementation of APCs and an update on a national task force for EMS education, he says. ■