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Inside

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Warning: Emergency department nurses are at higher risk for violence

Many don't report attacks, but there are many reasons why you should

If a confused Alzheimer's patient shoved you during a procedure, would you report the incident? What if an irate, intoxicated patient threatened you with a knife? Research suggests many ED nurses consider such assaults to be just "part of the job," reports **Lisa Erickson**, MSN, CEN, CCRN, FNP, assistant professor of nursing at Southwest Tennessee Community College in Memphis.

A recent study showed patients had assaulted 56% of ED nurses surveyed during the previous year, yet 29% of those were unreported.[1] "This is not counting the ones that the nurses had 'forgotten about,'" says Erickson, the study's principal investigator.

As an ED nurse, your risk for patient assaults is six times higher than other health care and social service workers.[2] Studies have shown that assaults occur in all areas within the nursing community, including general floors and home health, Erickson acknowledges.[3,4]

"However, due to the nature of patients seen in EDs, which includes injuries related to drugs, alcohol, and violence, plus the emotional stress of a sudden accident or illness on the patient and their families, ED nurses are at a higher risk than most nurses," Erickson explains.

Most EDs are easily accessible to the public at all hours of the day, Erickson

EXECUTIVE SUMMARY

ED nurses are at higher risk for patient assault than other nursing specialties, but many of these assaults go unreported.

- The risk to ED personnel is six times higher than other health care and social service workers.
- You need to report assaults so resources can be allocated to address the problem.
- After a nurse is assaulted, the entire ED staff should be debriefed and the nurse should be given counseling.

adds. "This makes the staff easier targets than if an assailant had to take an elevator up five floors."

Another factor contributing to more assaults by patients in EDs is waiting times, Erickson asserts. "Patients who are sick and/or injured come to EDs expecting to be seen immediately. They become easily agitated by long waits."

The body of research showing risk to ED personnel is growing rapidly, reports **Betty Wendt Mayer**, RN, MSN, ARNP, an ED nurse practitioner at Florida Emergency Physicians in Maitland. "More research is available on violence against psychiatric workers, but we are quickly catching up," she notes. **(See resource box of literature on violence against emergency department staff, p. 61.)**

Mayer notes one important difference between the two nursing specialties: "The difference is that even though bad things happen in the psychiatric areas, the nurses there have extended training in management of violent patients." **(See resource box for list of courses to take, p. 59.)**

Nurses don't report assaults

Here are some of the reasons that ED nurses do not report assaults, according to Erickson and Mayer's research:

• **ED nurses take assaults for granted.**

According to Erickson's study, the biggest factor in nonreporting was habituation. "Nurses were so used to 'minor' assaults that they actually forgot about them by the time the shift was over," she says.

• **There is a perception that reporting might be "whining" or troublemaking.**

Nurses want to be seen as patient advocates, says Mayer. "This is particularly true if the patient has some physiological reason for bizarre behavior, such as retardation, hypoxia, or Alzheimer's, as opposed to illegal drug abuse," she says. "Until it is acknowledged that *no* violence is acceptable, this will remain a problem."

• **There is a lack of time to fill out incident reports.**

With overwhelming patient loads and the amount of paperwork necessary for routine patient care, reports generally are not filed unless a nurse is seriously injured, says Erickson.

"In addition, if a report is filed, many hospitals require extensive follow-up with employee health during the employee's own time," she adds.

• **There is a lack of support for nurses who are assaulted.**

This blasé attitude may come from peers, supervisors, administration, the police, and the judicial system, Erickson stresses. "Nurse assaults are not a high priority," she says.

Assaults must be tracked

You must report all patient assaults, urges Erickson. Here are the reasons:

• **Occupational Safety and Health Administration (OSHA) requirements.**

According to OSHA regulations, you're required to enter the following injuries on the OSHA Log of Injury and Illness:

— an injury that requires more than first aid;
— a lost-time injury;
— an injury that requires modified duty;
— an injury that causes loss of consciousness.

You also must enter on the log any injury caused by an assault that is otherwise recordable. The regulations

Take these 6 steps after an assault

Here are six steps to take immediately after you are assaulted, recommended by **Lisa Erickson**, MSN, CEN, CCRN, FNP, assistant professor of nursing at Southwest Tennessee Community College in Memphis:

1. Get to safety, sit down, and take some deep breaths. Get medical attention, if needed.
2. Immediately notify your supervisor and file an incident report.
3. Notify your supervisor that you would like to call police, if appropriate.
4. Follow through on any legal action taken.
5. Ask for staff to be debriefed about the incident.
6. Obtain personal counseling as necessary. ■

COMING IN FUTURE MONTHS

■ New approaches for acute coronary syndrome

■ How to update your decontamination plan

■ New recommendations for bag-mask ventilation

■ Effective ways to screen for elder abuse

require a fatality or catastrophe resulting in the hospitalization of three or more employees must be reported to OSHA within eight hours, including those related to workplace violence. **(See excerpt of *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* enclosed in this issue.)**

• **Ability to track assault patterns.**

You need to apply the same stringent standards to documenting assaults as you would to complying with risk management requirements, says Erickson. "Nursing 101 is 'if it wasn't charted, it wasn't done,'" she notes.

Erickson is working to develop legislation to make the assault of a health care provider a felony in her home state of Tennessee. "However, I have little data to show that it is a problem," she notes. "Why should administration or legislators care about something that supposedly happens so infrequently?"

• **Validation.**

Documenting occurrences is the first step to correcting the problem, says Erickson. "It makes the statement that we are not going to tolerate it any more."

• **Allocation of hospital resources.**

File reports so that administrators can understand the true severity of the problem, Mayer advises.

"Your word is never enough. It must be documented," she adds. "Hospitals are not willing to spend money on protective devices and security if there is no record of such incidents occurring."

There are measures that hospitals can take to decrease patient assaults; however, they all cost money, says Erickson. "As nurses increase reporting of their assaults, hospitals can track turnover rates and missed work days related to assaults."

SOURCES AND RESOURCES

For more information about reporting patient assaults, contact:

- **Lisa Erickson**, MSN, CEN, CCRN, FNP, 1720 Bucksnort Road, Covington, TN 38019. Telephone: (901) 475-6483. Fax: (901) 476-8294. E-mail: doggies7@earthlink.net.
- **Betty Wendt Mayer**, MSN, CEN, ARNP-CS, 1084 Torchwood Drive, Deland, FL 32724. Telephone: (904) 738-3336. Fax: (904) 738-5733. E-mail: bmayer@com1.med.usf.edu.

Below is a partial listing of resources pertaining to management of violent patients:

- **Crisis Prevention Institute** (CPI) offers three levels of intervention training. For more information, contact CPI, 3315-K N. 124th St., Brookfield, WI 53005. Telephone: (800) 558-8976 or (262) 783-5787. Fax: (262) 783-5906. E-mail: info@crisisprevention.com. Web: www.crisisprevention.com.
- **REB Training International** offers Management of Aggressive Behavior (MOAB) courses, which provide skills training for management of violent behavior. For more information, contact REB Training International, P.O. Box 845, Stoddard, NH 03464. Telephone: (603) 446-9393. Fax: (603) 446-9394. E-mail: rebtrng@monad.net. Web: www.rebtraining.com.

What to do after an assault

Take the following steps to encourage nurses to report assaults:

• **Debrief the staff after an assault occurs.**

Erickson recommends a debriefing of the entire staff as soon after the event as possible. "Unit debriefings reinforce the notion of 'This could happen to any nurse; it was not the nurse's fault that an assault occurred,'" she says.

Debriefing also provides peer support and validation of the assault, says Erickson. "Group meetings also make it possible for brainstorming of solutions to the department's assault problems," she notes.

• **Pay for counseling for nurses who are assaulted.**

Depending on the nature of assault and/or injuries, personal counseling should be offered and paid for by the institution, says Erickson. "After an assault, many nurses find themselves being more defensive at work and to their patients," she explains. "Through verbal or nonverbal language, they may actually make themselves prone to a repeat assault."

The ED will save money on decreased nurse sick days and higher retention rates by providing counseling to nurses after an assault, says Erickson.

Should you call police?

Only one-third of nurses surveyed in Erickson's study said they would actually press charges against an assaultive patient.

"The majority of nurses I spoke with believe the deciding factor to call the police is patient intent," she notes. "There is a difference between a drunk, belligerent patient who kicks you and a confused, elderly lady who takes a swing at you."

Even for the latter example, Erickson recommends conferring with the patient and/or family. "The goal is to convey that this is unacceptable behavior and to reach a decision on how to prevent this from occurring

Know what to document after an assault

There are important items to document after an assault to prevent future incidents and learn from the current one, urges **Betty Wendt Mayer**, RN, MSN, ARNP, an ED nurse practitioner at Florida Emergency Physicians in Maitland.

Mayer recommends documenting the following facts after an assault:

• **The timing, setting, and circumstances that *preceded* the incident.** For example: "Subject pacing in the waiting room for approximately 15 minutes, crying, has odor of alcohol, threatening triage nurse with leaving without being seen, etc."

• **What the observer of above behavior did to de-escalate at the times.** "Nurse X explained the triage procedure to patient at 10:10 a.m., rechecked vital signs at 10:30 a.m. Patient's manner did/did not alter."

• **The dialogue between the perpetrator and the victim or other staff members, quoted exactly.**

• **If, when, and who the observing staff member notified when violence threat was suspected or actuated.** For example, Nurse X "called the charge nurse and hospital security at 11 a.m."

• **Because research also shows many perpetrators are "frequent flyers," include documentation of verbal threats or violent incidents in the patient chart to give the caregivers a heads-up the next time.** ■

in the future," she explains.

If you do decide to file a police report, be sure to show up at court, Erickson urges. "If you don't, it again reiterates the idea that the assault of a nurse is 'no big deal,'" she says. **(See next month's issue for tips on how to prevent an assault.)**

References

1. Erickson L, Williams-Evans SA. Attitudes of emergency nurses regarding patient assaults. *J Emerg Nurs* 2000; 26:210-215.
2. Mahoney B. The extent, nature, and response to victimization of emergency nurses in Philadelphia. *J Emerg Nurs* 1991; 17:282-284.
3. Poster E. A multinational study of psychiatric nursing staffs; beliefs and concerns about work safety and patient assault. *Arc Psychiatr Nurs* 1996; 10:365-373.
4. Carmel H, Hunter M. Staff injuries from inpatient violence. *Hosp Community Psychiatry* 1989; 40:41-46. ■

Give choices to agitated patients

When ED staff at University of California at Irvine Medical Center in Orange were about to search an agitated patient, he pulled a knife out and began cutting his wrist.

"He said that voices were telling him to do it," recalls **Sherlene Shepp**, RN, MICN, clinical nurse supervisor, who ordered the patient to close the knife and throw it on the ground.

"He waited a second, looked at me and asked, 'If I do it, will you sit down and talk to me?' she recalls. Shepp agreed, and just as the police arrived, he closed the knife and threw it on the floor. She then went into the room and sat and talked to the patient.

The patient continued to cooperate throughout his stay in the ED. "I think he did so because we were honest, direct, and followed through with what we said," says Shepp. "Luckily, the knife was dull and did little damage."

When a patient is in a crisis, it might help to give them options, recommends Shepp. "If you approach them and say, 'I am going to do this,' they get defensive," she says. "Instead, say, 'I don't want you to hurt yourself or the team,' then give them options."

Here are ways to give choices to agitated patients:

• **Determine what is upsetting the patient.**

Patients in crisis are scared from being out of control and possibly bad past experiences, she says. "Ask patients if they feel they need medication, if they are hungry, or if they want to talk," Shepp suggests.

When one patient was lashing out because he was afraid to get medicated, Shepp informed the patient that he decides whether he gets medicated. "By being violent, of course they would medicate him. But if he was cooperative, we would not force him to take something he did not want," she says. " He asked, 'I really have a choice?' I told him, 'Yes.'"

The man agreed to talk to the doctor calmly and then take a nap, says Shepp. "He was transferred to an inpatient bed without incident," she reports. "Just remember that these patients are as scared as you are. If you respect the patient, it goes a long way."

• **Be direct.**

An agitated patient has conflicting feelings and ideas, notes Shepp. "This is a time when they need structure," she advises.

In addition to giving patient options, you need to be direct, Shepp says. "For example, I will tell a patient, 'I will not allow you to hurt yourself or the staff. Would you like medication to help relax you?'"

For further research on patient assaults

Here is a partial listing of literature on violence against ED nurses:

• Mayer BW, Smith FB, King CA, et al. **Factors associated with victimization of personnel in emergency departments.** *J Emerg Nurs* 1999; 25:361-366.

• Lanza M, Carifio J. **Blaming the victim: Complex (nonlinear) patterns of causal attribution by nurses in response to vignettes of a patient assaulting a nurse.** *J Emerg Nurs* 1990; 17:299-309.

• Mahoney B. **The extent, nature, and response to victimization of emergency room nurses in Pennsylvania.** *J Emerg Nurs* 1991; 17:283-291.

• Poster E, Ryan J. **A multiregional study of nurses' beliefs and attitudes about work safety and patient assault.** *Hosp Community Psychiatry* 1994; 45:1,104-1,108.

• Rose M. **A survey of violence toward nursing staff in one large Irish accident and emergency department.** *J Emerg Nurs* 1997; 23:214-219.

• Pane G, Winarski A, Salness K. **Aggression directed toward emergency department staff at a university teaching hospital.** *Ann Emerg Med* 1991; 20:283-286.

• Lanza M. **How nurses react to patient assault.** *J Psychosoc Nurs Ment Health Serv* 1985; 23:1, 6-11.

• Emergency Nurses Association. **1994 ENA survey on prevalence of violence in U.S. emergency departments.** *J Emerg Nurs* 1994; 20(6):34A.

• Koop N, Gilbert P. **California Emergency Nurses Association's informal survey of violence in California emergency departments.** *J Emerg Nurs* 1992; 18:433-439.

• Blank C, Mascitti-Mazur J. **Violence in Philadelphia emergency departments reflects national trends.** *J Emerg Nurs* 1991; 17:318-321. ■

You have to set limits and stick to what you say, Shepp adds. "If this patient was to escalate, I would ask him to remain in one area, and tell him if he cannot do that or won't take medications, physical restraints may be needed," she explains.

• Be honest about what will occur if the patient is violent.

Shepp never tells patients they won't be restrained. "I always let them know that we will protect them no matter what," she says. "I am very honest that their behavior is what decides what measures we have to take."

• Take the patient seriously.

Shepp recalls seeing nurses and physicians walk out of patients' rooms laughing over the situation.

"I feel that if everyone remembered that this patient could be his or her loved one, it would really help," she says. "Also remember that some of your patients may be hearing voices already or paranoid, and this would only escalate them."

Give an agitated patient the same respect, dignity, and confidentiality that you'd provide any ED patient with, Shepp stresses.

• Avoid physical harm if a patient does become violent.

"You need to know where the exits are and have a clear path to get away from someone if you need to," says **Diane Presle**y, RN, MSN, director of nursing for emergency services/critical care at Seton Medical Center in Austin, TX.

Determine if there are any potential weapons in the room, Presley advises. "If the patient is in restraint, know which limbs are restrained," she suggests.

Keep a safe distance from a potentially violent patient or visitor and know how to summon help, recommends Presley. "Predefined codes can alert the team to situations where immediate assistance is required," she says.

Many violent individuals decompress at this point, says Presley. "The team leader should speak in a organized manner with a calm voice," she notes. "Be sure that staff have removed jewelry, stethoscopes, scissors, and pens that could be used as weapons against them." ■

SOURCES

For more information on management of potentially violent patients, contact:

- **Diane Presley**, RN, MSN, Director of Nursing, Emergency Services/Critical Care, Seton Medical Center, 1201 W. 38th St., Austin, TX 78705. Telephone: (512) 324-1031. Fax: (512) 324-1401. E-mail: DPresley@seton.org.
- **Sherlene Stepp**, RN, MICN, Clinical Nurse Supervisor III, UCI Medical Center, 101 The City Drive, Route 128, Orange, CA 92868. Telephone: (714) 456-6549. Fax: (714) 456-5390. E-mail: cstepp@uci.edu.

Here's how to educate patients about asthma

After a child with severe asthma came to Hemet (CA) Valley Medical Center's ED nine times in one month with several life-threatening attacks, the need to improve asthma education became apparent, says **Jessica Lopez**, RRT, respiratory therapy educator at the facility's ED.

The child's mother had walked her one mile to the hospital during an acute attack, and she was admitted to the hospital three times at a cost of $100,000, notes Lopez, who helped coordinate the hospital's asthma education committee.

Not only is asthma becoming more prevalent in the United States, but the severity is increasing as well, warns **Barbara Weintraub**, RN, MPH, MSN, pediatric critical care nurse practitioner at Northwest Community Hospital in Arlington Heights, IL.

"Many, if not most, ED visits for asthma could be avoided with better preventive practices by patients and their families," she says. Here are ways to develop an effective asthma education program:

• **Track data.**

Lopez receives a data sheet from information systems for all asthmatic children seen in the ED, which is compiled quarterly and presented at the ED asthma meeting.

"By tracking frequent ED visits, referrals for further education and home visit assessments can be properly done," she says. **(See QA/I Retrieval Form for pediatric asthma patients, p. 63.)**

• **Develop an asthma education pack.**

At Hemet Valley's ED, a packet of information is given to the patient and family.

"Discuss the information with them before discharge," Lopez recommends. "Make sure to show the patient and family each item in the pack when discussing information." **(See Environmental preventions for asthma, p. 66.)**

Your local representatives for asthma medications often will provide free materials to use in your education program, says Lopez.

• **Teach patients how to monitor their peak flows.**

Peak flow results measure how much air can be exhaled in one second and are an indicator of asthma severity, Weintraub explains. "Typically, the peak flow will start to drop prior to the onset of the sensation of either breathlessness or wheezing," she says. "Therefore, daily monitoring of peak flows for chronic asthmatics could prompt them to initiate the next 'step' of treatment."

Asthma guidelines from the Bethesda, MD-based National Heart, Lung, and Blood Institute, recommend a "stepwise" approach to asthma treatment, says Weintraub. **(For more information on the new asthma guidelines and an excerpt of the guidelines, see *ED Nursing*, March 1999. For ordering information, see resource box, p. 66.)**

"Asthmatics need to be aware of the importance of not only maintaining their ongoing treatments, such as anti-leukotriene inhibitors, but when to start the next step of treatment, such as oral steroids," she says.

Asthma patients need to be taught the difference between their rescue medications and their preventive medications, she stresses. They also need to become aware of their personal asthma triggers and avoid them whenever possible, says Weintraub.

"Keeping a log of when you wheeze, what you were doing, and who you were with prior to the asthma attack can help pin down those triggers," she adds.

• **Don't overwhelm the patient with information.**

Education in the ED should be offered in tiny steps, recommends **Rita K. Cydulka**, MD, residency director for the department of emergency medicine at MetroHealth Medical Center in Cleveland.

"Most patients who are feeling poorly will be unable to absorb a lot of new information. If the physician or nursing staff offers too much, they will probably take away nothing," she notes.

Instead, Cydulka suggests offering a small but important "morsel" of information. "For example, educate patients on metered dose inhalants, daily maintenance medication, daily peak flow measures, or the importance of an action plan," she says. "That way, we can begin to make an impact."

• **Create an asthma charting form.**

At Hemet Valley, an asthma committee with

(Continued on page 66)

EXECUTIVE SUMMARY

An asthma education program significantly can improve the care of asthma patients.

- A multidisciplinary asthma committee should include representation from the ED, respiratory therapy, quality assurance, pharmacy, and social services.
- Give patients information in small doses to avoid overwhelming them.
- Every asthmatic child should be educated about peak flows and asthma triggers and provided with a spacer and metered dose inhaler.

QA/I RETRIEVAL FORM
PEDIATRIC ASTHMA PATIENTS - EMERGENCY DEPARTMENT

Date	MR#	Vital signs reassessed and doc. prior to d/c from ER, including resp. effort	Documentation of education material given on d/c (E if admitted)	Documentation of referrals needed/given	Pulse and resp. rate included at least q1h	PEFR if ≥ 5 y/o SpO2 if ≤ 5 y/o	Responsible nurse	Responsible CRT
TOTAL compliance								

LEGEND: + Criteria met, - Criteria not met, E exception, d/c discharge, PEFR Peak Expiratory Flow Rate, SpO2 oxygen saturation via pulse oximeter

rev. 7/98

Source: Hemet (CA) Valley Medical Center.

Suspected Problem: Pediatric Asthma (less Than 18 years)

TRIAGE CATEGORIES: ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

INITIAL NURSING ASSESSMENT

Name _____
Chief Complaint (PQRST) _____
_____
_____
Ht _____ Known Trigger? _____
Wt _____ Explain? _____
Pulse Ox _____
PEFR if ≥ 5 y/o _____

PMD _____ Date _____ Time _____
Age _____ ☐ M ☐ F Temp _____ ☐ O ☐ R ☐ T
P _____ R _____ BP O _____
Allergies ☐ NKA _____
_____
Medications(Taken at Home) ☐ None _____
_____
_____
Last Tet. Tox. _____

INTERVENTION PRIOR TO ARRIVAL

☐ None
☐ O_2 @ _____ L via _____
☐ O / P Airway ☐ ET Tube
☐ IV _____ Rate _____
Site _____
☐ Medications _____
☐ Hare Tx.
☐ Spinal Precautions
☐ Splint

INFORMANT ☐ Patient ☐ Parent ☐ Other _____
HOW ARRIVED ☐ Walked ☐ Ambulance Co. _____

Medical History

☐ Asthma / COPD ☐ Hypertension
☐ Cardiac ☐ Diabetes
☐ Pacemaker ☐ CVA/Seizure
☐ Surgery _____
☐ Other _____
☐ Interpreter Needed - Language _____
☐ Wheelchair ☐ Crutches ☐
☐ No Pertinent Previous HX
☐ Renal Disease
☐ P.U.D.
☐ None Available

INTERVENTION

☐ Card. Monitor
☐ O_2@ _____ L
Via: ☐ Mask ☐ Cannula
☐ Cooling Measures _____
Pre Flow _____ Pulse Ox. _____ Other _____
☐ Dressing ☐ Wet ☐ Dry ☐ Pressure
☐ Betadine ☐ Soak ☐ Scrub ☐ Swab ☐ Ice Bag

DISPOSITION FROM TRIAGE

☐ Registration Time _____
☐ Emergency Dept. Time _____
☐ X-Ray Time _____
☐ Waiting Room Time _____
Triage Nurse

PEDS

Weight _____
Length _____
Head Circumference _____
Immunizations Current Yes ☐ No ☐
Developmental Delay Yes ☐ No ☐

NEURO

☐ Alert ☐ Dizziness
☐ Oriented x _____ ☐ Purposeful Response to pain
☐ Age Appropriate ☐ Non-purposeful Response to pain
☐ Repetitive Questions ☐ Slurred Speech
☐ Dysphasia Aphasia ☐ Facial Droop ☐ R ☐ L
☐ Loss of Consciousness How Long _____
☐ Other _____

BILAT. GRIPS

☐ Equal ☐ Gag Reflex ☐ Nonresponsive to very painful stimuli
☐ Weak ☐ R ☐ L ☐ Flaccid

AFFECT / COPING

☐ Responsive and Cooperative
☐ Anxious
☐ Agitated
☐ Crying
☐ Depressed
☐ Lethargic
☐ Obvious Discomfort
☐ Other _____
PUPILS
☐ Perl
☐ Other

G.I.

☐ W.N.L.
☐ Nausea
☐ Vomiting X _____
☐ Diarrhea X _____
☐ Constipation
☐ Fecal Incontinence
☐ Bleeding ☐ Emesis ☐ Rectal
☐ Pain Location _____
Bowel Sounds ☐ + ☐ ∅
☐ Last BM _____
☐ Abd. Distension
☐ Dysphagia
☐ Other _____

EXTREMITIES ☐ N/A — Neuro-Vascular Assessment

	Temp	Pulse	Sensation	Mobility	CP Time
☐ RA					
☐ LA					
☐ RL					
☐ LL					

C=Cold H=Hot W=Weak A=Absent W.N.L. (Unless Indicated)
I=Immediate D=Delayed

SKIN

☐ W.N.L. ☐ Hot
☐ Cyanotic ☐ Cool
☐ Pale ☐ Diaphoretic
☐ Jaundiced ☐ Moist
☐ Flushed ☐ Dry
☐ Edema ☐ Pitting ☐ Non-pitting
☐ Rash - Type _____
Site _____
☐ Decubitus - Stage _____
Location _____

URO ☐ W.N.L.

☐ Incontinent ☐ Retention
☐ Frequency ☐ Nocturia
☐ Pain, Burning ☐ Foley
☐ Hematuria ☐ Other _____

Pt. Teaching	Education Done	Comprehension
Asthma Triggers		
Inhaler/Spacer		
PEFR		
Danger Signs		
Medications		
Pathophysiology		

INJURY/LACERATION

LABEL AND SHADE AREAS INVOLVED
☐ N/A
A - Abrasions
B - Bruise
C - Burns
D - Foreign Body
E - Laceration
F - Puncture
G - Possible Fx
H - C/O pain
I - Reddened
J - Hematoma
K - Avulsion
S - Swelling
L - Other _____

RESPIRATORY ☐ N/A

R L BREATH SOUNDS
☐ ☐ Clear
☐ ☐ Rales
☐ ☐ Rhonchi
☐ ☐ Wheezes
☐ ☐ ☐ Insp. ☐ Exp.
☐ ☐ Diminished
☐ Dyspnea
☐ Retraction
☐ Shallow
☐ Tachypnea
☐ Cough
☐ Productive

CARDIAC ☐ W.N.L. 0-10 _____

☐ Chest Pain
☐ Dull
☐ Sharp
☐ Radiating
☐ Non-radiating
☐ Murmur
☐ Epigastric
☐ Substernal
Duration _____ Rhythm _____

EARS ☐ N/A

☐ Hearing Difficulty ☐ None ☐ R ☐ L
☐ Hearing Aid Present
☐ Pain ☐ R ☐ L
☐ Tinnitus
☐ Discharge

EYES ☐ N/A

Visual Acuity o.s. _____ o.d. _____
☐ Blind
☐ Other _____

RN SIGNATURE

PATIENT IDENTIFICATION

ER DATA BASE PEDIATRIC ASTHMA
VALLEY HEALTH SYSTEM
Emergency Services
☐ Hemet Valley Medical Center
☐ Menifee Valley Medical Center
☐ Moreno Valley Community Hospital

96-0115-4 (06/99)

TIME / INITIALS	NURSING DIAGNOSIS / PROBLEM
	☐1. Ineffective airway clearance R/t bronchospasm and
	Increased mucous production.
	Goal: Secretions controlled/bronchospasm decreased
	☐2. Ineffective gas exchange R/T alveolar congestion, V/Q
TIME / INITIALS	mismatch.
	Goal: Cyanosis and adventitious lung sounds
	decreased.
	☐3. Other:
	Goal:

TIME / INITIALS	INTERVENTIONS (20 minutes)
	Baseline PEFR ≥ 5 years:

	INTERVENTIONS 1 HOUR (Response to interventions)
	P R SpO2 PEFR
	Resp Effort
	Lung Sounds
	Skins
	Loc
	Re-evaluation/Procedure/Interventions/Physician

	INTERVENTIONS 2 HOUR (Response to Interventions)
	P R SpO2 PEFR
	Resp Effort
	Lung Sounds
	Skins
	Loc
	Re-evaluation/Procedure/Interventions/Physician

PATIENT IDENTIFICATION

TIME / INITIALS	INTERVENTIONS 3 HOUR (or on discharge)
	P R SpO2 PEFR
	Resp Effort
	Lung Sounds
	Skins
	Loc
	Re-evaluation/Procedure/Interventions/Physician

TIME / INITIALS	MEDICATIONS/IV's	DOSE	ROUTE OR SITE	FLUID INTAKE

TIME / INITIALS	FLUID OUTPUT		
	SOURCE	AMOUNT	APPEARANCE

DISCHARGE / TRANSFER SUMMARY	
Admit:	Room #
Discharge:	Time:
Report called to:	Time:
Rx Given:	
Goals Met?	
If no, explain:	
Education Materials given and explained	
Variance report filed?	
Pt. Valuables:	

REFERRALS
Social Services.
Huff and Puff
Other:

PATIENT PERSONAL AFFECTS	
ITEM	DESCRIPTION

NURSE SIGNATURE / CLASSIFICATION	TIME
Primary / Relief	
Primary / Relief	
C.R.T	

96-0115-4 (06/99)

Source: Hemet (CA) Valley Medical Center.

(Continued from page 62)

representation by ED nurses and physicians, the prehospital liaison, respiratory therapists, quality assurance staff, the hospital's pharmacist, social worker, and the pediatric nurse manager combined the charting needs of the nursing and respiratory departments in a single form.

"We also included a charting check for education and comprehension of education given," notes Lopez. **(See asthma charting form, pp. 64-65.)**

The new charting form was shared with every nurse, respiratory therapist, and ED physician, says Lopez. "The form was revised five times before we settled on a usable, acceptable form that almost everyone could agree upon," she explains.

The asthma charting form is initiated at the triage area and follows the asthma patients throughout their ED visit, says Lopez. "If the patient is admitted to the hospital, it continues to follow the patient in order to provide continuity of care," she explains.

Asthmatic patients are given a form that can be used by day care, child-care givers, and school health providers. "This form consists of a care plan set up by the physician and patient," says Lopez. **(See Asthma Student Action Information form, enclosed in this issue.)**

Notify school health nurses about ED visits by children with asthma so they can be followed up with asthma management at school, says Lopez. **(See what to say to school nurses, p. 67.)**

• Explain that asthma is a chronic disease.

Teach patients that asthma does not go away just because they feel better, stresses Weintraub. "Patients must see a primary care provider and take medications as prescribed," she says. "Simply following the care guidelines given by the care provider can prevent the majority of ED visits, not to mention countless deaths, which do still occur due to asthma." ■

SOURCES AND RESOURCE

For more information about asthma education programs, contact:

- **Rita K. Cydulka,** MD, Department of Emergency Medicine, MetroHealth Medical Center, Room S1-203, 2500 MetroHealth Drive, Cleveland, OH 44109. Telephone: (216) 778-5088. Fax: (216) 778-5349. E-mail: rcydulka@metrohealth.org.
- **Jessica F. Lopez**, RRT, Hemet Valley Medical Center, 1117 E. Devonshire Ave., Hemet, CA 92543. Telephone: (909) 766-6450. Fax: (909) 766-6466. E-mail: gargielle@hotmail.com.
- **Barbara Weintraub**, RN, MPH, MSN, Northwest Community Hospital, 800 W. Central Road, Arlington Heights, IL 60005. Telephone: (847) 618-5432. Fax: (847) 618-5419. E-mail: bweintraub@nch.org.

The National Heart, Lung, and Blood Institute's *Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma* (NIH Publication 97-4051) is available on the Web site (www.nhlbi.nih.gov; click on "clinical guidelines") or for $7 for single copies, plus $2 shipping and handling. An abbreviated version of the guidelines, *Practical Guide for the Diagnosis and Management of Asthma* (NIH Publication 97-4053), also is available free on the Web site or for $5 for single copies, with no shipping and handling charges for orders under $6. To order, contact:

- **National Heart, Lung, and Blood Institute Information Center**, P.O. Box 30105, Bethesda, MD 20824-0105. Telephone: (301) 592-8573. Fax: (301) 592-8563. Web: www.nhlbi.nih.gov.

Environmental preventions to use for asthma patients

There are easy, inexpensive methods that can improve the environment for asthmatics, according to **Jessica Lopez**, RRT, respiratory therapy educator for the ED at Hemet (CA) Valley Medical Center. Lopez recommends sharing the following tips with patients and their families:

1. One bottle boric acid solution (8 oz) added to water (2-3 gallons) only in steam cleaner. Clean 9x15 room. If carpets need to be cleaned; clean carpets, then rinse carpet thoroughly once with water only, then use boric acid solution. Allow carpet to dry thoroughly. Use solution every three months.

2. Cover pillows and mattress with zippered plastic covers.

3. In central heat and air system, change disposable filters every month if possible or every three months without fail. Washable-type filters should be cleaned monthly and allowed to dry completely before returning. When washable filters no longer fluff up, replace them. (3M now has a filter that picks up even 0.4 mc particles such as viruses.)

4. Cleaning and disinfecting household surfaces can be done using one part white vinegar and one part tap water. Wipe down surfaces in kitchen bathroom,

play areas, and any washable surface. Allow to dry thoroughly.

5. Weekly, remove bedspread comforter, pillows, and stuffed animals from room. Hang on clothesline for two hours or place in dryer on "air fluff" for 20 minutes to remove dust and dander from these items.

6. Change bedding weekly. Wash bedding in hot water and dry thoroughly. Vacuum mattress if not covered with plastic. If there is a cover on the mattress, wipe down with vinegar solution. ■

Here's what to say to school nurses

Children with asthma might need your help to ensure their school asthma management program is adequate, says **Barbara Weintraub**, RN, MPH, MSN, pediatric critical care nurse practitioner at Northwest Community Hospital in Arlington Heights, IL.

"There have been cases of children who told their teacher that they needed to visit the nurse to use their inhalers," she says. "Unfortunately, the teachers felt that the child was trying to get out of class, so they did not allow them to go to the nurse."

This type of scenario should not occur, stresses Weintraub. "Any child who feels they need their inhaler should be allowed access to it without question."

Weintraub offers the following list to use when contacting school health nurses to ensure appropriate asthma management is being done:

• School health nurses must be able to recognize a possible asthmatic emergency and have a written plan of action should one occur.

"Although many asthmatics feel short of breath during an asthma attack, there is a small subset of asthmatics who do not experience this breathlessness," says Weintraub. "They are at the highest risk of death from asthma."

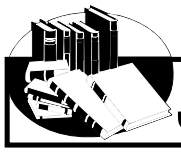
• All school personnel should learn to recognize the signs of respiratory distress and be prepared to initiate treatment once that is recognized.

• Schools should bring in appropriate personnel to teach the signs and symptoms of respiratory distress, some of which can be subtle in children.

• There should be a written policy that any child who asks to use their inhaler should be allowed to without question or judgment on the part of the teacher.

"They should also have in their policy that any child who needs their inhaler more often than once in two hours is probably in need of more definitive care," says Weintraub.

• As part of their asthma education, schools should include information on the difference between rescue inhalers and maintenance inhalers, and the chronic nature of the disease. "This is especially important, as many schools have health aides rather than nurses," says Weintraub. ■



JOURNAL REVIEWS

Koziol-McLain J, Price DW, Weiss B, et al. **Seeking care for nonurgent medical conditions in the emergency department: Through the eyes of a patient.** *J Emerg Nurs* 2000; 26:554-563.

Patients seeking ED care for nonurgent medical diagnoses did *not* perceive themselves as having an urgent problem, according to this study. The patients typically had been unsuccessful in gaining access to alternative non-ED health care settings and went to the ED as a result, say the study's findings.

This finding has important implications for care delivery, say the researchers. They argue that the goal of shifting nonurgent visits from the ED to other health care settings does not consider the patient's perspective. They write: "Uninsured patients' reasons for seeking care in the emergency department are far more complex than can be conveyed by a medical chief complaint or diagnostic label."

Here are some of the reasons discovered by the researchers:

• Patients "tough it out" before deciding to seek care at the ED.

• Patients make decisions to seek care by consulting friends and relatives.

• Patients may decide to seek care because of worsening symptoms and their effect on work and sleep.

• Work schedules and transportation barriers have an impact on a patient's decision to seek care.

• Patients may try to access nonemergency care settings before they go to the ED.

The study demonstrated the existence of other issues in the lives of uninsured patients who seek help for a nonemergency problem in the ED.

"For some persons, familial and social relationships [have] been disrupted. For others, distress was related to physiologic health, spiritual health, or social support," they wrote. "The ED visit was, in many ways, like sending out a distress call." ▼

Stone S, Gonzales R, Maselli J, et al. **Antibiotic prescribing for patients with colds, upper respiratory tract infections, and bronchitis: A national study of hospital-based emergency departments.** *Ann Emerg Med* 2000: 36:320-327.

Even though they are usually ineffective, antibiotics still are commonly prescribed for ED patients with upper respiratory tract infections, says this study from the University of Colorado Health Sciences Center in Denver. Using data from the 1996 National Hospital Ambulatory Medical Care Survey, performed by the National Center for Health Statistics in Hyattsville, MD, antibiotic prescribing rates were examined for 2.7 million ED visits for colds, upper respiratory tract infections, and bronchitis.

The study found antibiotics were prescribed for 24.2% of patients with common colds and upper respiratory tract infections and for 42.2% of patients with bronchitis.

The researchers recommend ED clinicians and managers develop and implement strategies for more judicious use of antibiotics. "Unless we curtail our use of antibiotics, we face the prospects of higher costs, increased morbidity, and higher rates of death from common bacterial infections," they wrote. They recommend:

• giving patients "over-the-counter" prescription pads that educate patients about effective cold and cough preparations;

• emphasizing careful diagnosis of upper respiratory syndromes, deferral of antibiotic use, and a "watch-and-wait" approach for common colds, purulent rhinitis, and acute cough illnesses;

• participating in the development of clinical guidelines to promote judicious antibiotic use, possibly including computer-assisted decision supports and physician practice profiling;

• encouraging use of influenza and pneumococcal vaccines for patients in high-risk groups;

• distributing educational materials to providers and patients, such as brochures developed by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics.

[Editor's note: Small quantities of educational materials on appropriate antibiotic use are available at no charge from the CDC, including brochures titled A New Threat to Your Health Prescription Pad*, which is a checkoff list for symptomatic therapy for upper respiratory infection, and* Q&A Sheet on Antibiotic Resistance*. Materials also can be ordered from the CDC's Web site: www.cdc.gov/antibioticresistance. Click on "Materials for Health Care Providers." Bulk quantities also may be obtained through the Public Health Foundation, which has a link from the CDC Web site. If you don't have access to the Web, contact Lisa Bridges at the CDC. Telephone: (404) 371-5377. Fax: (404) 371-5434.*

The American Academy of Pediatrics has a book titled The Principles of Judicious Use of Antimicrobial Agents: A Compendium for the Health Care Professional (Item No. MA0114). *Copies are $34.95 plus $7.50 shipping and handling. A brochure titled* Your Child and Antibiotics (Item No. HE0219) *is available in English and Spanish in pads of 100. The cost is $34.95 plus $7.50 shipping and handling. To order, contact AAP, P.O. Box 747, Elk Grove Village, IL 60009-0747. Telephone: (888) 227-1770 or (847) 434-4000. Fax: (847) 228-1281. E-mail: pubs@aap.org. Web: www.aap.org. Click on "Publications," then "AAP BookStore," then "New and Most Requested Topics" and scroll down to the brochure's name.]* ■

How to care for patients with body piercings

When **Rene Steele**, RN, had to place a catheter in a male patient who had his penis pierced, he would not allow the procedure to be done.

"He refused to let me take it out because he was afraid the piercing would close up," she recalls.

After Steele, an ED nurse at University Hospital in Cincinnati, explained the infected piercing was the probable cause of his inability to urinate, the patient allowed her to remove the jewelry and proceed.

Another patient swallowed a tongue piercing and came in complaining of abdominal pain, reports **Diana Meyer**, RN, MSN, CCNS, CCRN, CEN, clinical nurse specialist for emergency services at St. Joseph Hospital in Bellingham, WA. "Unfortunately, it didn't make it all the way through her intestinal tract and caused a serious infection," she explains.

If you haven't seen a patient with a body piercing yet, you probably will soon, says **Reneé Semonin Holleran**, RN, PhD, chief flight nurse and clinical nurse specialist at University Hospital. "It's safe to say that the trend of body piercing will continue, even in the rural areas," she predicts. "I continue to be amazed at the adults who get body piercings." Here are ways to change your practice when caring for patients with body piercings:

• **Resist the urge to judge.**

Body piercing now is commonplace in mainstream society, notes Meyer. "You should take it in stride and develop an attitude of acceptance toward patients with body piercings," she says.

• **Realize that jewelry can exacerbate traumatic injuries.**

Eyebrow piercings and earrings have caused injury when pulled during fights, says Holleran. Also, the objects can tear the skin, she adds.

Carefully assess the location of jewelry if holes are present in the tongue, nose, or other areas of the face, Holleran says. "The jewelry may become loosened and easily aspirated or fall down into the back of the patient's mouth," she warns.

Care must be taken when rapidly removing clothing during resuscitation if piercings are present, advises Holleran. When jewelry is pulled, it can tear the skin. "Localized tissue injury is the biggest risk. Also, there is the risk for scarring when chunks of skin are removed."

• Be aware of potential for infections.

Often, problems stem from the patient failing to properly clean their piercing as instructed to prevent infection, says Steele. "There is a great deal of care that goes into caring for a piercing," she says.

The biggest complication with body piercing is probably infection, Holleran agrees. "Patients have developed serious cellulitis from piercing, particularly in areas with poor circulation or where poor technique has been used."

The development of cellulitis can lead to loss of tissue, extremity function, and systemic infection, says Holleran. "Cellulitis could also lead to chronic wound infections as well," she adds.

The following are risk factors for cellulitis, says Holleran: poor skin preparation for the piercing, dirty equipment, poor wound care after the piercing, and pre-existing conditions such as diabetes and immunosuppression.

If a patient has a minor local infection, it might be advisable to remove the jewelry, says Meyer. However, she cautions if the infection is more extensive, the jewelry should not be removed. "This will only cause the skin to close, while causing abscess development in deeper skin structures," she explains.

A better management plan is to leave the jewelry in and allow drainage of purulent material to continue, says Meyer.

EXECUTIVE SUMMARY

Body piercings can cause infection and exacerbate traumatic injuries.

- Patients have developed serious cellulitis from piercing, particularly in areas with poor circulation.
- If piercings are present, remove clothing carefully during resuscitation to avoid tearing the skin.
- Tongue, nose, lip, or chin piercings can cause airway obstruction by aspiration of the object.

SOURCES

For more information about body piercing injuries, contact:

- **Reneé Semonin Holleran**, RN, PhD, University of Cincinnati Medical Center, P.O. Box 670736, Cincinnati, OH 45267. Telephone: (513) 584-7522. Fax: (513) 584-4533. E-mail: reneeflightnurse@msn.com.
- **Diana Meyer**, RN, MSN, CCNS, CCRN, CEN, Emergency Services, St. Joseph Hospital, 2901 Squalicum Parkway, Bellingham, WA 98225. Fax: (360) 715-4118. E-mail: dmeyer @peacehealth.org.
- **Rene Steele**, RN, University Hospital, 234 Goodman St., Cincinnati, OH 45267. Telephone: (513) 584-8148. E-mail: rhianon63@hotmail.com.

• Ask if piercings were done by a professional.

While professional piercers follow an aseptic surgical technique, piercings done with a spring-loaded "gun" place a person at risk for infectious disease, warns Meyer. The guns are infrequently sterilized and not easily cleaned, she explains.

If piercings were done by an unlicensed individual, you should include some additional screening in the patient's care for HIV and hepatitis so you can recommend prophylactic care, if needed, says Meyer.

• Consider airway management.

Airway management problems may occur with a patient with a tongue piercing who has facial injuries, says Steele. **(See story on removal of body jewelry, below.)** Objects in the patient's tongue, around the mouth, and in the nose could cause potential airway obstruction by aspiration of the object, notes Holleran.

"Anything that is in the patient's mouth may interfere with one's ability to manage their airway in a crisis," she warns. ■

Should you remove body jewelry?

Body jewelry can interfere with procedures such as intubation, X-rays, and Foley catheters, warns **Diana Meyer**, RN, MSN, clinical nurse specialist for emergency services at St. Joseph Hospital in Bellingham, WA. "If jewelry is really in the way of your treatment or diagnostic plan, then you

definitely have to remove it."

This may be easier said than done, Meyer acknowledges. "Removing the jewelry can be quite frustrating for the uninitiated," she says. Here are some things to consider when removing body jewelry:

• **Don't remove the jewelry unless it's necessary.**

Surprisingly, body jewelry often doesn't need to be removed, says Meyer. "It's more of a compulsion on our part and may not actually need to come out."

For example, chest and nipple piercings do not necessarily need to be removed for electrical therapy, says Meyer. "Their presence is benign unless the paddles are placed directly over the jewelry," she notes.

However, chest piercings that consist of long thin metal strips running under the skin may interfere with electrical therapy, Meyer adds. "Obviously, the presence of any metal on the body can wreak havoc with our ability to get clear radiological studies," she says.

If there is a way to preserve the jewelry, do so, advises **Rene Steele**, RN, an ED nurse at University Hospital in Cincinnati. "Some are very expensive; just as we take care of 'normal' jewelry, we should try to take care of that which is 'not so normal' as well."

• **Ask the patient to remove the jewelry.**

If the patient is awake and alert, your best bet is to ask them to remove the jewelry, says Meyer. "It does not work like the jewelry that most of us wear."

The following procedures necessitate removal of body piercings:

— Catheterization. The penis piercing known as a "Prince Albert" can make placing a urinary catheter difficult, says **Kathleen Flarity**, ARNP, MN, CEN, CFRN, ED nurse practitioner at Overlake Hospital in Bellevue, WA. "There is a rod that is placed in some individuals with this piercing, which extends inside the urethra," she notes. "That is a potential injury since it is unyielding, as well as making catherization difficult."

Piercing of the genitals can interfere with catheterization by blocking the meatus, particularly if the head of the penis if pierced, says **Reneé Semonin Holleran**, RN, PhD, chief flight nurse and clinical nurse specialist at University Hospital in Cincinnati. "Jewelry will have to be removed to prevent the risk of infection in this area."

— Airway management. Facial body piercings can make resuscitation more difficult, says Flarity. "A piercing between the eyebrows can make it difficult to get a good seal with the bag valve mask. Tongue piercings can make intubation more difficult."

Piercings in or around the oral cavity might be hazardous during airway management, says Holleran. "Remove tongue/lip piercings, uvula piercings, and septum piercings."

However, Flarity cautions there is a danger of creating a foreign body in the airway with removal, so the removal should be handled very carefully.

"Obviously, you don't want to drop any piece of the jewelry into the mouth," she says.

For example, to remove a tongue piercing (a rod with a ball on either end), Flarity recommends taking two pairs of hemostats and ensuring they are locked into position. Next, hold one ball stationery with the first pair of hemostats, and hold the second ball with the other pair, rotate until it unscrews, and pull the rod out, never letting go with the hemostats, she says.

— **Cervical spine immobilization and evaluation.** Cheek, chin, and throat piercings may interfere with the ability to stabilize the cervical spine, so jewelry at these sites might need to be removed, says Meyer.

— Application of military anti-shock trousers for pelvic fracture stabilization. Remove navel piercings and any genital piercings, says Holleran.

"They could pierce the pants and render them ineffective, as well as, with the pressure exerted by the pants, cause additional injury to the patient," she explains.

SOURCE AND RESOURCES

For more information about removal of body piercing jewelry, contact:

- **Kathleen Flarity**, ARNP, MN, CEN, CFRN, Emergency Department, Overlake Hospital, 1035 116th Ave. N.E., Bellevue, WA 98004. Telephone: (425) 688-5200. Fax: (425) 688-5667. E-mail: Kflarityr@aol.com.

The Association of Professional Piercers has a Web site (www.safepiercing.com) which includes a consumer's guide to choosing a piercer and aftercare instructions for facial, body, and oral piercings. For more information on body piercing, contact:

- **Association of Professional Piercers**, PMB 286, 5446 Peachtree Industrial Blvd., Chamblee, GA 30341. Telephone: (888) 515-4APP. E-mail: secretary@safepiercing.org.

Anatometal offers ring opening plier to remove captive bead ring jewelry. The cost is $76 plus $5 for shipping. For more information, contact:

- **Anatometal**, 411 Ingalls St., Santa Cruz, CA 95060. Telephone: (888) ANOMETAL or (831) 454-9880. Fax: (831) 454-0163. Web: www.anatometal.com. (Click on "tools and accessories" and "ring opening pliers.")

— Insertion of a urinary catheter. Remove piercings in the head and body of the penis and any clitoral piercings, since they may interfere with the passing of the catheter, according to Holleran.

— Childbirth. Remove any genital piercings, says Holleran. "In childbirth, it may interfere with the delivery, or it could injure the baby," she explains. "It may also get pulled on, which may cause pain or injury.

— Any type of radiographs, computerized tomography scans and magnetic resonance imaging. All jewelry should be removed for radiographs so they do not interfere with interpretation, says Holleran.

• Become familiar with the various types of jewelry.

Learning the correct way to remove the jewelry will expedite nursing or emergency treatments, says Steele. "Take the time to ask if anyone [on the medical staff] knows how to remove the jewelry correctly, in order to prevent further injury," she recommends.

Most types of jewelry, known as "barbells" or "labrets," are removed by unscrewing one of the balls

CE objectives

After reading this issue of *ED Nursing*, the CE participant should be able to:

1. Identify clinical, regulatory, or social issues relating to ED nursing (See *Warning: Emergency department nurses are at higher risk for violence; Give choices to agitated patients; Should you remove body jewelry*? and *Journal Reviews* in this issue).
2. Describe how those issues affect nursing service delivery.
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. ■

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Editorial Questions

For questions or comments, call Joy Daughtery Dickinson at (229) 377-8044.

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at the end of the bar, then pulling the bar through the soft tissue, says Meyer. Nurses tend to be confounded by the "captive bead ring" closure used in many piercings.

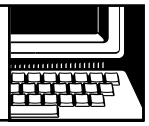
"The bead is held in place by the tension of the ring," Meyer explains. Ideally, use a spreader tool, available at body piercing establishments, she says**. (For more information, see resource box, p. 70.)** The tool inserts into the middle of the ring and opens it so the bead drops.

If you don't have a spreader tool, take a pair of pliers and spread the ring apart, says Meyer. The bead will drop, and you can pull the ring through the opening.

• **Don't use ring cutters.**

When you use a ring cutter on a finger, the ring just pulls through, but that's not the case with body jewelry, she explains. "This will create sharp edges and do some damage trying to pull it through the patient's soft tissue," says Meyer. ■

WEB ALERT



Site offers handouts for your patients

Vital stats:
Site: Clinical and Patient Education Department at the Medical University at South Carolina
Address: www.musc.edu/medcenter/education/cpeducation (click on "education materials")

If you're like most ED nurses, you're always on the lookout for good patient handouts. This site, affiliated with the Medical University at South Carolina Medical Center (MUSC) in Charleston, offers you over 250 patient education handouts.

Topics such as "stroke" or "pain" can be entered as keyword search terms, or you can access a list of topics.

It's not enough to have good handouts — you also need to make sure patients can read what you give them, stresses **Karen Rankine**, RN, MN, coordinator of patient/family education for MUSC. All materials are at the sixth- to eighth-grade reading levels, and each has the specific reading grade level listed (evaluated by Prose: The Readability Analyst, manufactured by MicroBrothers Software in Boulder, CO), she says.

The site can help you to develop a packet of information on a particular diagnosis, such as asthma or stroke, says Rankine.

If you want to obtain national guidelines, the site features links to national organizations such as the Atlanta-based Centers for Disease Control and Prevention and the Elk Grove Village, IL-based American Academy of Pediatrics.

Materials are geared toward patients as well as health care providers, so the site is also helpful for consumers who want to learn more about their condition, Rankine notes. ■

SOURCE

For more information, contact:

- **Karen Rankine**, RN, MN, Clinical and Patient Education Department, Medical University of South Carolina, P.O. Box 250337, 169 Ashley Ave., Room 742, North Tower, Charleston, SC 29425. Telephone: (843) 792-5078. Fax: (843) 792-5972. To contribute your own patient education materials to the site, send an e-mail to: hammersa@musc.edu.

Excerpt: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

Hazard Prevention and Control

After hazards of violence are identified through the systematic work site analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incidence response can be an important tool in preventing future incidents.

Engineering Controls and Workplace Adaptation

Engineering controls, for example, remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those actions presented in the following paragraphs. The selection of any measure, of course, should be based upon the hazards identified in the workplace security analysis of each facility.

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones, and private channel radios where risk is apparent or may be anticipated, and arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors — installed or hand-held, where appropriate — to identify guns, knives, or other weapons, according to the recommendations of security consultants.
- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in those situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations and install deep service counters or bullet-resistant, shatter-proof glass in reception areas, triage, admitting, or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
- Establish "time-out" or seclusion areas with high ceilings without grids for patients acting out and separate rooms for criminal patients.
- Provide client or patient waiting rooms designed to maximize comfort and minimize stress.
- Ensure counseling or patient care rooms have two exits.
- Limit access to staff counseling rooms and treatment rooms controlled by using locked doors.
- Arrange furniture to prevent entrapment of staff. In interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp comers or edges, and/or affixed to the floor. Limit the number of pictures, vases, ashtrays, or other items that can be used as weapons.
- Provide lockable and secure bathrooms for staff members separate from patient-client and visitor facilities.
- Lock all unused doors to limit access, in accordance with local fire codes.
- Install bright, effective lighting indoors and outdoors.
- Replace burned-out lights, broken windows, and locks.
- Keep automobiles, if used in the field, well-maintained. Always lock automobiles.

Administrative and Work Practice Controls

Administrative and work practice controls affect the way jobs or tasks are performed. The following examples illustrate how changes in work practices and administrative procedures can help prevent violent incidents.

- State clearly to patients, clients, and employees that violence is not permitted or tolerated.
- Establish liaison with local police and state prosecutors. Report all incidents of violence. Provide police with physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats to a supervisor or manager (e.g., can be confidential interview). Keep log books and reports of such incidents to help determine any necessary actions to prevent further occurrences.
- Advise and assist employees, if needed, of company procedures for requesting police assistance or filing charges when assaulted.
- Provide management support during emergencies. Respond promptly to all complaints.
- Set up a trained response team to respond to emergencies.
- Use properly trained security officers when necessary to deal with aggressive behavior. Follow written security procedures.
- Ensure adequate and properly trained staff for restraining patients or clients.
- Provide sensitive and timely information to persons waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
- Ensure adequate and qualified staff coverage at

(Continued)

all times. Times of greatest risk occur during patient transfers, emergency responses, meal times, and at night. Locales with the greatest risk include admission units and crisis or acute-care units. Other risks include admission of patients with a history of violent behavior or gang activity.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
- Establish a list of "restricted visitors" for patients with a history of violence. Copies should be available at security checkpoints, nurses' stations, and visitor sign-in areas. Review and revise visitor check systems, when necessary. Limit information given to outsiders on hospitalized victims of violence.
- Supervise the movement of psychiatric clients and patients throughout the facility.
- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
- Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Employees should never enter seclusion rooms alone.
- Establish policies and procedures for secured areas, emergency evacuations, and for monitoring high-risk patients at night (e.g., open vs. locked seclusion).
- Ascertain the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors. Establish a system — such as chart tags, log books, or verbal census reports — to identify patients and clients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. Update as needed.
- Treat and/or interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (e.g., rooms with removable partitions).
- Use case management conferences with co-workers and supervisors to discuss ways to effectively treat potentially violent patients.
- Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. Consider using certified employee assistance professionals (CEAPs) or in-house social service or occupational health service staff to help diffuse patient or client anger.
- Transfer assaultive clients to acute-care units, "criminal units," or other more restrictive settings.
- Make sure that nurses and/or physicians are not alone when performing intimate physical examinations of patients.
- Discourage employees from wearing jewelry to help prevent possible strangulation in confrontational situations. Community workers should carry only required identification and money.
- Periodically survey the facility to remove tools or possessions left by visitors or maintenance staff that could be used inappropriately by patients.
- Provide staff with identification badges, preferably without last names, to readily verify employment.
- Discourage employees from carrying keys, pens, or other items that could be used as weapons.
- Provide staff members with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lighted, and safely accessible to the building.
- Use the "buddy system," especially when personal safety may be threatened.
- Conduct a comprehensive post-incident evaluation, including psychological as well as medical treatment, for employees who have been subjected to abusive behavior.

Post-Incident Response

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for victimized employees and employees who may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of severity. Transportation of the injured to medical care should be provided if care is not available on site.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These include short and long-term psychological trauma, fear of returning to work, changes in relationships with co-workers and family, feelings of incompetence, guilt, powerlessness, and fear of criticism by supervisors or managers. Consequently, a strong follow-up program for these employees will not only help them to deal with these problems, but also to help prepare them to confront or prevent future incidents of violence.

There are several types of assistance that can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical incident stress debriefing, or employee assistance programs may be provided to assist victims. CEAPs, psychologists, psychiatrists, clinical nurse specialists, or social workers could provide this counseling, or the employer can refer staff victims to an outside specialist. In addition, an employee counseling service, peer counseling, or support groups may be established.

In any case, counselors must be well-trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels

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among victims and witnesses. In addition, such counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

Training and Education

Training and education ensure all staff are aware of potential security hazards and how to protect themselves and their co-workers through established policies and procedures.

All Employees

Every employee should understand the concept of "universal precautions for violence," i.e., that violence should be expected but can be avoided or mitigated through preparation. Staff should be instructed to limit physical interventions in workplace altercations whenever possible, unless there are adequate numbers of staff or emergency response teams and security personnel available. Frequent training also can improve the likelihood of avoiding assault.

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards.

The training program should involve all employees, including supervisors and managers. New and reassigned employees should receive an initial orientation prior to being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations, and drills.

Topics may include Management of Assaultive Behavior Professional Assault Response Training, police assault avoidance programs, or personal safety training such as awareness, avoidance, and how to prevent assaults. A combination of training may be used depending on the severity of the risk.

Required training should be provided to employees annually. In large institutions, refresher programs may be needed more frequently (monthly or quarterly) to effectively reach and inform all employees. The training should cover topics such as:

- the workplace violence prevention policy;
- risk factors that cause or contribute to assaults;
- early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults;
- ways of preventing or diffusing volatile situations or aggressive behavior, managing anger, and appropriately using medications as chemical restraints;
- information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences;
- a standard response action plan for violent situations, including availability of assistance, response to alarm systems, and communication procedures;
- how to deal with hostile persons other than patients and clients, such as relatives and visitors;
- progressive behavior control methods and safe methods of restraint application or escape;
- the location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- ways to protect oneself and co-workers, including use of the "buddy system";
- policies and procedures for reporting and record keeping;
- policies and procedures for obtaining medical care, counseling, workers' compensation, or legal assistance after a violent episode or injury.

Supervisors, Managers, and Security Personnel

Supervisors and managers should ensure employees are not placed in assignments that compromise safety, and encourage employees to report incidents. Employees and supervisors should be trained to behave compassionately toward co-workers when an incident occurs.

They should learn how to reduce security hazards and ensure employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and make any necessary changes in the physical plant, patient care treatment program, and staffing policy and procedures to reduce or eliminate hazards.

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders, and ways to handle aggression and defuse hostile situations.

The training program also should include an evaluation. The content, methods, and frequency of training should be reviewed and evaluated annually by the team or coordinator responsible for implementation. Program evaluation may involve supervisor and/or employee interviews, testing and observing, and/or reviewing reports of behavior of individuals in threatening situations.

Record keeping and Evaluation of the Violence Prevention Program

Record keeping and evaluation of the violence prevention program are necessary to determine overall

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effectiveness and identify any deficiencies or changes that should be made.

Record keeping

Record keeping is essential to the success of a workplace violence prevention program. Good records help employers determine the severity of the problem, evaluate methods of hazard control, and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who "pool" data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories, and training, among others, can help identify problems and solutions for an effective program.

The following records are important:

• **Occupational Safety and Health Administration (OSHA) Log of Injury and Illness.** OSHA regulations require entry on the Injury and Illness Log of any injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness. (This applies only to establishments required to keep OSHA logs.) Injuries caused by assaults, which are otherwise recordable, also must be entered on the log. A fatality or catastrophe that results in the hospitalization of three or more employees must be reported to OSHA within eight hours. This includes those resulting from workplace violence and applies to **all** establishments.

• **Medical reports of work injury and supervisors' reports for each recorded assault should be kept.** These records should describe the type of assault, i.e., unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost time, and the nature of injuries sustained.

• **Incidents of abuse, verbal attacks, or aggressive behavior — which may be threatening to the worker but do not result in injury, such as pushing or shouting and acts of aggression toward other clients — should be recorded, perhaps as part of an assaultive incident report.** These reports should be evaluated routinely by the affected department.

• **Information on patients with a history of past violence, drug abuse, or criminal activity should be recorded on the patient's chart.** All staff who care for a potentially aggressive, abusive, or violent client should be aware of their background and history. Admission of violent clients should be logged to help determine potential risks.

• **Minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken should be documented.**

• **Records of all training programs, attendees, and qualifications of trainers should be maintained.**

Evaluation

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate program success. Responsible parties (managers, supervisors, and employees) should collectively re-evaluate policies and procedures on a regular basis. Deficiencies should be identified and corrective action taken.

An evaluation program should involve:

- establishing a uniform violence reporting system and regular review of reports;
- reviewing reports and minutes from staff meetings on safety and security issues;
- analyzing trends and rates in illness/injury or fatalities caused by violence relative to initial or "baseline" rates;
- measuring improvement based on lowering the frequency and severity of workplace violence;
- keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate their effectiveness;
- surveying employees before and after making job or work site changes or installing security measures or new systems to determine their effectiveness;
- keeping abreast of new strategies available to deal with violence in the health care and social service fields as they develop;
- surveying employees who experience hostile situations about the medical treatment they received initially and, again, several weeks afterward, and then several months later;
- complying with OSHA and state requirements for recording and reporting deaths, injuries, and illnesses;
- requesting periodic law enforcement or outside consultant review of the work site for recommendations on improving employee safety.

Management should share workplace violence prevention program evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives, or other employee groups.

Source: Occupational Safety and Health Administration, Washington, DC. Web: www.osha.gov.

Valley Health System
A California Local Health Care District
1117 East Devonshire Avenue • Hemet, California 92543
(909) 652-2811 • TDD (909) 652-6173

Asthma Student Action Information

Student Photo

GENERAL INFORMATION

Name _____ Age _____

Teacher _____ Room _____ Grade _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

EMERGENCY AND PHYSICIAN CONTACTS

Emergency Contact #1 _____ (Name) _____ (Relationship) _____ (Phone)

Emergency Contact #2 _____ (Name) _____ (Relationship) _____ (Phone)

Emergency Contact #3 _____ (Name) _____ (Relationship) _____ (Phone)

Physician for Asthma Treatment _____ (Name) _____ (Phone)

Other Physician _____ (Name) _____ (Phone)

DAILY ASTHMA MANAGEMENT PLAN

Identify things that start asthma episode (check all that applies to student)

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Animals
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Carpets
- ☐ Pollens
- ☐ Molds
- ☐ Windy conditions
- ☐ Air pollution
- ☐ Foods #1 _____
- ☐ Foods #2 _____
- ☐ Other #1 _____
- ☐ Other #2 _____

Comments: _____

Control measures for school environment (list pre-medications, dietary restrictions, and environmental control to prevent asthma episode). _____

Peak Flow Monitoring Peak flow number _____ Monitoring times _____ _____ _____ _____

DAILY MEDICATION PLAN

	Name	Amount	Time to use
1.			
2.			
3.			
4.			

VHS COPY CENTER 96-8775-7 (9/9

Asthma Student Action Information

Name _____

EMERGENCY TREATMENT PLAN

Emergency action is necessary when the student has symptoms such as _____

_____

or has peak flow reading of _____ .

STEPS TO TAKE DURING ASTHMA EPISODE

1. **Give medication listed below.**
2. **Have student return to classroom if** _____

_____

3. **Contact parent**
   - ✓ Immediately if severe respiratory distress.
   - ✓ Any time treatment has been given, notify parents before child goes home from school.
   - ✓ Other parental instructions.
4. **Seek medical care if student has any of the following;** • GET EMERGENCY HELP NOW • GET EMERGENCY HELP NOW •
   - ✓ No improvement 15-20 minutes after initial treatment and a relative cannot be reached.
   - ✓ Peak flow of _____
   - ✓ Hard time breathing with:
     - ✗ chest and neck pulled in with breathing.
     - ✗ child hunched over.
     - ✗ child is struggling to breathe.
   - ✓ Difficulty walking.
   - ✓ Unable to talk in two or three words without struggling to breathe or hard to understand or hear words.
   - ✓ Stops playing and cannot start activity again.
   - ✓ Lips or fingernails are gray or blue.

IF THIS HAPPENS (#4)
GET
EMERGENCY HELP NOW!!!!!

GET EMERGENCY HELP NOW

• GET EMERGENCY HELP NOW • GET EMERGENCY HELP NOW • GET EMERGENCY HELP NOW •

EMERGENCY ASTHMA MEDICATIONS

	Name	Amount	Time to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Special Instructions: _____

_____

For Inhaled Medications:

☐ I have instructed _____ in the proper use of his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself. (It is recommended that the nurse/teacher be notified by student when use of inhaler is required for any respiratory distress).

☐ It is my professional opinion that _____ should not carry his/her inhaler medication by him/herself.

_____ _____ _____
Physician Signature Phone Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Signature Date

Source: Hemet (CA) Valley Medical Center.