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New regs up EMTALA ante: It's your job to help staff at 'remote sites' comply

Most emergency departments are not in compliance

If a security guard has a stroke in your hospital parking lot, would your ED staff know how to respond? If a woman goes into labor at a hospital clinic across the street from your ED, do you have a policy to address that scenario?

If your answer is "no," you are not in compliance with new requirements for the Emergency Medical Treatment and Active Labor Act (EMTALA), warns **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA. As of this month, EMTALA regulations have changed dramatically, she says.

The outpatient prospective payment system regulations issued by the Health Care Financing Administration (HCFA) have expanded EMTALA to include hospital outpatient facilities, which now are required to give anyone with a potential emergency condition a medical screening exam. Staff at these remote sites also must stabilize and, if necessary, transfer the patient. The new regulations are effective Jan. 10, 2001.

"It's now very clear that EMTALA is not just an ED law," Yeh emphasizes.

Executive Summary

As of Jan. 10, 2001, Emergency Medical Treatment and Active Labor Act regulations apply to hospital outpatient facilities.

- Staff at these locations must provide anyone with a potential emergency condition with a medical screening exam and stabilization, and, if necessary, must transfer the patient.
- The ED is responsible for helping remote site staff provide good patient care and comply with EMTALA.
- Remote sites cannot delay treatment for an EMTALA-related service by collecting copays.

The new requirements significantly "up the EMTALA ante," says **Larry B. Mellick**, MS, MD, FAAP, FACEP, chair and professor for the department of emergency medicine at the Medical College of Georgia in Augusta.

"This new regulation should finally push hospitals to get seriously organized to comply with EMTALA," he states. "The complexity of management and the opportunity for failure have now increased significantly."

However, most ED managers are not in compliance

with the new rules for remote sites, says **Stephen A. Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance. "Most do not realize their EMTALA exposures with this new set of regulations," he adds. **(See checklist, p. 4, and list of steps to take, p. 6.)**

Here are ways to comply with the new EMTALA regulations:

• **Make sure all ED staff understand that EMTALA cases at remote sites are their responsibility.**

Your ED probably will be responsible for direct field control of the people involved at the remote sites, according to Frew. "The ED should be making the transfer contacts if the patient has to go to another facility closer than the home facility," he says. **(See related story on the ED role in remote site cases, p. 3.)**

Staff need to realize that the patient being treated at the remote site is a crisis for the ED, says Frew. "The ED is responsible to enable the lesser trained personnel in the remote site to give good patient care, comply with the safety plan, and comply with EMTALA," he explains. **(See related story on the ED's role as an EMTALA consultant to remote sites, p. 5.)**

It's essential that all ED staff accept this responsibility, even though the patient didn't come to the ED for care, says Frew. "The biggest thing I fear is that ED staff will consider these calls to be someone else's problem and not handle them appropriately," he stresses.

Dialing 911 is not enough

You must remind remote site staff that 911 may not be used as a sole source of response, Yeh stresses. "If someone comes in to the lab or surgicenter complaining of chest pain, staff may not simply call 911 and consider their obligation complete," she says. "You may call 911 for support, but you must begin initial stabilization procedures until ambulance personnel arrive."

• **Consider how other hospitals are handling the new requirements.**

It's not enough for you to make sure that your hospital is complying with the new regulations, warns **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix. "If another hospital has a facility which falls under these regulations near your hospital, you will need to decide how you will deal with requested transfers from such facilities," he says. "You will also need to deal with requests to sign transfer agreements as required by the regulations."

Previously, urgent care centers basically were exempt from EMTALA, says Taylor. "In some cases, that will now change," he notes. "So hospitals will need to know when they have a duty to report suspected EMTALA violations for 'dumping' from these urgent care centers," he says.

If a patient is deteriorating rapidly, movement from the remote site back to the main campus is not appropriate, and if it is in the patient's best interest to be transferred, you must have prearranged transfer agreements with closer hospitals, says Yeh. The off-site location must provide appropriate transportation, equipment, and personnel to transfer the patient to the second, closer hospital, Yeh adds.

• **Address billing, signage, and record-keeping practices of remote sites.**

EMTALA regulations state that you may not delay treatment for preauthorization requests or to collect copayments, Yeh says.

"This is especially important for outpatient departments, surgicenters, and lab areas where typically you request copays prior to seeing the patient," she adds. "If it's an EMTALA-related service, the remote sites should not be doing copays prior to service."

Anyone who does intake registration and screening or who might receive questions about payment or copays needs to understand the implications of EMTALA, Yeh advises. "They need to ensure that no one is turned away because of the ability to pay," she says.

Under EMTALA, you need to keep records for five years and post nondiscrimination notices in the ED and admitting area, says Yeh. "Now, this applies to all sites. So outpatient sites must have the same record-keeping and nondiscrimination notices and the same on-call availability, as well," she notes.

Increased signage for staff at the off-campus departments is needed to remind them of their obligations,

recommends Mellick. "Additionally, mandatory educational schedules, job aids, and checklists are needed in an area that will be highly vulnerable to oversight," he stresses.

• Establish individualized protocols for dealing with emergencies at all off-site locations.

Your plan has to be commensurate with the location's ability to provide treatment, explains **Grena Porto**, ARM, CPHRM, director of clinical risk management for VHA, a Berwyn, PA-based alliance of more than 2,000 community-owned health care organizations.

"If the location has physicians and nurses, you'll be required to provide a higher level of screening than a facility that does not have that resource available," she says.

It's not expected that every single freestanding location will be able to provide the same level of care. You must have emergency response protocols individualized to each site's capabilities, says Yeh. "For example, if the site has a physician and nurse, then they are required to do stabilization. If there is no physician or nurse, then personnel must be trained to place a call to the ED describing the patient's condition and begin to initiate transfer requirements if necessary," she says.

• Make sure that patient consent for transfer is obtained.

Remote site staff will need to obtain consent from patients with an emergency medical condition for transfer to another facility, says Porto.

"This is not a time when you can rely on implied consent," she warns. "This is a challenge for outpatient settings where you often do not have written informed-consent forms."

When transferring a patient, written documentation is critical, Porto underscores. "If it's an outpatient setting and they do not have a physician there, then you need a policy stating who will initiate the transfer documentation," she explains. ■

Know ED's role in these 3 scenarios

You must determine the ED's role in three key scenarios to comply with new Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, says **Stephen A. Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance:

- code responses within the 250-yard zone;
- non-code responses within the 250-yard zone;
- telephone supervision or direct action to off-site locations when the ED is contacted by the remote site with an emergency.

In the case of code and non-code response in the 250-yard zone, your ED will be expected to assume significant response requirements, Frew warns.

"These will have to be carefully planned, including adequate personnel, alerting, field communications, and equipment for what is, in essence, an EMS-type field response," he explains.

Here are ways to ensure compliance:

• Determine who will provide the medical screening examination at each site.

Perhaps the most difficult issue for many hospitals will be determining when they need to have a 'qualified medical provider' capable of performing a medical screening examination, says **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix. "Administrators will have to go to the trouble of getting these personnel approved by the hospital governing board," he says.

• Determine whether the remote site must follow the "250-yard" rule or the outpatient department rule.

Any entity owned and operated by the hospital within 250 yards of the main hospital campus must comply with EMTALA, Yeh says. "That includes provider-based entities which are under the name and ownership of the hospital but provide different services," she says.

In that case, the rules require that the off-site policy be geared to the level of the personnel on-site and available to provide medical screening, stabilization, and make necessary transfer arrangements, Frew explains.

However, outpatient departments that provide similar services to the hospital must follow additional rules, Yeh notes. "They are now required to screen and stabilize patients within the capability of the total campus, not just the outpatient location," she explains.

The response mechanism has to be consistent, whatever level of care is provided, says Porto. "For example, you may make arrangements for patients to receive an MRI at your main location," she suggests.

In some cases, you might need to develop response teams for certain outpatient sites, Yeh suggests.

• Provide appropriate training for all staff.

Staff will have to be trained throughout the hospital to prepare for responding to an EMTALA case at

Compliance Checklist

Use this checklist developed by Stephen A. Frew, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA), to comply with new EMTALA regulations for hospital outpatient facilities:

☐ Determine 250-yard zone or marked campus, whichever is larger.
☐ Create site map.
☐ Visually mark the perimeter to help in planning.
☐ Evaluate private locations within that zone.
— Include streets, parking areas, and similar public areas.
— Include areas that the public would consider hospital services.
☐ Evaluate emergency notification options for all areas.

Evaluate physical obstacles:
☐ response time of EMS to scene;
☐ obstacles to movement of equipment;
☐ complications created by adverse weather situations;
☐ ask EMS to help in this assessment.

Determine who will be included in a "Zone" response:
☐ code;
☐ non-code;
☐ unknown situation.

Determine what equipment will be needed to respond:
☐ code;
☐ non-code;
☐ location of equipment for response;
☐ who is responsible for getting the equipment to the scene;
☐ what communication capability you will provide;
☐ ensure that all equipment is field-capable;
☐ consider EMS consulting assistance;
☐ order all necessary equipment STAT.

☐ Determine how to alert personnel and identify location.
☐ Create policies and procedures to support plan.
☐ Post plan outlines in all involved areas.
☐ Train all personnel in their respective roles.
☐ Field-test the plan several times before finalizing.
☐ Revise plan based on findings of tests.

a remote site, stresses Frew. He warns that ED managers must comply with the following inservice requirements:

— **Security.** Security and other people who are likely to be involved must have first responder, first aid, and cardiopulmonary resuscitation training, Frew advises.

— **Telephone operators or radio control personnel.** These individuals must be trained in their communications role in each of the above situations, says Frew. "For example, this may include alerting key individuals, coordination of EMS response, and scene-to-ED communications," he explains.

— **ED staff.** All staff members who are potentially responsible for zone response duty should be trained in first responder or EMT-level courses, Frew says.

Staff must be familiar with field conditions and active involvement with EMS at a scene, says Frew. "They have the medical skills but have to learn to apply them in a foreign environment," he explains.

• Give instructions to remote sites for all EMTALA cases.

For remote sites, the regulations specifically state that the home ED must be called for instructions, says Frew. "The ED physician should be giving instructions and assisting in obtaining necessary transfers. The ED is experienced in these issues, while remote sites are not," he adds.

For instance, this would be crucial for an outpatient laboratory that is manned by technicians only, says Frew. "The personnel at this site would be absolutely in over their heads if a person walked in off the street with a major emergency, like a gunshot wound, heart attack, or sudden labor," he explains.

The rule requires that the off-site location have policies and procedures in place to deal with this, Frew advises. "These might include immediate life-saving aid, call 911, and call the home ED for instructions," he says.

The role of the home ED should be first to walk the remote site staff through whatever care they can and should provide, Frew says.

"If the patient will need to go to a nearer hospital, the people at this lab are not going to be familiar with numbers to call or procedures to follow to get acceptance for transfers, let alone properly complete transfer forms," he warns.

With the goal of complying with EMTALA, Frew recommends the home ED remain on the line to coach and reassure the laboratory personnel.

"Meanwhile, the ED physician makes the call to the other ED, gets acceptance, and faxes over a transfer form," he explains. ■

Be an 'internal consultant' for your facility

As an ED manager, your input will be an absolute necessity for your hospital to comply with new Emergency Medical Treatment and Active Labor Act (EMTALA) regulations for outpatient facilities, argues **Larry B. Mellick**, MS, MD, FAAP, FACEP, chair and professor for the department of emergency medicine at the Medical College of Georgia in Augusta.

"ED staff have a better understanding of EMTALA than others, so it will be natural for the hospital to turn to them for guidance in the organizational and educational process," he says.

Consider this an opportunity to serve as an "internal consultant" for your hospital, suggests Mellick. "In order to be prepared, it might be wise to spend some time thinking through what your recommendations will be if consulted," he recommends.

Clearly, contact with ED staff from the remote sites is mandated, warns **Stephen A. Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance.

"Getting involved is not only required," he says. "It is also a matter of self-preservation to participate in the development of a system that will have the least negative impact on ED operations possible."

Here are effective ways to provide input on the new regulations:

• Prepare a draft plan, and present it to administration.

Instead of waiting for others to develop a plan for compliance, be proactive and do this yourself, Frew advises. "Say, 'Since this has to be in place by Jan. 10, we thought you would like our preliminary thinking on how to approach the issue,'" he says. **(See checklist, p. 4.)**

Your plan will be implemented as submitted or will open up a dialogue about possible changes, says Frew. "That shifts the burden to others to argue why there should be a change, rather than the ED arguing to get its issues addressed," he explains.

• Work with risk managers.

You should work with risk managers to identify new areas of exposure and develop EMTALA compliance programs for remote sites, says **Grena Porto**, ARM, CPHRM, director of clinical risk management for VHA, a Berwyn, PA-based alliance of more than 2,000 community-owned health care organizations. "Collaboration is the key to avoid duplication of effort," she stresses.

Your hospital's risk manager is probably acting as the point person on this issue, says Porto. "As such, the ED manager should contact the risk manager and ask what has been done and what they need to do to help move things along," she recommends.

• Develop policies with input from all departments that are affected by the new regulations.

The affected departments not only include the ED, but all outpatient departments and possibly the physician practices owned by the organization, says Porto.

The key is that you are part of the team working to find solutions, Porto stresses. "ED managers and other team members will run into problems if they charge headlong into this," she says. "There needs to be careful attention to the fact that this issue has far-reaching implications. All stakeholders are critical to the process."

Find out what you can do to contribute, Porto says. "The answer to that is going to depend on the type of organization, what has been done so far, who else is involved, and who is coordinating the effort," she explains.

Porto recommends reviewing existing policies. "It's not a good idea to go out and start educating remote-site staff without first looking at what is already being done," she says.

• Determine the need for emergency response capabilities at outpatient locations.

First, identify the sites, then determine what level of response they could reasonably provide, Porto advises.

Add ACLS training

As with staff involved in monitoring conscious sedation, you'll need to establish protocols and basic levels of training, such as advanced cardiac life support (ACLS), for responsible personnel, says Mellick.

• Help sites to develop a response system.

The new regulations state that the organization must respond within the capabilities of the entire organization, not just the remote site, Porto says. "The ED plays a critical role in helping remote sites to coordinate emergency response."

A carefully worded policy is the first key to demonstrating compliance with EMTALA, says Porto. "The burden of proof will lie with the provider when investigators come around, so you need an action plan to show beyond a shadow of doubt that you are complying with EMTALA," she says.

• Offer to help educate outpatient staff.

Hospitals should create a low-level administrative structure for overseeing education and training on EMTALA issues, similar to the system to ensure compliance with Joint Commission on Accreditation of

13 steps to compliance with new regulations

Here's a "to do" list for compliance with the new Emergency Medical Treatment and Active Labor Act (EMTALA) regulations for hospital outpatient facilities, compiled by **Larry B. Mellick**, MS, MD, FAAP, FACEP, chair and professor for the department of emergency medicine at the Medical College of Georgia in Augusta:

1. Identify hospital off-campus service sites that will fall under the new legal requirements.
2. Send notifications and specifics of the new requirements to any facility or organization that is located off the main hospital campus and has been determined under this statute to be a department of the hospital.
3. Since most administrators in these locations will not completely understand EMTALA, provide a brief but complete synopsis of the law.
4. Set up a "legal hotline" within your institution to answer general questions concerning EMTALA or the new requirements.
5. Create a hospital task force to review areas of risk within the institution and to develop general guidelines for protocol development.
6. Consider establishing an EMTALA "czar" to oversee these activities within the institution and assist with enforcement if necessary.
7. Develop information resources within the institution of staff knowledgeable in EMTALA who might act as "internal consultants." Consider enlisting the risk management department to provide this service.
8. Ask legal services to develop a "boiler plate" transfer agreement for those patients needing to be transported to another hospital because of the gravity of their condition.
9. Identify individuals at each of these off-campus locations to take overall leadership and responsibility for EMTALA education, training, and oversight.
10. Allow each site to develop its own drafts of protocols and transfer agreements within a clearly defined deadline.
11. A task force should be created at each off-campus location to format these EMTALA policies and protocols. These drafted protocols should be presented and reviewed by the hospital EMTALA task force to ensure compliance and completeness.
12. Develop plans for annual review of compliance and to establish mandatory annual reviews of protocols and policies and staff education.
13. Plan for appropriate EMTALA signage for patients and staff at each of these locations. ■

Healthcare Organizations requirements, recommends Mellick. "Remember: 'We didn't know' won't carry any weight at the time of an investigation of an alleged EMTALA violation," he says.

Make yourself available for questions concerning EMTALA in general, urges Mellick. "Be available for immediate advice when patients present to the outpatient setting and stimulate specific questions," he says.

Mellick also recommends offering to give an in-service on the basics of EMTALA policies. "However, legal points can sometimes be vague or unclear. So always be sure that your information is accurate and consistent with hospital resources by reviewing it with your legal services," he cautions.

Formerly, only ED staff needed to know about EMTALA, but the bar has gone up, says Porto. "Now, virtually every staff member in the facility needs to know what is required," she underscores. "That includes parking lot attendant and the individual who greets patients at the door. Even the security guard might be patrolling the premises and come across somebody who has an emergency medical condition." ■

Sources

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New needlestick law means take steps now

(Editor's note: This is the second of a two-part series on needlesticks and the emergency department. This month, we cover prevention of needlestick injuries and reporting requirements.)

As an ED manager, you have more incentive than ever to prevent and track needlestick injuries.

"Eliminating needlesticks can save hospitals thousands of dollars for treatment and make employees much safer and happier, as well," says **Barbara Pierce**, RN, MN, director of emergency services for Huntsville (AL) Hospital System.

A 1999 compliance directive from the Washington, DC-based Occupational Safety and Health Administration includes a requirement for you to involve employees in the selection and evaluation of safer needle devices. **(See safer needle devices vendor listing, p. 8.)**

Months later, the Needlestick Safety and Prevention Act was passed. The new federal law requires you to track needlestick injuries with a sharps injury log recording the following information:

- the type and brand of device involved in the incident;
- the department or work area where the exposure incident occurred;
- an explanation of how the incident occurred;
- the information must be recorded and maintained in a way that protects the confidentiality of the injured employee. **(See sharps injury log, inserted in this issue.)**

Executive Summary

To comply with requirements from the Occupational Safety and Health Administration and a new federal law, you'll need to take steps to prevent and track needlestick injuries:

- The Needlestick Safety and Prevention Act requires you to keep a sharps injury log listing where and how the injury occurred, and the type and brand of device used.
- Review data to spot trends in needlestick injuries caused by equipment design flaws and behavior patterns.
- ED staff must be trained annually in needlestick injury prevention, including proper disposal of sharps, universal precautions, and what to do if a needlestick occurs.
- To enforce universal precautions, give staff verbal and written warnings and role-model appropriate behavior.

You have to make needlestick prevention a priority, urges Pierce. "It is our safety initiative for this year," she reports. "We monitored areas with the highest rates and intervene, conducted a housewide survey, and formed task forces." **(See sample sharps action plan, p. 9.)**

Here are ways to comply with prevention and reporting requirements:

• Have an internal reporting mechanism.

This reporting mechanism should provide for confidentiality, swiftness in reporting, the ability to alert all appropriate personnel (infection control, risk management, employee health), and a way to follow up, says **Darlene Matsuoka**, RN, BSN, CEN, CCRN, ED clinical nurse educator at Harborview Medical Center in Seattle.

"The physical needs of the injured employee take precedence," she stresses. "There should be a system set up for employees to be screened and treated in an expeditious manner."

At Harborview's ED, an incident report is filled out in triplicate and submitted to the nurse manager. "She ensures proper treatment was done and routes it to the appropriate departments for follow-up," says Matsuoka. If the injury occurred during the day, the employee reports to employee health. If it occurs after hours, the employee goes to the ED.

In either location, the puncture is treated, the employee's blood drawn, and prophylaxis is started as necessary, Matsuoka explains. "Prophylaxis is started only within a small time window and if the source patient was high-risk," she says. "The source patient is also tested as able."

The incident report then goes into a computer database, so trends can be monitored and individual data pulled up as needed, says Matsuoka.

A central person needs to review all the data on sticks to identify trends, says Pierce. "You need to find repeat injuries due to equipment design flaws and behavior patterns," she says.

• Do a walk-through of the ED.

As you examine storage areas in your ED, ask the following questions, says Pierce:

— Is equipment convenient for the staff to get? For example, are needle boxes at the right height and in the right places?

— Is there an adequate supply for the patient volume?

— Are there any obstacles to access?

Identify and eliminate any barriers to staff use, Pierce says. "Ask staff where they feel equipment should be," she suggests.

• Ask staff to test equipment.

Have staff try out equipment and provide input,

(Continued on page 10)

Safer Needle Devices Vendor Listing

Here is a partial listing of vendors that offer safer needle devices:

- Adapt-Med International, 694 Pleasant Valley Road, Suite 4, Diamond Springs, CA 95619. Telephone: (800) 222-8445. Fax: (530) 621-1310. Web: www.adaptmed.com.
- Auto Suture Co., U.S. Surgical Corp., 150 Glover Ave., Norwalk, CT 06856. Telephone: (800) 722-8772. Fax: (800) 544-8772. Web: www.ussurg.com.
- Baxter Healthcare Corp., Route 120 and Wilson Road, Round Lake, IL 60073. Telephone: (800) 422-9837. Fax: (888) 229 0020. Web: www. baxter.com.
- B. Braun Medical, 825 12th Ave., Bethlehem, PA 18018. Telephone: (800) 227-2862. Fax: (610) 997-5515. Web: www.bbraunusa.com.
- Becton Dickinson, One Becton Drive, Franklin Lakes, NJ 07417. Telephone: (888) 237-2762. Fax: (800) 847-2220. Web: www.bd.com.
- Bemis Manufacturing Co., 300 Mill St., PO Box 901, Sheboygan Falls, WI 53085-0901. Telephone: (800) 558-7651. Fax: (920) 467-8573. Web: www.bemismfg.com.
- Bioject Medical Technologies, 7620 SW Bridgeport Road, Portland, OR 97224. Telephone: (800) 683-7221 ext. 436. Fax: (503) 624-9002. Web: www.bioject.com.
- Biomedical Disposal, 3690 Holcomb Bridge Road, Norcross, GA 30092. Telephone: (770) 300-9595. Fax: (770) 300-9599. Web: www.biodisposal.com.
- Bio-Plexus, 129 Reservoir Road, Vernon, CT 06066. Telephone: (800) 223-0010. Fax: (860) 870-6118. Web: www.bio-plexus.com.
- Care Medical. Distributed by Empire Medical Products, 43 S. Allen St., No. 1, Albany, NY 12208. Telephone: (800) 836-8492.
- Edge Medical, 1107 Fair Oaks Ave., Suite 106, South Pasadena, CA 91030. Telephone: (310) 275-7654.
- Ethicon. Telephone: (800) 873-3636. Web: www.ethicon.com.
- Frontline Medical Products, 2737 Palma Drive, Ventura, CA 93003. Telephone: (805) 658-1601. Fax: (805) 658-7625.
- Greiner Vacuette North America, 4238 Capital Drive, Monroe, NC 28112. Telephone: (888) 286-3883. Fax: (800) 726-0052. Web: www.vacuette.com.
- ICU Medical, 951 Calle Ananencer, San Clemente, CA 92673. Telephone: (800) 824-7890. Fax: (949) 366-8368.
- Innovative Laboratory Acrylics, P.O. Box 956, Brighton, MI 48116. Telephone: (800) 777-5511. Fax: (810) 229-2365.
- JMS North America, 22320 Foothill Blvd., Suite 350, Hayward, CA 94541. Telephone: (510) 888-9090. Fax: (510) 888-9099. Web: www.jmsna.net.
- Kendall Healthcare Products Co., 15 Hampshire St., Mansfield, MA 02048. Telephone: (800) 325-7472. Fax: (800) 637-9775. Web: www.kendallhq.com.
- Maxxim Medical, 10300 49th St. N., Clearwater, FL 33762. Telephone: (800) 346-8849. Fax: (727) 561-2180. Web: www.maxximmedical.com.
- MedCare Medical Group, 234 Old Homestead Highway, East Swanzey, NH 03446. Telephone: (800) 243-2442. Web: www.medcaremed.com.
- MEDgenesis, 10900 Red Circle Drive, Minnetonka, MN 55343. Telephone: (800) 888-5957. Fax: (800) 307-3334. Web: www.medgenesisinc.com.
- Medisystems Corp., 701 Pike St., Suite 1600, Seattle, WA 98101. Telephone: (800) 369-6334. Fax: (888) 373-4366.
- New Medical Technology, 1500 W. Oak St., Suite 200, Zionsville, IN 46077. Telephone: (800) 522-1512. Fax: (317) 733-9563. E-mail: sales@newmedicaltechnology.com. Web: www.newmedicaltechnology.com.
- North American Medical Products, 3 Walker Way, Albany, NY 12205. Telephone: (800) 488-6267. Fax: (518) 218-0405. Web: www.nampinc.com.
- Owen Mumford, 849 Pickens Industrial Drive, Suite 14, Marietta, GA 30062. Telephone: (800) 421-6936. Fax: (770) 426-5365. Web: www.owenmumford.com.
- Post Medical, P.O. Box 29863, Atlanta, GA 30359. Telephone: (800) 876-8678. Fax: (770) 928-4949. Web: www.postmedical.com.
- Retractable Technologies, 622 S. Mill St., Lewisville, TX 75057. Telephone: (888) 703-1010. Fax: (972) 221-9786. Rtisales@iglobal.net. Web: www.vanishpoint.com.
- Roche Diagnostics, 9115 Hague Road, Indianapolis, IN 46250. Telephone: (800) 428-5074.
- Safety 1st Medical, 1740 E. Garry Ave., Suite 108, Santa Ana, CA 92705. Telephone: (800) 997-2331. Fax: (949) 476-5559. Web: www. safety1stmedical.com.
- Safety Syringes, 1925 Palomar Oaks Way, Suite 204, Carlsbad, CA 92008. Telephone: (877) 477-0776. Fax: (760) 918-0565. Web: www.ssafetysyringes.com.
- SIMS Portex, 10 Bowman Drive, P.O. Box 0724, Keene, NH 03431. Telephone: (800) 258-5361. Fax: (603) 352-3703. Web: www.simsportex.com.
- Tri-State Hospital Supply Corp., 301 Catrell Drive, Howell, MI 48843. Telephone: (800) 248-4058. Fax: (517) 546-9388.
- Univec, 22 Dubon Court, Farmingdale, NY 11735. Telephone: (631) 777-2000. Fax: (631) 777-2786. E-mail: univec@univec.com. Web: www.univec.com.
- Venetec International, 12555 High Bluff Drive, Suite 170, San Diego, CA 92130. Telephone: (800) 833-3895. Fax: (858) 350-7899. Web: www.statlock.com.

Sharps Safety Action Plan

GOALS & STRATEGIES	LEAD RESPONSIBILITIES	PARTNERS
Collect and analyze data on needlestick injuries ❑ Define exposures ❑ Select data collection tools ❑ Develop method of trending and analyzing data including device specific sharps injuries ❑ Identify high risk/high incidence needlestick sources ❑ Evaluate and recommend a (computerized) database system for needlestick injuries	**Employee health** ❑ Coordinate data collection system ❑ Review literature and data to determine major needlestick risk sources ❑ Prepare ongoing reports for trending and analysis	**Infection control, emergency department, workers' compensation** ❑ Provide input ❑ Collect needlestick data **Information services** ❑ Assist with evaluation of current software ❑ Recommend system-wide software based on results of evaluation
Update employee health post exposure prophylaxis procedures ❑ All exposed employees receive appropriate treatment as established by recognized authorities	**Employee health** ❑ Research and provide standard of practice information ❑ Develop standards for care ❑ Develop information, checklist and form packet for use with all BBP exposures ❑ Provide education and support as necessary	**Infection control, emergency department, occupational health, nursing supervisor** ❑ Form work group to review existing protocols and revise and/or develop standardized protocols ❑ Implement protocols
Develop system-wide safer work practice standards for sharps ❑ Identify safer work practices ❑ Incorporate safety practices into performance evaluations and discipline as appropriate on case-by-case basis	**Employee health, safety director, infection control** ❑ Identify safer work practices and performance expectations **Human resources** ❑ Develop guidelines for safety performance standards enforcement **Physician champion/risk services** ❑ Develop guidelines and performance standards for physicians	**Frontline health care workers** ❑ Participate in the identification of safer work practices ❑ Participate in the development of safety performance standards **Medical executive committees** ❑ Provide input, incorporate into policy, and enforce through Peer Review
Develop Cal/OSHA and needlestick safety education ❑ Provide employees and physicians with information on standard precautions, needle safety and new devices	**Employee health, infection control, staff development** ❑ Evaluate existing training tools, best practices ❑ Create education tools for employees	**Department managers, frontline health care workers** ❑ Provide input on needs, best practices
Implement appropriate devices to reduce needlesticks ❑ Evaluate available products for effectiveness and safety ❑ Select products that best meet established criteria ❑ Trial products ❑ Implement product	**Materials management** ❑ Negotiate vendor contracts based on task force product/vendor recommendations ❑ Coordinate product and vendor selection process **Employee health, infection control, nursing director** ❑ Develop criteria for product evaluation ❑ Assist/coordinate education and evaluation process	**Product evaluation task force, frontline health care workers** ❑ Make recommendations on products and vendors ❑ Provide information and assist with product research **Finance** ❑ Provide input to selection and evaluation process ❑ Determine funding mechanism and resource allocation **Department managers** ❑ Complete implementation of selected devices

Source: This chart has been excerpted from *The California Guide to Preventing Sharps Injuries* and is reprinted with permission of the California Healthcare Association. The cost is $35 for the manual or $55 for a manual with a Microsoft Word disk, plus $5 per item for shipping. To order the manual, contact: California Healthcare Association, Publishing Sales Center, 1101 North Market Blvd., No. 9, Sacramento, CA 95834. Telephone: (800) 494-2001 or (916) 552-7522. Fax: (916) 928-1643. E-mail: srussi@calhealth.org. To obtain copies of the order form, go to the Web: www.calhealth.org. Click on “resources” and then “publications.”

(Continued from page 7)

Pierce advises. "We have replaced gloves that the staff did not like and that didn't hold up to the wear and tear of the ED environment," she says. "We also recently changed out all of the needle boxes related to a poor design which led to injuries of the staff."

Equipment is changing rapidly, so ensure that you are using the best possible devices to protect the staff, says Pierce. "A common complaint about wearing goggles is blurred or distorted vision. So to avoid splash exposure, we are looking at ordering prescription goggles for staff," she reports.

• Make sure staff comply with universal precautions.

Wearing universal precautions must be a performance expectation, urges Pierce. "Don't allow the staff any room for choice," she says.

Enforcement is a challenge, Pierce acknowledges. "First, you have to clearly define the expectations and what to wear for what procedure. For example, this may include gloves, gown, or mask," she says.

If staff don't comply, follow the hospital disciplinary policy as needed, including verbal and written warnings, Pierce advises. "The public expects that staff will wear gloves and use proper gear," she says. "Many have complained when staff fail to dress out appropriately. Respond to these complaints."

Reward "good behavior" when possible, Pierce recommends. "Remind staff to dress out when they are not, hand them gloves or goggles as needed, and give positive feedback," she says. "Staff respond better to positive action, but when nothing else works, then discipline is the answer."

Pierce recommends using leadership to role-model appropriate behavior. "We tried a campaign with catchy pictures of ED doctors and key people wearing gloves," she says. "It had some success and brought some attention to the problem."

• Educate staff.

Any staff involved in patient care needs to be trained and re-trained annually in needlestick injury prevention, says Pierce. She recommends that the following topics be covered:

— epidemiology, including needlestick statistics, the costs to the hospital for exposures, and the risks (hepatitis C, HIV, etc.);

— how to protect yourself;

— proper disposal of sharps;

— the gear to wear and when to wear it;

— what to do if you are stuck.

Staff should be counseled after needlestick injuries, recommends Pierce. "This is for education and not discipline. They need to understand what happened and how to change their behaviors — for example, recapping — so that it won't happen again," she says. "They can be sent for repeat training as needed."

Staff behavior can be changed only if they understand the impact if they fail to change, Pierce says. "Awareness is key," she adds. "You cannot totally eliminate needlesticks, but they can be minimized with behavior changes, equipment changes, and education." ■

Sources

For more information about preventing and reporting needlestick injuries, contact:

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- **Barbara Pierce**, RN, MN, Emergency Services, Huntsville Hospital System, 101 Sivley Road, Huntsville, AL 35801. Telephone: (256) 517-8202. Fax: (256) 517-2982. E-mail: barbarapi@ECS.hhsys.org.

How to cope with the media after a mistake

If something goes wrong when taking care of a patient in your ED, you may have a public relations nightmare to deal with besides a bad outcome and medical or legal issues, warns **Norman J. Schneiderman**, MD, FACEP, chief of staff at the emergency and trauma center at Miami Valley Hospital in Dayton, OH.

Here are ways to manage the media after a misdiagnosis occurs:

• Respect the patient's right to privacy.

Information about a patient's condition or treatment should not be released to the press without getting permission from the patient, says **Gregory L.**

Executive Summary

When a bad outcome occurs in your ED due to a mistake made by staff, be proactive in addressing media inquiries.

- Don't answer questions about a patient's condition or treatment without permission.
- State your point clearly regardless of what reporters are asking.
- Contact patients after a misdiagnosis occurs.

Henry, MD, FACEP, vice president of risk management for Emergency Physicians Medical Group in Ann Arbor, MI.

Avoid answering probing questions by raising the issue of privacy, says **Stephen Colucciello**, MD, FACEP, assistant chair and director of clinical services for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. "Make the privacy comment right off the bat," he suggests.

Explain that the medical care of every individual is a private matter and not for public discourse, says Colucciello. "If somebody is going to talk to the press about a medical error, then it can be the patient," he says.

• **Have a planned response when talking to a reporter.**

Make your point first regardless of what question they ask, Henry advises. "You are going to be portrayed in a sound bite for 11 or 12 seconds, so never put out anything that is juicy and bad upfront," he says.

Never repeat a negative, says Henry. "For instance, don't repeat the term 'misdiagnosed,' he cautions. "It doesn't matter what you say or do at that point. All they have heard is that one word."

In general, avoid discussions with reporters about medical errors, says Colucciello. "Don't admit guilt to the press," he advises. "Tell them, 'we're looking into it, we want all the facts, our goal is to give the highest possible care to all patients. Explain that there are privacy issues."

• **Use one spokesperson.**

Only one person should deal with reporters about a specific incident, Henry recommends. "The media should always be referred to the person who is going to handle it," he says. "That could be a physician or the chief of the department. It must be a person who understands the bigger picture, not a nurse or a tech."

Tell reporters, "All statements about care of Mr. XX will be handled by this doctor or administrator," Henry advises. "When President Reagan was shot, only one doctor spoke to reporters, except at a press conference, when the same doctor mediated and directed questions to the surgeon," he notes.

Sources

For more information about public relations, contact:

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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 How to cope with media after a mistake, p. 10, in this issue.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See New regs up the EMTALA ante: It's your job to help "remote sites" comply, p. 1; Update on new needlestick regs for tracking injuries, p. 7; and Know ED's role in these 3 scenarios, p. 3.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

A clinical spokesperson should be "out front" for the hospital, says **Steven J. Davidson**, MD, MBA, chair of the department of emergency medicine at Maimonides Medical Center in Brooklyn, NY. "A PR spokesperson can provide background and respond to questions, but statements and press conferences must be conducted by a lead hospital clinician, such as the ED director," he explains.

• **Consider calling a press conference.**

If reporters latch onto a high-profile case and misinterpret the care you provided, a press conference might be helpful, says Schneiderman. "If you feel the case was diagnosed properly, that excellent care was given, and there was no untoward effect, you may want to call a press conference to straighten that out," he suggests.

For example, in the case of the former President Ford, who was diagnosed with a sinus infection but returned hours later with stroke symptoms, a hospital spokesperson could explain that you often can't make a diagnosis based on early signs of stroke and point out that the former president is doing very well, Schneiderman says. **(For additional information on the case involving former President Ford and treatment of VIPs, see *ED Management*, November 2000, p. 121, and August 2000, p. 90.)**

• **Be proactive with PR.**

If you become aware that a patient is later given a different diagnosis, be aggressive in reacting, says Schneiderman. There are ways to do this without admitting you made a mistake, he suggests.

"You can say, 'I heard that the day after we treated you, you went to another ED and they diagnosed you with a stroke. I was surprised and concerned, because I thought we had done a thorough evaluation,'" he suggests.

At that point, you can gauge the patient's response, says Schneiderman. "The response may be 'I plan to talk to my attorney.' You can respond by saying, 'That is your option, but I wanted to see how you were feeling,'" he advises.

Being proactive may prevent more media involvement, says Schneiderman. "You may prevent an incident from being blown out of proportion," he notes. ■

Sharps Injury Log

SHARPS INJURY LOG

Date & time of injury	Job classification/ Department	Location of incident	Body part injured	Device brand & type; *protective mechanism?*	How injury occurred[1]	Employee's opinion[2]

[1] Include: a) procedure being used b) body part involved in exposure, and c) whether injury occurred before, during or after activation of mechanism.

[2] If sharp had no protection, include: a) employee's opinion as to whether protection would have prevented injury, and b) whether any other engineering, administrative, or work practice control could have prevented the injury.

NOTE: *This sample log was developed by Peggy Raumann, RN, Infection Control Practitioner, and Martha Magdaleno-Hernandez, LVN, from the San Gabriel Valley Medical Center. Reprinted with permission.*

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