AMERICAN HEALTH CONSULTANTS®

ED NURSING

Inside: 2001 ED Nursing Reader Survey

Vol. 4, No. 6

Inside

April 2001

Are you putting patients at risk with dangerously high diversion rates?

EDs report high rates year-round — You need strategies

EDs closed for hours at a time. Ambulances transporting patients to hospitals that take an extra 20 minutes to reach. Overloaded EDs forced to accept patients because *all* EDs in the area are on diversion status.

Do these disturbing scenarios sound all too familiar? While high diversion rates used to occur only in flu season, overcrowded EDs in many areas now are confronting the problem year-round, due to factors such as hospital cost-cutting, an aging population, and the nursing shortage, according to experts interviewed by *ED Nursing*.

When many EDs in the same area go on diversion status, all must open their doors — even if they're dangerously overcrowded. "When everyone is on divert, *no one* is," according to **George D. Velianoff**, RN, DNS, CHE, executive vice president of nursing for the Emergency Nurses Association in Des Plaines, IL. "Patients will come to the closest facility regardless," he says.

If EDs are experiencing unsafe levels of overcrowding, this situation can put critically ill patients at risk, he stresses. One recent case underscores this danger: When an elderly patient with joint pain arrived at an overcrowded ED in Boston, he was left unattended and died after going into cardiac arrest.

EXECUTIVE SUMMARY

EDs nationwide are reporting year-round record diversion rates, which put patients at risk for adverse outcomes.

- If all EDs are on diversion status, they all must be opened to provide care for patients, which means patients may seek care at dangerously overcrowded EDs.
- Create new nursing roles, such as an "access nurse" to interact with referring physicians and a "triage nursing supervisor" to coordinate with ICU.
- Educate other departments to view diversion as a hospitalwide problem, not an "ED problem."

Diversion should be used only as an absolute last resort, says Velianoff. "Usually, when you are on diversion, so is everyone else," he says. "That puts the EMS folk and the patients at risk of driving around town to find a hospital." **(See Communication of a Diversion Message, p. 75; and sample Diversion Plan and Diversion Decision Diagram, inserted in this issue.)**

Two roles cut diversion

Here are effective ways EDs have reduced their diversion rates:

• **Create new nursing roles.**

Two new nursing roles created at Massachusetts General Hospital in Boston have been key in preventing ED ambulance diversion, reports **Mary Fran Hughes**, RN, MSN, the ED's nurse manager.

An ED "access nurse" receives referrals from physicians who are sending their patients into the ED for evaluation or admission, Hughes explains. "The access nurse is able to assist the referring physician in identifying if it is appropriate for the particular patient to be a direct admit to the inpatient area, bypassing the ED, and can facilitate this process if needed," she says.

A triage nursing supervisor receives all requests for ICU beds, from areas of the hospital such as the ED and externally from other hospitals. "This individual prioritizes the acceptance of patients by the ICUs and coordinates the transfers of patients to the appropriate ICUs," says Hughes.

• **Analyze reasons for diversion.**

At Massachusetts General's ED, length of stay was examined by diagnoses and treatment modality, says Hughes. "For example, we identified that patients were queuing up waiting for CT scans in our department," she explains. "By working with our radiology colleagues and senior management of the hospital, we were able to install a second CT in the ED."

It also was determined that waits for certain lab test results were prolonging the disposition decision for some patients. "We worked with our laboratory staff and senior management to create an on-site laboratory in the ED for quick turnaround of selected lab tests," says Hughes.

• **Create a physician-nurse team.**

At Massachusetts General, a physician/nurse team was created to begin evaluation of patients who are waiting in the waiting area for an ED stretcher to open up, Hughes reports.

"This team initiates lab and X-ray studies, completes screening exams, and starts IV hydration and medications," she says.

• **Switch to "internal disaster" mode.**

Implement "internal disaster" mode to bring resources to the ED and move patients to other areas of the hospital when needed, says Velianoff. "This mode requires a different staffing plan to be put into action, like you do when there is a disaster call," he explains.

The "internal disaster" mode also might include canceling of elective admissions and establishing transfer agreements with other facilities in advance, Velianoff advises.

• **Don't allow diversion to be treated as an "ED problem."**

The ED needs to push the process of reducing diversion rates, but not allow it to be deemed an "ED problem," warns **Mary M. MacLeod,** RN, BSN, MBA, director of emergency services and pre-hospital care for Hamilton Health Sciences Corp., a four-facility hospital system based in Ontario, Canada. "Find individuals who are willing to bring it to the senior management table for discussion and an action plan," she advises.

Obtain support from a chairperson in the inpatient area and the chief of staff of the physician group, MacLeod recommends. "Do not do this with emotional plea. You need to develop a skilled strategy with some hard data to back it up," she says.

MacLeod suggests asking other departments, such as quality assurance, to help with the data indicators and how to present them to get the full effect.

The goal is to "tell the story" with data, ask for help from the whole hospital, and give a few recommendations as to how change could start, says MacLeod. **(See story on what data to measure, p. 76.)**

• **"Stay a bed ahead."**

Diversion often occurs because of problems securing inpatient beds for ED patients ready to be admitted, Hughes notes. "The senior management of our hospital is working with ED managers to decrease length of stay for admitted patients and increase availability of inpatient beds to the ED," she reports.

(Continued on page 76)

COMING IN FUTURE MONTHS

- Comply with Joint Commission patient safety standards
- Dramatically improve the way you manage pain in children
- Update on sentinel events and infusion pumps
- Bring parents along on pediatric transports

Communication of a Diversion Message

When communicating your diversion message, the following questions must be answered, according to **James J. Augustine**, MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting.

Why is the diversion occurring? It could be due to:
- ☐ safety reasons;
- ☐ ED compromised;
- ☐ certain hospital services unavailable;
- ☐ CT scan;
- ☐ monitored beds;
- ☐ critical care beds;
- ☐ dialysis, etc.;
- ☐ labor and delivery;
- ☐ a "nearby" hospital not compromised in its ability to deliver care.

Who is diverted? This list might include:
- ☐ all patients;
- ☐ care can take place temporarily in "parking lot" with rendezvous with on-site transport vehicles;
- ☐ no care can occur; facility and ED staff fully compromised;
- ☐ message must go out by EMS channels plus to the general public through the media;
- ☐ EMS patients;
- ☐ all EMS patients;
- ☐ patients who have an identified need that EMS personnel can recognize;
- ☐ all monitored patients;
- ☐ all trauma patients;
- ☐ all critical care patients
- ☐ all patients who may require CT scan (strokes, head injury);
- ☐ all patients utilizing a special hospital service, such as dialysis and labor and delivery, which is compromised.

How large a population and EMS system will be affected?
- ☐ Diversions from a regional referral center, such as the children's hospital, the trauma center, or the burn center, will need to be communicated widely.
- ☐ A hospital isolated in a large geographic area will be more difficult to divert.

What are the legal implications?
- ☐ Care compromise is not as defensible if uncompromised care is available for a patient within a reasonable transport time.
- ☐ Diversion policy must be developed and applied consistently and not subject to real or perceived financial motivation.
- ☐ Diversion, rendezvous, and transfer incidents each have EMTALA implications. Documentation should support medical judgment, clear communications, consistency, and lack of financial motivation.

How long will diversion last? It could last:
- ☐ a foreseeable and predictable time frame that is short (hours);
- ☐ an unknown but short time frame (hours);
- ☐ an unknown and lengthy time frame (structural collapse from an earthquake).

How will message be communicated and to whom? Communication could include:
- ☐ other surrounding EDs (by phone, fax, radio, or electronic interchange);
- ☐ local EMS;
- ☐ regional EMS;
- ☐ general public media;
- ☐ physician offices.

Is the ED physician medical control able to override the diversion decision? Options include:
- ☐ no, as in situations in which the ED is unsafe;
- ☐ yes, when the ED physician can assist in patient care in locations such as the parking lot;
- ☐ yes, when the ED can accommodate the patient, then arrange transport to another hospital;
- ☐ yes, when the ED physician can arrange a rendezvous with a skilled transport vehicle (helicopter or mobile intensive care unit);
- ☐ yes, when the patient will be evaluated in the ED and then further disposition decisions are made.

Is there a specific site to divert to? Options include:
- ☐ yes, (all children under the age of 14 are being diverted to _____ hospital);
- ☐ no, but call us and we may be able to help make decisions with you;
- ☐ no, and we cannot help make decisions (phones, radio and/or staff are unavailable).

Is rendezvous in the parking lot an option?
- ☐ The ED and/or hospital is compromised, but the parking lot available to transfer patients to another hospital with a higher level of care.
- ☐ A vehicle is placed in the parking lot with appropriate staff to perform rendezvous.
- ☐ ED staff available in the parking lot to assist in evaluation, urgent treatment, and the destination decision.
- ☐ EMTALA implications are addressed by good documentation.

SOURCES AND RESOURCES

For more information on diversion, contact:

- **Mary Fran Hughes**, RN, MSN, Emergency Department, Massachusetts General Hospital, 55 Fruit St., Boston, MA 02114. Telephone: (617) 724-4127. Fax: (617) 726-9202. E-mail: mhughes@partners.org.
- **Mary M. MacLeod**, RN, BSN, MBA, Emergency Services and Pre-Hospital Care, Hamilton Health Sciences Corp., Hamilton, Ontario, Canada L8L 2X2. E-mail: maclemar@hhsc.ca.
- **George D. Velianoff**, RN, DNS, CHE, Emergency Nurses Association, 915 Lee St., Des Plaines, IL 60016. Telephone: (800) 900-9659 or (847) 460-4000. Fax: (847) 460-4004. E-mail: GVelianoff@ena.org.

A publication titled *Diversion Policy Resource Guide* is available from the Emergency Nurses Association. The 12-page softcover guide contains information about developing an appropriate diversion policy to comply with the Emergency Medical Treatment and Active Labor Act. The cost is $7 for members plus a $5 shipping charge and $15 for nonmembers, plus $5 shipping and handling. To order a copy, contact:

- **Emergency Nurses Association**, 915 Lee St., Des Plaines, IL 60016-6569. Telephone: (800) 243-8362. Fax: (847) 460-4002. E-mail: astorders @ena.org. Web: www.ena.org/products/start.asp.

Guidelines for ambulance diversion are available from the American College for Emergency Physicians (ACEP). The guidelines were published in October 1999 as a policy resource and education paper (PREP) to supplement ACEP's January 1999 policy statement on ambulance diversion. Single copies are available free of charge. To order a copy of the policy statement or the PREP guidelines, contact:

- **American College of Emergency Physicians**, 1125 Executive Circle Drive, Irving, TX 75038-2522. Telephone: (800) 798-1822, ext. 6 or (972) 550-0911. Fax: (972) 580-2816. E-mail: info@ acep.org. Web: www.acep.org. For the January 1999 policy statement, go to "Policies/Resources" and click on "ACEP Policy Statements." Click on "List all policy statements" and scroll down to "Ambulance Diversion." For the October 1999 guidelines, click on "PREPs" on the home page.

Availability of testing, earlier discharge times, and staffing and support for the inpatient areas are being addressed, says Hughes. Two areas for additional inpatient beds will be opening over the next several months, she adds.

Constantly ask yourself: "If we have to accommodate one more patient right now, how would that happen?" MacLeod advises. "Most delays come from poor planning or no planning for the 'what if' scenario."

Plan for seasonal fluctuation in your patient population if there are any, recommends MacLeod. "Patient volumes are greater in the winter in colder climates, so plan for extra beds at this time," she says. ■

Here's what you need to measure

Want to reduce your diversion rates? You'll need to select indicators in order to track your progress, says **Mary M. MacLeod**, RN, BSN, MBA, director of emergency services and pre-hospital care for Hamilton Health Sciences Corp., a four-facility hospital system in Ontario, Canada. She suggests tracking the following:

- redirect or bypass rates for ambulances by day of week and time of day in eight-hour increments;
- admitted patient numbers by day of week and by department;
- calculation of lost revenue days on insurance of a patient not being in a inpatient bed;
- diagnostic delays;
- the time from the admissions order is written until the patient gets an inpatient bed by department;
- canceled surgeries due to no beds;
- cancellation rate for scheduled care of any kind;
- length of time from patient being "admitted" until the time they reach their inpatient bed;
- ED redirect and critical care bypass rates;
- length of stay for key diagnostic groups;
- telemetry or monitor rates and outcomes;
- consultant/specialist response time to ED after a referral is made;
- elective patient transfer wait times;
- isolation case rates;
- patient satisfaction.

A two-week "snapshot" of these data is all you need, says MacLeod. "Keep it simple," she advises.

Once data are collected on the various chosen indicators, the next step is to prioritize your needs and determine how changes will be handled, says MacLeod. "For instance, if you have high infection and therefore high isolation rates, and you have to close beds to keep the

infection contained, then you'll need to tackle this issue," she explains.

MacLeod offers solutions for this scenario:

• Close all extra beds and move the staff to another area.

• Open a closed area and move staff to that area to keep the bed numbers the same.

• If there is one patient needing isolation in a four-bed room, move the patient to a private room instead of closing the remaining three beds.

• Make sure that staff practice frequent hand washing. "This is key to keeping the area open and functioning even with isolation needs," MacLeod says.

• Obtain input from infection control nurses about patient needs and how beds can be used on the area. "Areas are often quick to close, but take a long time to reopen," says MacLeod. ■

Do you know which airway support method to use?

Not sure whether to use endotracheal (ET) intubation, laryngeal mask airways, or bag-mask ventilation to support a child's airway? New pediatric advanced life support (PALS) guidelines from the Dallas-based American Heart Association (AHA)[1] give you clear-cut recommendations, says **Teresa Ostler**, RN, ED educator and PALS coordinator at Primary Children's Medical Center in Salt Lake City. **(See resource box for information on how to obtain the guidelines, p. 78.)**

Here are current recommendations for each method of advanced airway support:

• **Bag-mask ventilation.**

Because bag-mask ventilation is safe, efficacious, and performed by all levels of emergency personnel with minimal training, and because a misplaced ET tube is lethal, bag-mask ventilation is now recommended unless the rescuer is experienced at pediatric intubation, says **Barbara Weintraub**, RN, MPH, MSN, pediatric critical care nurse practitioner at Northwest Community Hospital in Arlington Heights, IL.

She stresses that proper bag-mask ventilation takes practice. "Failure to make an adequate seal with the face mask leads to underventilation and, as a result, hypoxemia," Weintraub says.

All nurses who are expected to perform bag-mask ventilation as part of their job should receive training in this skill from experienced practitioners, such as in a PALS course, and then practice this skill on a regular basis, she advises.

Bag-mask ventilation is an effective airway maneuver for most situations, says Weintraub. "Bag-mask ventilation should be a priority in airway management, rather than endotracheal intubation, in most pediatric critical care situations," she adds.

Bag-mask ventilation using the "E-C" hand position is the recommended technique, says Wolff. "The thumb and forefinger ("C") encircle the top of the mask. The remaining three fingers ("E") are used to stabilize the mask by holding the jaw," she explains.

Use of LMAs emphasized

• **Endotracheal intubation.**

According to the guidelines, the primary emphasis will be on improved bag-mask technique and use of laryngeal mask airways (LMAs), instead of endotracheal intubation, says Ostler.

The AHA recognizes the difficulty in maintaining the skill level of pre-hospital providers who don't have the opportunity to practice their skills on a regular basis, says **Michele Wolff**, RN, MSN, CCRN, professor of nursing at Saddleback College in Mission Viejo, CA.

• **Laryngeal mask airways.**

The new guidelines recommend the use of LMAs, when properly placed by trained professionals, says Wolff.

The LMA is a tube with a large cuff on the distal end that is placed in the child's pharynx and advanced to the point of resistance, Wolff explains. "When the balloon is inflated, the hypopharnyx is sealed, leaving an opening in the airway above the glottis," she says.

These devices can be safely used in children who do not have a gag reflex, advises Wolff. "They have most frequently been used in the operating room," she says. "As with tracheal intubation, proper training and practice are needed for providers to learn and retain their skills."

There is evidence that LMA placement techniques may be easier to master than tracheal intubation

EXECUTIVE SUMMARY

New guidelines clarify when to use endotracheal (ET) intubation, laryngeal mask airways, or bag-mask ventilation to manage a child's airway.

- Because a misplaced ET tube is lethal, bag-mask ventilation should be used unless the rescuer is skilled at pediatric intubation.
- Bag-mask ventilation using the "E-C" hand position is the recommended technique.
- The guidelines recommend the use of laryngeal mask airways, but only when properly placed by trained professionals.

RESOURCES

The *Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care* were published in the Aug. 22, 2000, issue of *Circulation*, the official journal of the American Heart Association (AHA). Reprints are available for $20 plus $7 shipping and handling. To order, contact:

- **Channing L. Bete**, 200 State Road, South Deerfield, MA 01373-0200. Telephone: (800) 611-6083 or (413) 665-7611. Fax: (800) 499-6464 or (413) 665-2671. Web: www.channing-bete.com.

Key changes are outlined in the AHA web site: www.cpr-ecc.americanheart.org. Click on "What's New" for information on major changes in the guidelines, training materials, training courses, and international programs.

The Fall 2000 issue of *Currents* contains a 28-page summary of the new guidelines. Individual copies are available for $5, including shipping and handling. To order a copy, contact Pro Education International, 27500 I-45 N., Suite 124, Spring, TX 77386. Telephone: (888) 999-4210 or (281) 419-8596. Fax: (281) 419-8238. E-mail: support@CurrentsOnLine.com. The complete guidelines are available in CD-ROM format with full search capability for $20 plus a $4.95 shipping charge. They can be ordered at: www.CurrentsOnLine.com/sales/guidelines2000.htm.

techniques, notes Wolff. "As with any new practice, nurses are advised to consult their state boards of nursing to determine their scope of practice related to placement of these devices," she advises.

It might be more difficult to maintain proper LMA placement during transport as compared to tracheal intubation, says Wolff. "Therefore, use of these devices for transport may be problematic," she says. "Currently, pediatric-sized LMAs are only available as a relatively expensive, nondisposable item. There is a limited range of sizes available, so this device may not fit some infants and children properly."

Reference

1. Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation* 2000; 102:suppl I. ■

JOURNAL REVIEWS

Fry M. **Triage nurses order X-rays for patients with isolated distal limb injuries: A 12-month ED study.** *J Emerg Nurs* 2001; 27(1):17-22.

Triage nurses can safely, accurately, and appropriately assess patients and order X-rays for patients with distal limb injuries before physician assessment, says this study from St. George Hospital in New South Wales, Australia. Triage nurses were educated on X-ray protocols, pain assessment, radiation safety information, and documentation guidelines. Over one year, triage nurses ordered 876 X-rays and physicians ordered 930, with equal proportions of upper and lower limb X-rays. The triage X-ray abnormality rate was 43%, and the medical staff abnormality rate was 33%.

These results show that the triage nurses ordered fewer X-rays than the physicians and with greater accuracy. The researcher speculates that this difference might be explained by the triage nurses' need to identify positive clinical findings before ordering X-rays, while physicians often order X-rays based on suspicion.

By having their distal limb X-rays ordered as soon as the patients arrived in the ED, the film was available by the time the patient was seen by the physician, the researcher stated.

"The early triage X-rays ordered by the nurse reduced frustration for both staff and patients," wrote the researcher.

Although some triage nurses thought ordering X-rays slowed the triage process, all acknowledged the benefits of this practice. Additionally, the triage nurses reported an increase in clinical confidence and job satisfaction.

According to the study's findings, the ED staff said this new triage practice increased patient satisfaction and improved patient flow and waiting times. "The ED personnel perceived that triage nurse-initiated X-rays assisted with the problem of aggressive patients frustrated with long waiting times," wrote the researcher. ▼

Horn K, Gao X, Williams J, et al. **Conjoint smoking and drinking: A case for dual-substance intervention among young emergency department patients.** *Acad Emerg Med* 2000; 7:1,126-1,134.

It's possible to identify conjoint cigarette smokers and drinkers in the ED setting through a brief screening, says this study from West Virginia University School of Medicine in Morgantown.

The study found conjoint cigarette smoking and alcohol use was prevalent among the 1,169 young adult ED patients who were screened. The Alcohol Use Disorders Identification Test (AUDIT) screening tool was used to assess alcohol problems, and cigarette smoking status was determined by asking patients: "Do you currently smoke cigarettes?" Of the participants, 43% screened positive for alcohol problems, and 61% of those were current cigarette smokers. Here are key findings about conjoint users:

- Women were more likely to be conjoint users rather than drinkers only.
- Conjoint users were more likely than drinkers only to have high school or less education.
- Conjoint users were more likely than drinkers only to have emotional problems, which was self-reported by patients using a survey tool.
- Marijuana use was more common among conjoint users than drinkers who did not smoke commercial cigarettes.
- Young females who had low educational levels, were not currently students, had some emotional problems, and/or currently used marijuana were at highest risk of conjoint drinking and smoking commercial cigarettes.

The researchers suggest EDs use a screening and brief intervention approach to address conjoint use. For example, after asking if the patient smokes and administering the AUDIT test, providers could briefly address stress management and coping skills, give patients educational materials, and stress self-help techniques.

"This type of approach includes minimal demands on providers' time and resources, emphasizes self-help and behavioral self-management techniques, and has shown effectiveness with reducing hazardous drinking and smoking cessation," they wrote. ▼

Kuhn M, Bonnin RL, Davey MJ, et al. **Emergency department ultrasound scanning for abdominal aortic aneurysm: Accessible, accurate, and advantageous.** *Ann Emerg Med* 2000; 36:219-223.

Even ED physicians with limited training can accurately identify the presence or absence of abdominal aortic aneurysms (AAAs) with bedside ultrasound scanning, says this study from Royal Adelaide Hospital in Australia.

The aortic ultrasound scans are a useful screening tool for high-risk ED patients and also rapidly verify the diagnosis in patients who might need immediate surgical intervention.

Patients with suspected AAAs had ultrasound scanning by an ED physician. Of 68 scans, 26 were positive, 40 were negative, and two were indeterminate. The scan interpretations were 100% accurate.

The potential impact of the ED scans was ascertained by comparing the pre-ultrasound and post-ultrasound assessment plans. The study found the ED scans would have improved the care of 46 patients and would not have adversely affected any patient.

In patients with AAAs, the ultrasound examinations appeared to benefit all aspects of patient care: improving diagnostic accuracy, eliminating additional investigations, improving treatment decisions, and expediting the patients' transfer to surgery.

The researchers argue performance of bedside aortic scans by ED physicians instead of ultrasonographers might ensure 24-hour availability of this service. They write: "We believe that bedside aortic scans by emergency physicians will have a significant impact on patient care and should be incorporated into the standard management of patients older than 50 years of age who present with abdominal/back pain." ■

Here's how to prevent assaults by patients

***(Editor's Note:** This is the second of a two-part series on violence in the ED. Last month's* ED Nursing *covered reporting and documentation of assaults. This month, we tell you how to prevent assaults.)*

When a belligerent 32-year-old man came to the ED at Community Medical Center in Missoula, MT, demanding Percocet for ear pain, the ED physician refused to give him the medication.

"He had been to our facility three times in less than two weeks and had an extensive work-up, including a CT of the head. All tests and exams were normal, and a cause for his continued pain could not be found," explains **Dianne Rallis-Peterson**, RN, CEN, charge nurse for the ED.

When the ED physician offered an alternative pain medication, the patient became hostile and started shouting obscenities. "The patient's anger escalated to the point where he started throwing things onto the floor and verbally threatened to harm us," says Rallis-Peterson. "While the physician calmly interacted with him, we activated our 'response team' and called the police."

Within one minute, the patient was surrounded by several individuals from the response team. By the time the police arrived, the patient had left the ED. "When he saw the number of men who were closely watching him, the patient realized that he couldn't

EXECUTIVE SUMMARY

You must take active steps to prevent assaults by patients and assure your personal safety.

- If your ED does not have a security guard, form a "response team" of individuals to come to the ED for support when staff feel threatened.
- Consider the underlying cause of violent behavior, such as intoxication, delirium, or psychosis.
- Assess all patients for violent tendencies.

continue to intimidate us," says Rallis-Peterson.

She points to the scenario as the type of proactive approach you'll need to take to increase your safety.

Response team outnumbers patient

Here are other ways to prevent assaults:

• Form a "response team."

At Community Medical Center, the ED has no security guard, but a "response team" is called by dialing "2222" when staff members feel threatened by a patient. The members on the team are all men from various areas throughout the hospital and include male nurses on the floors, maintenance workers, the orderly, and the house supervisor.

"The idea is that people who are out of control or threatening to the staff will settle down once they see they are outnumbered," Rallis-Peterson explains. "The number may vary, but generally we have four to seven men come to the ED in less than a minute," she says.

She notes that the response team is not allowed to touch the patient in a threatening manner. "If the patient is truly threatening with a weapon, we call 911 and get law enforcement to respond," she says.

• Have at least one area that is secure.

Community Medical Center's ED has a unit that is behind a locked door. "It's not only the patients that can be violent. Their friends and family members have also been a threat to us on occasion," says Rallis-Peterson. "It's good to have a barrier between us and them if needed."

• Determine what's causing the patient to be violent.

Treatment may depend on your finding the underlying reason for the patient's behavior, says Rallis-Peterson. "This may require all the skill we have, and a large amount of intuition," she notes.

For example, the root of the problem might be pain, fear, drug-induced behavior, or a psychosis or delirium from a metabolic disorder, she says.

"For instance, it does no good to treat a patient with an antipsychotic medication if their behavior is the result of an insulin reaction," she says.

• Realize that any patient can become violent.

Any patient may cause physical harm, says Rallis-Peterson. "It's not just the gang members packing heat. It could be the 5-year-old who doesn't want his lab work drawn and delivers a swift kick to the nurse's rib

Use all of your senses to assess ED patients

The way you assess a patient for violence can prevent assaults from occurring, according to **Dianne Rallis-Peterson**, RN, CEN, charge nurse for the ED at Community Medical Center in Missoula, MT.

"Nurses need to use all of their senses when assessing a patient," she stresses. She recommends using your senses to answer the following questions:

• **Smell.** Is there a scent of alcohol, ketones, or marijuana? "Any of these scents can be a harbinger of violence," says Rallis-Peterson.

• **Sight.** Does the patient appear rigid or agitated? Does he or she seem depressed? What is the color of the skin (cyanotic, pale, etc.)? Is there evidence of recent needle tracks? Is there evidence of previous head injury such as scars or deformity of the head? Is his or her hygiene indicative of neglect?

• **Sound.** What is the tone of voice like? Is the person verbally abusive? Is there hostility in his or her voice, or does his or her voice sound menacing? Are they speaking in monotones? A monotone voice, coupled with lack of eye contact and "flat" facial expression, might indicate depression or drug abuse, says Rallis-Peterson.

"You may get a feeling that something isn't right with this person, just as if you were glared at by the patient," she says. "That makes you a little more alert for possible psychological problems."

• **Touch.** Is his or her skin cold and clammy, as in an insulin reaction? Or is it hot and dry, indicating a high fever?

• **Intuition.** How does this person make me feel? "I am aware of the hairs on the back of neck standing up when something isn't right about a person," says Rallis-Peterson. "You may begin to feel antsy around the patient or become hyperalert." ■

Here's a checklist to prevent violence

Remove environmental factors in your ED that may provoke those with violent tendencies, urges **Tracy G. Sanson**, MD, FACEP, assistant medical director for the department of emergency medicine at Brandon (FL) Regional Medical Center.

She recommends using the following checklist to prevent violence:

- ☐ Have greeters direct patients and family members.
- ☐ Give realistic expectations, and keep patients informed about delays.
- ☐ Provide consultants with specialized equipment, a quiet place to dictate, centralization of charts, and necessary paperwork.
- ☐ Have policies for dealing with patients in police custody, psychiatric patients for medical clearance, weapons and traffic in the ED, controlled access to the ED and hospital, police and security responsibilities, and response time to calls for help.
- ☐ Review incident reports to look for trends of involvement by ED personnel, then provide counseling and education.
- ☐ Provide a welcoming, calming surrounding.
- ☐ Reduce irritating background noise.
- ☐ Have clean waiting rooms and bathrooms.
- ☐ Have telephones and vending machines.
- ☐ Ensure parents control their children in the waiting room and the examination rooms. Consider a children-only room or volunteer "sitter" program.
- ☐ Install security lighting and protective barriers.
- ☐ Improve surveillance and your ability to monitor offensive behavior by positioning trained personnel in the waiting room and installing monitored security cameras.
- ☐ Develop safe money-handling procedures, such as having a locked safe box at the checkout desk and posting signage about the amount of cash on hand.
- ☐ Have trained and experienced staff.
- ☐ Increase staff at peak and night periods to reduce stress and delays and help meet realistic deadlines.
- ☐ Address adequate outside lighting.
- ☐ Examine and address employee isolation factors, such as staff who are isolated from the rest of the ED at registration or triage. Ensure they have a mechanism to immediately summon help, such as a silent duress button, and arrange escorts to parking lots.
- ☐ Provide security personnel.
- ☐ Request increased police patrol in the area.
- ☐ Post laws against assault, stalking, or other violent acts. Obtain copies of these from your hospital's legal counsel.
- ☐ Post signs addressing on-site cash or narcotic availability.
- ☐ Control access to the ED by installing security cameras at all doors to monitor and deter "tag-along" entrances, installing locks requiring a swipe of an ID card, and having visitors obtain a pass and sign in with security.
- ☐ Review management strategy for layoffs and disciplinary actions to ensure the employee has had access to counseling services, confidential employee assistance programs, and community programs to assist in their transition.
- ☐ Ensure access to employee assistance program or other counseling program.
- ☐ Develop a policy regarding restraining orders. **(For more information on restraint, see *ED Nursing*, October 2000, p. 149, and December 2000, p. 27.)** ■

cage, or the demented 80-year old who grabs the nurse by the hair and bites and claws at her hands," she says.

Any individual put in the right situation might become violent, stresses **Tracy G. Sanson**, MD, FACEP, assistant medical director for the department of emergency medicine at Brandon (FL) Regional Medical Center.

"Patients at risk for violence include the executive with a migraine who will miss a meeting, the parent with a child about to get off a school bus, the consultant again dealing with malfunctioning equipment," she says. "The list goes on and on and fills our EDs every day."

All patients need to be assessed for their potential for violence at each visit, Rallis-Peterson stresses. "Coworkers need to be aware and listening for escalating tension," she adds. **(See ways to assess patients, p. 79.)**

• Don't allow a patient's agitation to become "contagious."

Let your calm demeanor soothe a distraught patient, advises Rallis-Peterson.

"I try to stay in control, so that the patient can get in control," she says.

• **Never say exactly what you are thinking if you are getting angry.**

"That can be very hard, especially if the patient is verbally abusive," admits Rallis-Peterson. "But anything said that inflames the patient further can escalate a trend toward violence."

She recommends avoiding accusatory phrases such as: "Your problem is worse because you are a noncompliant patient," or "What happened to your last prescription? You just received 20 Percocet yesterday."

Don't patronize or be condescending, she advises. "Often, agitated patients are highly sensitive to what the nurses are saying and doing," she notes. "They get very upset if they see the nurses off in a group talking about them." ■

SOURCES

For more information about prevention of assaults, contact:

- **Dianne Rallis-Peterson**, RN, CEN, Emergency Department, Community Medical Center, 2827 Fort Missoula Road, Missoula, MT 59801. Telephone: (406) 728-4100. Fax: (406) 327-4505. E-mail: Dpetson@aol.com.
- **Tracy G. Sanson**, MD, FACEP, Department of Emergency Medicine, Team Health Affiliate, Brandon Regional Medical Center, 119 Oakfield Drive, Brandon, FL 33511. Telephone: (813) 681-0503. Fax: (813) 948-8477. E-mail: oaks61596@aol.com.

Could this assault have been prevented?

When **Dianne Rallis-Peterson**, RN, CEN, an ED charge nurse at Community Medical Center in Missoula, MT, was treating a patient with a head injury, the irate man grabbed the ends of her stethoscope and tried to strangle her by crossing it around her neck and pulling it tight.

The man falls frequently due to a head injury and often comes to the ED for suturing, she said. "On this particular day, he received a nasty laceration to his forehead and was in an angry mood when he arrived," she recalls. "Everything we did to help him was making him more irritable. Even washing the blood off of his face, neck, and hands didn't appease his bad mood."

The nurse found herself getting irritable. "When the man said there was something wrong with the bandage on his head, I told him that it was fine and needed to stay on," she recounts. "The wrap was perfect, the bleeding was controlled, and his ears where pinned flat against his head and not folded over. It looked fine to me."

In response, Rallis-Peterson raised her voice and told the man to leave the bandage on. "I stood in front of him with my hand on my hip, made a loud sigh, and looked annoyed," she says. "He knew I was getting exasperated. I'm sure my body language and tone of voice spoke volumes."

Suddenly, the man reached for the ends of the stethoscope and wrapped them around her neck. "He got my attention — 100% of it! He told me what I needed to hear through his clenched teeth," she recalls. "I began to choke and grabbed his hands. He let go."

Here, Rallis-Peterson analyzes what she could have done to prevent this assault:

First, she failed to address the reality that she was losing her patience. Rallis-Peterson says if she had acknowledged her increasing tension, she would have requested a co-worker to assist or take over the patient's care.

"We do this a lot for each other when we have a patient that we 'just can't take anymore,'" she says.

Nurses swap patients

Some patients react well to some nurses but not with others, notes Rallis-Peterson. "The same goes for the staff. There are a few patients that I simply have a terrible time tolerating," she admits. "They frustrate me to no end. In those cases, I'll purchase a double latte or soft drink of the nurse's choice if they take over the care. The offer is reciprocal, too."

Secondly, Rallis-Peterson didn't pay attention when the man complained about the dressing being too tight. "He had just sustained a good bump to his head, there was swelling and tenderness, plus he had a whopper of a headache," she notes. "In my enthusiasm to control all bleeding, which actually was not a problem at the time, I applied a nice tight dressing, unaware at how painful it was for him."

Rallis-Peterson left the bedside shaken, and a co-worker loosened the dressing and gave him a couple of Tylenol. When she returned and apologized to the patient for the dressing problem, the man also apologized and thanked her for taking care of him.

"I always take off my stethoscope and roll it up in my pocket when I have this person in the department. I encourage others to do the same," she says.

To prevent future violence, staff should be encouraged to report all incidents, even minor ones, urges **Tracy G. Sanson**, MD, FACEP, assistant medical director for the department of emergency medicine at Brandon (FL) Regional Medical Center. "This includes intentional verbal or physical behavior that threatens, intimidates, or results in injury, as well as acts of violence against a person or property," she adds. **(See Sample Incident Report, inserted in this issue.)**

Nurses are more likely to report incidents if they know the form used is confidential and it identifies its destination, such as the hospital's risk management department or safety committee, says Sanson. "Credibility is dependent upon whether reports are handled quickly and effectively." she adds.

Word spreads quickly and damages the whole process when a report is made and nothing is done, when a report is handled improperly, or when the allegations are not treated confidentially, stresses Sanson.

Avoid these problems by maintaining an internal tracking system of all threats and incidents of violence,

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 *Are you putting patients at risk with dangerously high diversion rates? Do you know which airway support method to use?* 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. ■

Subscriber Information
Customer Service: (800) 688-2421 or Fax (800) 284-3291.
World Wide Web: http://www.ahcpub.com.
E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $299. With approximately 16 CE contact hours, $349. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $239 per year; 10 or more additional copies, $179 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $48 each. (GST registration number R128870672.)

Editorial Questions

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

ED Nursing™ (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to ED Nursing™, P.O. Box 740059, Atlanta, GA 30374-9815.

ED Nursing™ is approved for approximately 18 nursing contact hours. This offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: Staci Kusterbeck.
Vice President/Group Publisher: Brenda Mooney.
Managing Editor: Joy Daughtery Dickinson, (joy.dickinson@ahcpub.com).
Production Editor: Nancy McCreary.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Sanson urges. "Either staff experiencing or observing the behavior may file a report," she says. "Consider starting a hotline for staff to report these incidents."

Most violent and aggressive behavior is criminal in nature, says Sanson. She recommends calling the police immediately if a patient does any of the following:

• makes any threats: verbal or physical;

• acts destructively (hits the walls, destroys equipment, or hits someone);

• is noisy, hyperactive, and won't quiet down after one or two requests;

• is armed (e.g., gun, knife, or broken bottle).

Do not try to negotiate with a person displaying this level of aggression, says Sanson. "Allow the police to come and evaluate the situation, even if the situation calms down," she advises. ■

Your ED can create a 'pedi-corner' for kids

Create a designated "pedi-corner" to store all of your pediatric resource materials, recommends **Wrennah L. Gabbert**, RN, MSN, CPNP, CFNP, education coordinator for emergency services at Cook Children's Medical Center in Fort Worth, TX.

This ensures that materials are easily accessible with 24-hour access, she says. The pedi-corner consists of the following:

• a shelf with several current, user-friendly nursing and medical pediatric textbooks, such as a pediatric specific dermatology text;

• a file cabinet drawer with developmental assessment forms such as standardized height, weight, and head circumference documentation forms; vaccine information sheets; and age-specific health promotion and education materials in well-marked file folders;

• a three-ring binder with original copies of all the forms available in the file cabinet drawer, current immunization guidelines, and an up-to-date list of in-house and external pediatric referral and support systems with appropriate beeper numbers, telephone extensions, and contact information.

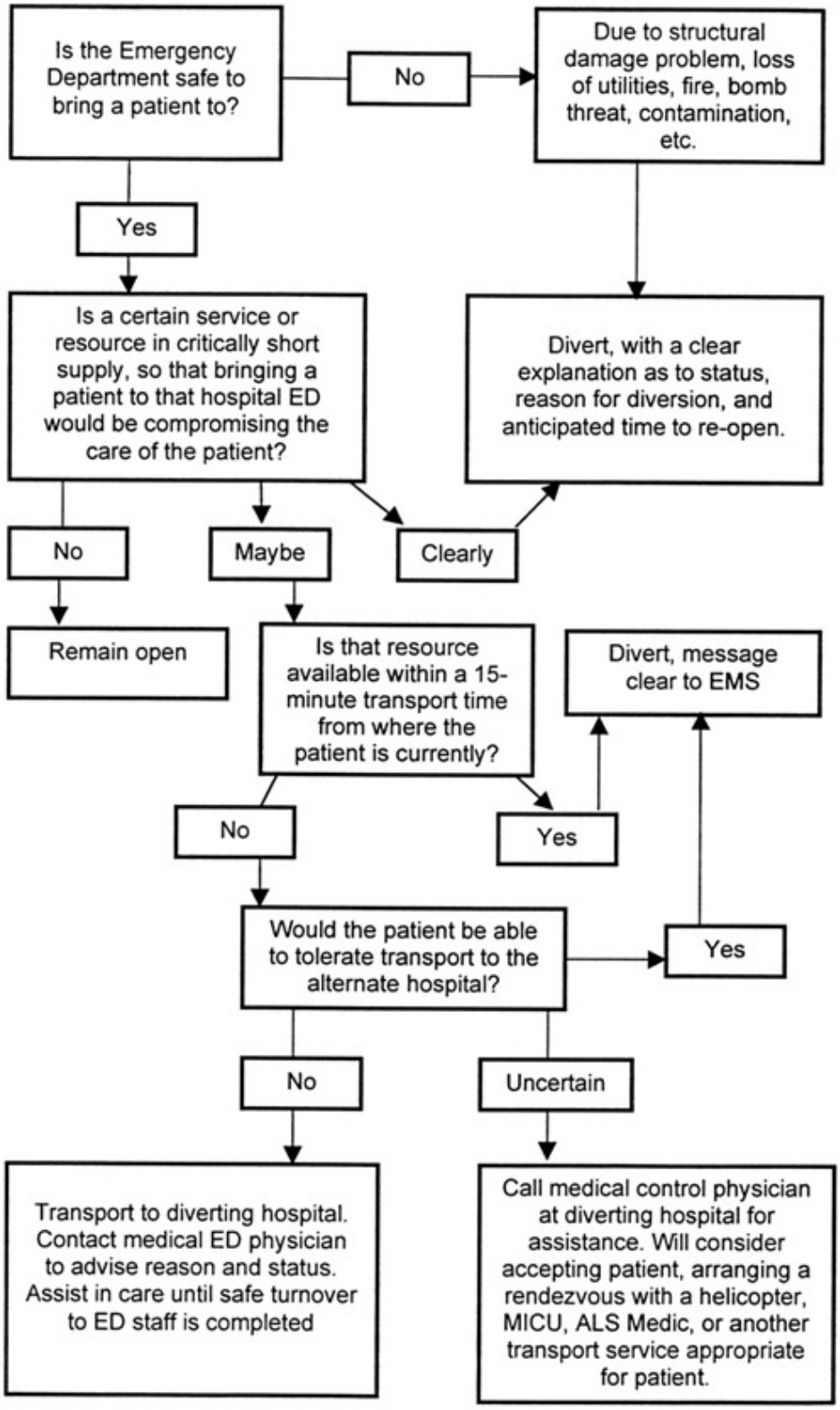
"We found our brightly colored, inexpensive three-ring binder and clear plastic page protectors were essential to help catalog, update, and organize our written materials," says Gabbert. "Additionally, the page protectors kept splatters and spills from ruining our resources."

Barney, a big brown bear with a crooked grin, sits on top of the file cabinet and "keeps watch" over the pedi-corner, says Gabbert. "He also serves as an easily identifiable landmark for clinic personnel, especially new or part-time employees," she adds.

Initially, posters were used as an inexpensive way to add color and a distinctive "kid-friendly" appearance to the wall behind the pedi-corner, Gabbert says. "Later, we were able to get a large bulletin board mounted so we could post seasonal safety and health promotion messages," she notes. "Frequently, we found our patients and their parents lingering to get a close look at our corner wall and read the latest message."

By storing all pediatric resources in one designated area, less time is spent searching for equipment or information, says Gabbert. "That leaves you with more time to discuss age-specific health promotion and educational materials with our young patients and their families," she adds. ■

Diversion Decision Diagram



Source: Premier Health Care Services, Dayton, OH.

Desert Springs Hospital Diversion Plan 2000-2001

The Emergency Department sees approximately 35,000 patients yearly with an admissions rate of 24%. The national average admission rate is reported at 17% to 18%. This may suggest the acuity at Desert Springs Hospital is greater than the average ED. This higher than average admission rate coupled with inefficiencies in patient flow, shortage of ICU beds and staff, has caused the ED to back up, necessitating the need for the ambulance service to divert patients to other facilities. The number of hours on emergency divert has increased from 18% to 32% and from 31% to 77% for critical care divert. The following recommendations are suggested to streamline the admission process and decrease the length of stay of admitted patients in the Emergency Department, thereby reducing the number of hours on divert:

A. Facility recommendations.

1. Expand critical care by 12 beds. Project to be complete and operational by Dec. 1, 2000.
2. Utilize outpatient holding area for post-percutaneous transluminal coronary angioplasty (PTCA) recovery to allow additional capacity in Intermediate Care. Intermediate Care currently has 22 beds, and many of them are utilized for post-PTCA patients.
3. Utilize lounge chairs in pre-op for discharged patients waiting for transportation.
4. Utilize the flow behind the back section of the ED for overflow, mental health, and inebriated patients.

B. Patient flow recommendations.

1. Divert Avoidance Response Team (DART) to be activated prior to the ED necessitating divert. Criteria: 3 ICU/CCU holds and/or 10 admitted holds in any level of care combination. DART includes administrator on call, medical director, nursing supervisor, admit nurse, housekeeping supervisor, case manager, ED manager and/or ED physician. The goal of DART is to take a proactive approach to divert avoidance and change the culture of diverting first and then attempting to alleviate the backlog.
2. Develop a standardized short order sheet for initial orders to allow for quick initiation of the admission process. Currently, the time difference between the decision to admit the patient and actually completing the initial orders is 60-75 minutes. The admission process begins once the initial admission orders are recorded, NOT when the ED physician decides to admit the patient.
3. Work with managed care companies to expedite the admission process. Patients are currently held for several hours in the ED waiting for admission assessment by the managed care physician.
4. Implement a nurse/transporter team to facilitate the admission from the ED to the nursing unit. This team would transport the patient, perform initial orders, and perform the orientation of the room and nursing unit to the patient. This process would eliminate delays due to staff nurse unavailability at the time the admission is required.
5. Implement protocols to expedite routine testing to begin at point of triage.
6. Identify a gatekeeper to meet and greet ambulance upon arrival.
7. Implement bedside registration with short form registration for ED patients to expedite initial assessment process.
8. Enforce ICU/CCU and Intermediate Care admission criteria to assure appropriate patient placement.
9. Radiology to transport patients from the ED instead of ED staff.
10. Laboratory to draw patients in Radiology instead of waiting for return to ED to expedite processing of lab tests.

C. Equipment recommendation.

1. Rent monitors and ventilators to prevent unavailability experienced last year.

D. Staffing recommendations:

1. The nursing/tech schedule in the ED has traditionally been static with no swing shifts coinciding with busier times in the department. Schedules are being restructured with additional swing shifts to increase staffing during busier hours.
2. Continue to recruit RNs and CNAs to meet staffing standards.
3. Work with statewide nursing recruitment task force to change regulations to allow paramedics to function in the ED.

Source: Desert Springs Hospital, Las Vegas.

Sample Incident Report

Incident: Date_____ Time _____ Place_____

Person completing report _____

Victim description
Name: _____
____Age ____Gender
____Stranger
____Visitor
____Personal relation
____Employee
____Co-worker
____Supervisor
____Patient
Medical record number _____
____Other
If other, describe:_____

Supervisor: Has supervisor been notified? Yes____ No____

Describe the incident._____
_____
_____
_____
_____

____ Verbal threat, intimidation
____ Physical threat/gesture
____ Physical assault

Did the assault involve a firearm? If so, describe._____
Did the assault involve another weapon (not a firearm)? If so, describe._____
Was the victim injured? If yes, please describe_____
_____
_____

What happened prior to the event?_____
_____
_____

What events triggered the incident?_____
_____
_____

(Continued)

Assailant description

Name:_____

____Age ____Gender
____Stranger
____ Visitor
____Personal relation
____Employee
____Co-worker
____Supervisor
____Patient
Medical record number _____
____Other
If other, describe:_____

_____

Please identify any risk factors applicable to this incident.
____Alcohol
____Illicit drugs
____Mental illness
____Grief reaction
____Violent history
____Organic illness
____Delays
____Trauma related
____Other
If other, describe:_____

Other risk factor: _____
Other risk factor: _____

What steps could be taken to avoid a similar incident in the future? _____

_____

_____

Interventions
____De-escalation
____Physical restraint
____Chemical restraint
____Arrested
____Evicted

Security: Not involved ____ Present____ Notified _____

Response time _____

Police: Not involved ____ Present____ Notified _____

Response time _____

Source: Tracy G. Sanson, MD, FACEP, Brandon (FL) Regional Medical Center.