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Frustrated by the nursing shortage? Try these tactics instead of bonuses

Even cruises don't work — Here are some creative ideas

Do you have high vacancy rates for nursing positions in your ED? Sources interviewed by *ED Management* say they are feeling the pinch of a nationwide nursing shortage and are finding it nearly impossible to recruit and retain staff nurses.

Even with unprecedented sign-on bonuses of up to $10,000, many EDs are unable to attract and hire qualified nurses, reports **Cindy Asche**, RN, BSN, nurse manager of the ED at Medical City Dallas Hospital. "One of the EDs in our system even promised nursing applicants cruises, and it still had vacancies," Asche says.

The supply of emergency nurses will only get scarcer over the next few years, predicts **George D. Velianoff**, RN, DNS, CHE, executive vice president of nursing for the Emergency Nurses Association in Des Plaines, IL. Aging nurses are retiring, while fewer students are enrolling in nursing schools every year, Velianoff explains. **(See story on starting an ED nurse internship program, p. 112.)**

To make matters worse, demoralized nurses are leaving the profession, he says. "You can't force mandatory overtime, staff at minimal critical levels, abuse your work force, and expect nurses to stay and be happy," he argues. **(See story on providing nursing staff with flexible schedules, p. 111.)**

Many EDs already struggle to keep staff nursing positions filled, Velianoff says. "Some are using a greater percentage of assistive personnel, including

Executive Summary

There is a nationwide shortage of ED nurses due to an aging work force, fewer students enrolling in nursing schools, and demoralized nurses leaving the profession.

- Effective strategies for retaining staff include developing career ladders, starting a nurse leadership program, and sending nurses to conferences.
- When hiring nurses, address how well they fit into your ED's culture.
- Morale-boosting programs help nurses feel valued.

paramedics, but these measures have shown to increase wait times and length of stay."

To avoid being short-staffed, you'll need to find more creative solutions, urges Asche. "It looks like the nursing shortage is not going to get better any time soon," she warns.

Here are some effective ways to recruit and retain ED nurses:

✔ **Make sure you hire the right nurses.**

Hiring nurses who will fit into the work culture of your ED is key, says **Nancy Bonalumi**, RN, MS, CEN, director of emergency services for Pinnacle Health Hospitals in Harrisburg, PA.

"Technical skill is important, but an even more important factor is hiring someone with the right attitude," she says. "Nurses can learn skills such as starting an IV or drawing blood, but also consider attributes such a teamwork, courtesy, and customer service skills."

During the interview process, recruiters evaluate a nurse for his or her "fit" into the Pinnacle Health culture, says Bonalumi. A structured interview process assesses eight attributes of the organizational culture: customer service, courtesy, open communications, trust and understanding, empowerment, ability to meet financial commitments, control of one's own destiny, and "Pride in Pinnacle."

Those assessments help ED managers judge how well the nurse will fit into the department, Bonalumi says. "An effective method for determining cultural fit is asking employees to describe a time when they were very successful/unsuccessful in resolving a conflict, a work experience they are most/least proud of, or similar situations," she adds.

By hiring the right nurse, you increase the likelihood of retaining that person, she says. "Turnover costs can be very high if employees are hired only for technical skill. Failure to recognize work culture can significantly affect your bottom line."

✔ **Start a career ladder.**

At Tallahassee (FL) Memorial Hospital's ED, a career ladder was designed to help nurses who wanted to stay in the clinical area but also wanted to advance financially and in status, says **Cynthia Wright**, RN, MS, education coordinator for the ED. "The program encourages nurses to precept new nurses and do quality assurance and cost-saving projects," Wright explains. **(See Professional Nurse Advancement Program, enclosed in this issue.)**

Points are assigned for each task, and nurses are given a quarterly supplemental check ranging from $200 to $800, depending on the number of points earned, Wright says. "The nurse keeps track of what she does in a booklet and submits it to a nursing committee yearly after her department head reviews it."

The committee agrees on acceptable criteria for the career ladder, including new ideas proposed by nurses, she says. "Each interested nurse is given a packet which provides ideas for earning points. If a nurse has a new or innovative idea, she writes it into her packet."

✔ **Solicit positive comments about colleagues.**

At Norwalk (CT) Hospital's ED, a nurse manager started a "feel-good" program adapted from a grade school project. Every two weeks, she posted the names of five staff nurses in the staff lounge.

"Everyone who worked in the ED was invited to jot a positive note about the person" underneath that person's name, says **Laura J. Roepe**, RN, MA, CEN, former administrative manager of emergency nursing services and currently a clinical systems analyst for Tyco Healthcare, a division of U.S. Surgical Corp.

The project's goal was to show that the staff could find at least one positive thing to say about everyone in the ED, she explains. "After two weeks, I type out all of the comments onto a certificate and give it to the individual."

The project boosted nurses' morale, says Roepe. "It was quite uplifting for the individual to read how others felt about him or her. It also illustrated that their colleagues value them not only for clinical expertise, but also their personality."

Positive feedback is vitally important for nursing staff, she says. "The stresses of hospital nursing are enormous."

There is no downtime anymore, Roepe says. "Since there is not the opportunity to interact with other nursing departments, the staff within the ED need to become a functional, enjoyable family unit. Morale-boosting keeps us focused and happy."

COMING IN FUTURE MONTHS

- Use pagers to improve communication dramatically
- How to comply with most recent needlestick laws
- Ways to update staff on new ACLS guidelines
- Start a program to admit patients without delay

✔ **Send nurses to conferences.**

At Tallahassee Memorial Hospital, all full- and part-time ED nurses are rewarded for their hard work with the opportunity to attend national and local conferences. A random drawing for one assistant nurse manager and one charge nurse is done to select nurses to attend the annual Emergency Nurses Association conference, Wright says.

The money comes from the ED budget and is supplemented by educational grants given by pharmaceutical companies, she says. "There is no set number of nurses sent, it depends on the money available. Instead of pizza parties, we put money into this."

'Tons of ideas for how to make things better'

Sending staff nurses to the Emergency Nurses Association meeting helps the ED stay current with clinical and technological trends, she says. "Nurses come back with tons of ideas for how to make things better."

Last year, the hospital sent a nurse who hadn't been to a national conference in 20 years. "That's commonplace in nursing, whereas in other industries, it's customary to send employees to conferences in their field two or three times a year," Wright says.

Scheduling is difficult when several nurses are gone for the duration of a conference, she notes. "But this is a priority, so everybody works to make this happen. Nurses know that they may go next or have gotten to go, so they have incentive to help somebody else go."

It costs about $1,000 to send a nurse to a national conference, but the ED reaps benefits, she stresses. "If the hospital gives them something, they give more back to the hospital. Since we started this program, I've seen more participation, in terms of teaching and helping out in the department, and more willingness to be flexible."

✔ **Develop a leadership program.**

The department of nursing at Norwalk Hospital developed a leadership program to assist in retention, says Roepe. Nurses apply for the leadership role in their respective departments, are interviewed by the manager, and are evaluated by all of the staff for their leadership potential, she explains.

The selected nurse leaders meet every other week as a group to solve unit problems, and they meet monthly with the other unit leaders to discuss mutual problems, Roepe says.

There is no monetary reward, except pay for attending the meetings, she notes. "But nurses take pride in knowing they are helping to make the ED and the facility better," she says. "It is also a way to develop leadership behaviors in staff nurses, therefore being able to promote from within when available." ■

Sources

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Give nurses flexible schedules

Do you want the competitive edge when it comes to retaining nursing staff? Instead of sign-on bonuses or other incentives, offer nurses a flexible schedule, recommends **Cindy Asche**, RN, BSN, nurse manager of the ED at Medical City Dallas Hospital.

"If we want to retain nurses, we need to try and be more accommodating," Asche says. "This makes nurses want to stay at your institution, as opposed to going somewhere else or doing something else."

Medical City's ED managers work with every nurse to develop a schedule that's tailored for him or her, she says. "This is a real management headache, but we are committed to keeping our staff satisfied."

Some nurses are parents with child-care needs, and others are in school and need to plan around their classes. "We give them schedules that work for them," she says.

Recently, a nurse who had worked in the ED for several years had a baby and needed a specific schedule, Asche recalls. "She works opposite the days and times her husband does, so they don't have to put the child in day care," she says.

Another nurse works only evenings and no Wednesdays, she says, and "another nurse is trying to start a consulting business and wanted to be available during the week. So she only works 12-hour shifts on Friday, Saturday, and Sunday."

The trick is to try to meet as many of your nurses' individual needs as possible and work to fit all the employee schedules together, says Asche.

About a third of the nursing staff works special schedules to meet individual needs, she explains. "Although we still have some staff vacancies, we have fewer than most EDs our size. I attribute that to our flexible scheduling policy." Flexible scheduling has given the ED a competitive edge over other facilities in the area, Asche reports. "When nurses go to interview at another hospital, I always encourage them to ask about their work schedule," she says. "For example, one hospital requires ED nurses to work shifts three days on, three days off, two days on, two days off. It doesn't matter what is going on, that's the shift you work."

The trick is to meet as many of your nurses' individual needs as possible and work to fit all the employee schedules together.

Some ED nurses are PRN employees on staff who don't work a regular schedule, she says. "They pick up shifts as they want to. We try to have a lot of them and give them first crack at any available shifts so we can fill holes as needed."

ED has vacancy under 3%

At Pinnacle Health Hospitals in Harrisburg, PA, several scheduling options are offered to retain current ED employees, says **Nancy Bonalumi**, RN, MS, CEN, director of emergency services.

"We offer a 64-hour or 72-hour every-weekend schedule per two-week period that pays a 25% bonus," she explains. "This means nearly full-time pay for part-time work."

Current employees filled those slots. Weekend staffing coverage also was increased, which has boosted staff satisfaction, Bonalumi says.

Managers offer increased per diem rates to compete with salaries offered by staffing agencies, she says. "We are also offering premium pay to employees if they pick up prescheduled extra shifts to fill staffing needs."

Partly as a result of giving nurses scheduling options, the system's three EDs have a vacancy rate under 3% and have been successful in recruiting new nurses, Bonalumi reports. They have had 18 nurses start in the past three months in the three EDs, she says. "I consider that to be exceptional at a time when many facilities have vacancies open for months." ■

'Grow your own' nurses for staffing the ED

Having trouble finding experienced ED nurses due to the nursing shortage? Why not "grow your own" by starting an internship program for recent graduates?

Recent nursing school graduates often are capable of working in the ED, says **George D. Velianoff**, RN, DNS, CHE, executive vice president of nursing for the Des Plaines, IL-based Emergency Nurses Association. "They need to be able to prioritize multiple tasks and think critically," he says. "However, for this to be effective, a good mentoring and orientation program is needed — not two weeks of training and 'You're on your own.'"

HCA/North Texas Division, which has 10 EDs, has developed an innovative internship program. "This broadens the pool of applicants to include recent nursing school graduates and experienced nurses without an ED background," explains **Cindy Asche**, RN, BSN, nurse manager of the ED at Medical City Dallas Hospital. "A lot of nurses would like to work in the ED but don't have critical care experience, so they have never been able to get a foot in the door," says Asche. "Other nurses are burned out and need a change."

Here are some key components of the ED nurse internship program:

• **All EDs in the system share the workload.** No one hospital has to bear the entire cost of putting on an ED internship, Asche notes. For example, each ED took a different day to be responsible for providing lectures. "Several of us wrote the objectives and course curriculum so we could have quality control over what people are teaching."

• **Each ED makes autonomous decisions.** "Every ED in our system sets its own criteria, hires its own interns, sets a salary, and decides whether there will be a contract or bonus," Asche says.

• **Interns attend lectures in a central location, then work clinical shifts in their assigned EDs.** The six-week internship program is intensive and combines lectures with clinical shifts, she says. "The nurses are getting a phenomenal amount of education in that time. We feel that it will give them the knowledge basis for being a good ED nurse."

The coursework reviews the emergency nursing core curriculum, every major system in the body, and frequently seen emergency medical conditions, says Asche.

She estimates that $7,500 of educational nonproductive time is invested in each intern, including classroom time and clinical experience.

• **Each ED arranges lectures with experts.** Each ED tries to secure the most knowledgeable experts in its institution to teach segments of the course, says Asche. "For example, we got the nurse educator who teaches cardiac assessment for our hospital to do that segment, and we had our ED medical director do a lecture on overdose and substance abuse."

• **Every intern is assigned a staff nurse as a mentor for the 12-week program.**

The mentor's job is to make sure the intern is competent, she says. "They go over the things they have learned in class and put them into practical application."

Staff nurses are supportive of the mentoring program because they don't want to work short-staffed, she explains. "They like the prospect of being able to 'grow' their own nurses to fit into their unit. They are willing to do an awful lot so they are not working short." ■

Work with paramedics to improve care for kids

A child's tracheostomy tube had become displaced. Thanks to special emergency training, the EMT was able to resuscitate the child, who fully recovered.

"The child's parents, who are both physicians, credited the training received by the EMTs as being instrumental in their child's good outcome," says **Thomas Lawrence**, NREMT-P, program director for the Rhode Island Emergency Medical Services (EMS) for Children at Hasbro Children's Hospital in Providence.

Executive Summary

Prehospital providers might not be well-trained in managing pediatric patients, so you need to work with paramedics to improve care, particularly for children with special needs such as assistive devices.

- Share information about special-needs children with paramedics in the field, so they can anticipate problems that might occur.
- ED databases can be linked to 911 systems, so information about children with special health care needs is available to both emergency medical services personnel and ED physicians.
- A new national pediatric education course for basic and advanced prehospital providers is available, which includes training in special-needs children.

It's critical for EDs to work with paramedics to improve care of children, especially those with special needs such as chronic illnesses, according to **Marianne Gausche-Hill**, MD, FACEP, FAAP, director of emergency medical services at Harbor-University of California at Los Angeles Medical Center in Torrance.

"It is key for prehospital providers to be educated about children with special needs because more and more of these children are being integrated back into society," she says.

Technological advances have allowed more children to survive various illnesses and injuries, Gausche-Hill notes. "These children offer special challenges to prehospital providers because of a need for devices to assist with daily living. Also, medications may have side effects which could affect their care." **(For more information about special-needs children and emergency information forms, see *ED Management*, August 2000, p. 85.)**

EMS providers generally are not well-trained or experienced in pediatrics, Lawrence says, and that lack of training causes their anxiety levels to be high, even in situations with uncomplicated sick or injured children. Add the pressure of a child with special needs, and the presence of an emergency care plan is even more important, he stresses. "Giving paramedics some explanation of the child's condition becomes invaluable."

The following are some ways to work with prehospital providers to improve emergency care of special-needs children:

1. Instruct paramedics in managing problems that may occur.

When children with special needs are being transported to the ED, communicate with paramedics to alert them to potential problems, Lawrence suggests. "You may be put in the position of being the medical control and have to address complications arising during long transport times," he says.

If your out-of-hospital colleagues have access to basic information about the patient, they will be able to anticipate problems that might occur in the field, he advises. For example, a child with a ventricular peritoneal shunt with an obstruction might be having seizures and altered consciousness. If information is on file, paramedics can be alerted that it's not a simple seizure but instead is related to increased intracranial pressure, which requires a different approach, he explains.

2. Link your ED's database to 911 systems.

At Hasbro Children's Hospital, a Pediatric Emergency Dispatch Information System for Telephone

(Continued on page 115)

Source: Rhode Island Emergency Medical Services for Children, Providence.

Assistance and Treatment (PEDI-STAT) program works with paramedics to improve care of special-needs children. **(See PEDI-STAT Project Fact Sheet, p. 114.)**

The system identifies and enrolls children with special health care needs in a computer database and makes information available to EMS providers and ED physicians who treat those patients. Currently, 61 children are enrolled, Lawrence reports. The system is linked to Rhode Island's statewide enhanced 911 system.

"Although we had hoped to have an actual connection between enhanced 911 and our computer database, we have had to settle for less," he explains.

911 receives alert on special-needs child

A flag system on the 911 telecommunications screen alerts them that there is a child with a special health care need at that address. "This flag comes up regardless of the nature of the call to 911," Lawrence says.

The information is communicated to the dispatch center, which then conveys it to the responding ambulance, he says. "The only information the ambulance receives is that a child with special needs lives at that house. They may also be advised to call the Hasbro Children's Hospital ED for additional information."

3. Provide training to prehospital providers.

At Hasbro, training in the care of children with special needs during medical emergencies is provided to EMTs, Lawrence reports. Rhode Island EMS for Children, a federal grant-funded program, provides the training, which focuses mainly on the care of tracheostomies, from clearing a blocked tube to changing the tube, he says. "This, in particular, is an area that is not covered in many EMT courses, if any. The use of an adapted pediatric mannequin allows for hands-on training." **(See story on new PEPP course for paramedics, above right.)**

EMTs are taught to focus on the basic life support (airway, breathing, and circulation) method of patient care and to add tracheostomies to their list of ways to manage an airway, he says. "We have also had parents of a child with a complex medical history bring their daughter to the class so students can see for themselves how to care for trachs on real patients."

Other topics discussed during the sessions are the importance of background information on children with special health care needs, information on types of medical conditions that are included in the definition, and an overview in assessment and care, says Lawrence. ■

Update paramedics on new PEPP course

The PEPP course (Pediatric Education for Prehospital Providers) is the first national pediatric education course for basic and advanced prehospital providers. The course includes training in caring for special-needs children.

"It is case-based and provides a great opportunity for hands-on experience in skill stations," says **Marianne Gausche-Hill**, MD, FACEP, FAAP, director of emergency medical services at Harbor-University of California at Los Angeles Medical Center in Torrance, CA. Gausche-Hill is one of the developers of the course.

The course was started in March 2000 and is sponsored by the American Academy of Pediatrics. "This is a continuing education course, but EMS educators are integrating it into the primary curriculum for paramedics," she notes.

The PEPP course is designed for first responders, emergency medical technicians, and paramedics, says Gausche-Hill. The course content focuses on how prehospital professionals can better assess and manage ill or injured children, and it includes case-based lectures, discussions about caring for children with special health care needs, and training in skills including tracheostomy care, she adds.

A resource manual ($35), PEPP text ($36.95), CD-ROM toolkit ($195), and slide set ($195) are available. For more information, contact Kim Brophy, Jones and Bartlett Publishers, 40 Tall Pine Drive, Sudbury, MA 01776. Telephone: (800) 832-0034 or (978) 443-5000. Fax: (978) 443-8000. E-mail: info@jbpub.com. Web: www.PEPPsite.com. ■

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Patients can help with documentation

Save time with this medical record form

Would you like patients to help your staff document information on the medical record form? At South Jersey Health System in Bridgeton, NJ, a unique ED medical record form allows patients to start their records as part of the sign-in process, just as they would provide information in a physician's office. **(See South Jersey Hospital Emergency Department Record, enclosed in this issue.)**

The form was developed by a multidisciplinary group whose goals included:

- having patients fill out sign-in information directly on the triage sheet;
- streamlining patient and paper flow from entry point to discharge;
- increasing patient participation in the care continuum and reducing redundant interview and history procedures;
- avoiding duplicate documentation;
- allowing documentation to flow according to the sequence of events in the patient's visit.

At triage, the sign-in sheet instructs patients to fill out the top part of the form, which is placed nearby on the counter. That form becomes part of the medical record, says **Michelle Regan Donovan**, RN, BSN, president of Millennium Strategies, a health care consulting firm in Charlottesville, VA. Donovan helped develop the form.

The chart is placed in a designated space intended to notify the triage nurse who might be seeing another patient, she says. "Even if she has received four or five of these sheets, the triage nurse now has sufficient basic information for a 'primary' triage. That eliminates the verbal questioning of several patients who may have signed in on a sign-in sheet since her last check."

The triage nurse has the patient's name with its proper spelling, a chief complaint in the patient's own words, a phone number, and a family physician's name, says Donovan. "The hospital now has the recorded time of entry and a home phone number for risk management should the patient leave the hospital prior to being seen," she adds.

The form also offers documentation prompts for items required for safe and lawful billing, claim assignments, and claim processing, she says. For example, the form includes prompts for physicians' histories, physicals, and plan of care. "This reduces discrepancies in levels of examination and level of service fees billed out, which is a policy variant often cited in fraud and abuse investigation and prosecution," Donovan says.

Executive Summary

Patient medical record forms can include written input from patients, which saves time at triage and allows patients to participate in their care.

- If a patient leaves without being seen, nurses have the patient's name, chief complaint, and phone number for follow-up.
- ED managers report an average time savings of 10-15 minutes per patient, which improves overall patient flow.
- The triage nurse's workload is reduced when several patients come in at once with unknown chief complaints.

Triage time is decreased

Because full assessments are not completed in the triage area, the time a patient spends in triage is decreased, says **Sandra Dietrich**, RN, MSN, director of nursing for emergency services at South Jersey Health System Hospital. On average, the chart saves 10-15 minutes per patient, which improves overall patient flow, she says. "The physicians and nurses aren't hunting all over the place for the patient's chart and aren't waiting for each other to complete their documentation."

Previously, patients had to be asked for all information verbally, including their names and times of arrival, she says. "As long as it's legible, we can go right past that, so it saves time." **(See story on pros and cons of using the form, p. 117.)**

Patients used to sign a sheet when they arrived, but they only included their names and the arrival times because the chief complaint could be determined by others, says Donovan. "This created an inefficient process since the triage nurse still needs a chief complaint if she is to sort more than a single patient," she explains.

The form allows the triage nurse to get more information instead of just a name and time recorded on a publicly accessed sign-in sheet. "Joint Commission [on Accreditation of Healthcare Organizations] standards on patient confidentiality disallow the documentation of chief complaint on the sign-in sheet since other patients have access to same," she explains.

The form also reduces the liability and workload of the triage nurse when several patients appear at one time for triage with unknown reasons for visiting, Donovan says. "When the triage nurse has access to multiple charts initiated by the patient, she is able to

review these for determining the order of triage processing," she explains.

At St. Vincent's Medical Center in Jacksonville, FL, a patient medical profile form saves about 10 minutes on complicated patients with involved histories and two to three minutes on less complicated patients, says **Ralph Badanowski**, MD, FACEP, the ED's medical director. "The doctor, nurse, or physician's assistant can do a focused history using the profile as a guide," he says. **(See St. Vincent's Patient Medical Profile, enclosed in this issue.)**

The staff would have to obtain this history anyway to complete the necessary documentation and provide appropriate care, Badanowski notes. "This saves time, because the forms are filled out in the waiting room or registration while the patient is being processed." ■

Sources

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Should ED staff ask patients to document?

By using a patient medical record form that includes patient documentation, communication is much clearer between patients and staff, reports **Gwyn M. Parris-Atwell**, RN, MSN, NP-C, CS, CEN, clinical educator for emergency services at South Jersey Health System in Bridgeton, NJ.

"Patients are more involved because the form requires their input," she explains. "They have the opportunity to document in their own words so they feel they have more input."

The form eliminates the need to ask patients for their names, chief complaints, and medical histories numerous times, says **Michelle Regan Donovan**, RN, BSN, president of Millennium Strategies, a health care consulting firm in Charlottesville, VA.

As the organization's emergency services consultant, Donovan helped develop a medical record form that allows patients to start documentation at triage. "Previously, there was a great deal of wasted or duplicated documentation required by both physicians and nursing staff, often resulting in poor-quality reviews," she says.

The goal is to obtain necessary triage information which would, in turn, be available to the physician during his interview process, Donovan explains.

To avoid duplication, patients provide information for the social history and discharge documentation by completing the form in the triage area and examination room, says Parris-Atwell. "We went through the chart with a fine-tooth comb to eliminate any redundancy," she says.

The physician may need to clarify some of the information, but because the information is already on the front sheet, they should not have to go back and repeat the questions, says Parris-Atwell.

Patients appreciate not being asked the same questions over and over again, she says. "We get the information upfront and verify it once to make sure it's correct. The physician can simply review the information without asking the entire history again."

The form used at St. Vincent's allows the patient or family to give detailed history, including names of physicians, surgeons, cardiologists, medications, and previous surgeries, says **Ralph Badanowski**, MD, FACEP, the ED's medical director.

"It's similar to the form you fill out when you see your own personal caregiver," he says. "This avoids delay in notification of the right consultant."

Patients or family fill out the form in triage or in the treatment room if they arrive by ambulance, he says. "It is optional, but we get 75% compliance. They want you to know their medical history."

The value of the information can be indispensable, Badanowski says. "For example, consider the patient on insulin who does not consider this a medication and neglects to mention this, or the patients with allergies," he explains.

On discharge, medication mistakes can be avoided because allergies, pregnancy, or pre-existing conditions are clearly noted, he says. "The patient with multiple risk factors for heart trouble or stroke can be quickly identified at triage, so that time-sensitive treatments such as thrombolytics will not be delayed."

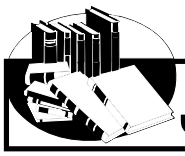
Occasionally, there is a problem with accuracy or legibility of the information patients provide, notes Parris-Atwell. "At times, the information is not correct, and there is sometimes a language barrier," she says. "Under 'today's problem,' they may write, 'I'm sick,' so we may need to get more information."

Concerns were raised regarding the numbers of patients who might need assistance in filling out the items due to illiteracy or language barriers, notes Donovan. "Registration clerks, who are often bilingual, and/or security officers stationed at the door and proximal to the triage area may direct or assist patients with this process as necessary," she says.

Patient information occasionally needs to be translated into medical terminology, says Parris-Atwell. "Sometimes, we have difficulty with how they describe something," she notes. "When the physician comes in, [patients] can repeat what they have written to clarify it. What we may call 'gastric,' they may call 'belly.'"

The patient medical profile form used by St. Vincent's Medical Center in Jacksonville, FL, includes a box asking whether the physician has reviewed the questionnaire, says Badanowski. "The physicians check the box or initial the form to document they read it."

If the information is inaccurate, the inaccuracy needs to be addressed in the documentation, he says. "The physician documents the past medical history, social history, and family history, so corrections are made there," he explains, adding that if the physician suspects a patient has filled out the form incorrectly, the physician asks the patient to confirm his or her answers. ■



JOURNAL REVIEWS

Feldhaus KM, Houry D, Kaminsky R. **Lifetime sexual assault prevalence rates and reporting practices in an emergency department population**. *Ann Emerg Med* 2000; 36:23-27.

The number of ED patients who have suffered sexual assaults at some point in their lives is high, but few victims report the assaults or receive medical care, according to this study from the Denver Health Medical Center and the University of Colorado Health Sciences Center, also in Denver. Verbal surveys were conducted with 360 female patients at an urban ED. Here are the key findings:

• The lifetime prevalence rate of sexual assault was 39%.

• Only 43% of patients who were sexually assaulted sought medical care after the incident.

• Of those who did seek medical care, an overwhelming majority — 78% — did so in an ED.

• Of the patients who sought ED care, 88% disclosed the sexual assault to the physician, but only 61% had medical evidence collected.

"Physicians should recognize the importance of the evidentiary examination, as this is often critical for the conviction of perpetrators, and they should encourage victims to request an evidentiary examination," recommend the researchers.

Survey results showed that victims of sexual assault who didn't report the crime to police or seek medical care often were embarrassed and feared public disclosure. Also, the survey indicated that women assaulted by a partner were less likely to seek medical care. ▼

Erickson L, Williams-Evans SA. **Attitudes of emergency nurses regarding patient assaults.** *J Emerg Nurs* 2000; 26:210-215.

There is still an alarming rate of patient assaults and underreporting of assaults on nursing staff in the ED, says this study. Here are the key findings:

• Of the nurses surveyed, 82% had been assaulted during their careers.

• Over half of nurses surveyed had been assaulted during the preceding year, and a third of those assaults were not reported.

• Of the 45 nurses who were victims of assault, only nine believed that reporting their assaults had been beneficial.

• Nurses who had previously taken an assault prevention class were less likely to be assaulted.

Two reasons nurses didn't report assaults were the time-consuming nature of reporting mechanisms and a belief that no benefit would be gained by reporting. The researchers recommend the following steps:

• restructuring incident reports;

• creating specific forms for nurses to report patient assaults;

• working cooperatively with nurses, administrators, law enforcement, and the legislature;

• incorporating risk assessment, assault prevention, and crisis intervention into basic nursing education programs.

Nurses need to become involved in their communities and in the political arena, argue the researchers. "Health care providers and their patients deserve protection from assaults and abuse," they say. "First and foremost, the myth that 'assaults are part of the job' needs to be rebuked before any real changes can occur." ▼

Mandelberg JH, Kuhn RE, Kohn MA. **Epidemiologic analysis of an urban, public emergency department's frequent users.** *Acad Emerg Med* 2000; 7:637-646.

Patients who use the ED frequently are usually indigent, homeless, alcohol abusers, or chronically ill, and there is a smaller subset of patients within that group who remain frequent ED users for several years, says this five-year study from the University of California-San Francisco School of Medicine, San Francisco General Hospital, and Johns Hopkins University School of Medicine in Baltimore.

The study's goal was to determine how frequent users of the ED differed from other patients. In this study, frequent users (patients who visited the ED five or more times during a one-year period) made up 3.9% of ED patients but accounted for 20.5% of ED visits.

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About a third of frequent users for one year remained frequent users the next year. However, only about half of those who remained frequent users the second year were still frequent users the third year. Because frequent users reflect urban social problems such as poverty and homelessness, a subset of patients will continue to account for a disproportionate share of ED visits, the researchers state. However, the primary goal of ED managers should be to better meet the needs of this group of patients, rather than discouraging frequent users, they warn. ■

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 *Frustrated by the nursing shortage? Try these tactics instead of sign-on bonuses*, on the cover, *Give nurses flexible schedules*, p. 111, and *Journal Reviews*, p. 118.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *Documentation guidelines updated by HCFA*, below.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.

Documentation guidelines updated by HCFA

New, simplified documentation guidelines are being pilot-tested by the Health Care Financing Administration (HCFA) in Baltimore.

"The basic approach is going back to the 1995 guidelines, making it simpler and specialty-based," says **Charlotte Yeh**, MD, FACEP, medical director of Medicare policy for the National Heritage Insurance Company in Hingham, MA. "There is more weighted emphasis on medical decision making."

The first set of documentation guidelines was issued in 1995 to clarify codes used under the Current Procedural Terminology coding system. Those guidelines were updated in 1997 in an effort to make them more specialty-based, but many physicians expressed concern that they were too cumbersome, according to Yeh.

The new guidelines aim to reduce the time physicians spend on administrative tasks, such as counting the elements of their services, she says. Instead, physicians will be provided with a series of scenarios for physical examinations and medical decision making to assign an appropriate service level, she explains.

"It's encouraging that HCFA is clearly trying to keep the dialogue going," she adds. "This shows that HCFA is committed to simpler guidelines which are specialty-based." According to HCFA, new guidelines could be in place as early as 2002.

It's significant that the documentation guidelines are specialty-based, Yeh emphasizes. "We are moving away from one-size-fits-all guidelines, toward guidelines that work for the unique characteristics of emergency medicine." ■

Source

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