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ED Management

The monthly update on Emergency Department Management

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June 2001

Are you putting patients in danger? Heed warning on infusion pumps

Surveyors want to see evidence of safety measures and education

An adult patient comes to the ED with dangerously low potassium levels, requiring potassium via IV pump. The total volume of potassium is reversed with the rate of infusion, due to a user error. Instead of receiving 20 milliequivalents/hour (mEq/hour), the patient received 60 mEq/hour in 20 minutes. After receiving three times the intended amount of potassium in a shorter length of time, the patient dies.

In response to tragic situations like this one, surveyors will be asking questions about the use of infusion pumps, says **Kathleen Catalano**, RN, JD, director of administrative projects at Children's Medical Center of Dallas and a former consultant specializing in regulatory compliance. Last year the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, issued a *Sentinel Event Alert* warning about the dangers of infusion pumps. **(See resource box to learn how to obtain the *Sentinel Event Alert*, p. 63.)**

Infusion pumps are potentially dangerous because the wrong drug concentration can be given, the wrong rate can be set, and there is a possibility of decreased respiratory rate with continuous narcotic infusion, warns **Cindy Bruns**, RN, BSN, CEN, quality management coordinator for the Emergency Center at Tallahassee (FL) Memorial Hospital.

Red flags for surveyors include the use of pumps without free-flow protection, multiple types of pumps in use, and lack of coordinated education including a multidisciplinary team to evaluate infusion pumps, says Catalano. If an

Executive Summary

During on-site surveys in 2001, surveyors will be asking about your use of infusion pumps.

- The ED is at higher risk for errors and adverse outcomes than other departments because of the types of drugs given and time constraints.
- Do not use pumps without protection from the free-flow of intravenous fluid/medication into the patient.
- If your hospital is considering a change in infusion pumps, make sure someone from the ED is involved in the product evaluation.

5 actions you must take now

You should do the following five things regarding the use of free-flow infusion pumps:

1. Identify all pumps with potential for free-flow errors, including those with confusing labeling.
2. Sequester/quarantine/phase out the use of unprotected devices.
3. Petition the Food and Drug Administration to withhold/withdraw approval of IV pumps that permit free-flow.
4. Petition manufacturers to stop production and sale of free-flow pumps.
5. Continue to report errors associated with the use of IV pumps that do not protect against free-flow so that accurate frequency and severity of these errors can be assessed. ■

Source: Reprinted with permission from the U.S. Pharmacopeia, *Practitioners' Reporting News*, "Free-Flow IV Pumps," 7/99, www.usp.org/reporting.

incident does occur, the ED is at higher risk for an adverse outcome than other departments because critical care drugs are given more frequently, she adds. **(See box with suggested actions from U.S. Pharmacopeia, above.)**

"Also, ED staff are under pressure of time constraints, so there is a higher risk of error," says Catalano.

Actions you can take now to avoid problems include:

• Do not use pumps without protection.

The *Sentinel Event Alert* warns against using pumps that don't provide protection from the free-flow of intravenous fluid/medication into the patient, says **Ann Kobs**, president and CEO of Type 1 Solutions, a Fort Meyers, FL-based compliance consulting firm specializing in preparation for Joint Commission surveys.

"Check what kind of pumps your organization uses," she advises. "If they do not have a lock-up mechanism, do not use them."

Free-flow pumps have no safety valve for the amount of fluid that will flow into a patient, Catalano says. "It's like a run-away IV left at wide-open," she explains.

Pumps not always user-friendly

Many infusion pumps on the market are not user-friendly, says Catalano. "Some are so 'busy' with instrumentation you can't tell what buttons to push to set the pump," she explains.

• Make sure staff read the *Sentinel Event Alert.*

Kobs suggests placing the *Sentinel Event Alert* into paycheck envelopes. "You should definitely post it in the break room. One surefire way to get staff to read it is to post it on the door inside the toilet stalls."

• Have staff train others to ensure competence.

Kobs points to "peer pressure" as an effective tool to ensure competence. "As a manager, I would observe and critique two of my 'weak links' until they had it perfect," she says. "Then I would charge them each with observing and critiquing two folks apiece. Then those four can each do two more until all staff are 'signed off' by their preceptor."

• Educate staff.

Even if appropriate pumps are used, infusion pumps can be dangerous, warns Kobs. "Problems can occur when the wrong drug concentration is given or the wrong rate is set," she says.

Kobs stresses that training and education are not foolproof. Even if inservicing is done appropriately, a patient, family member, or visitor might still handle a pump incorrectly, she notes.

Inservice all appropriate staff

Most EDs provide inservice education on the pumps for nurses, but not for other staff who might handle the pumps, she says. These individuals include orderlies, radiology technicians, and nurse assistants who transport patients. "At a minimum, they should know when to call for the professional person managing the pump," says Kobs.

If an individual has not been trained thoroughly on the use of the particular infusion pump used, do not have that person use the pump, urges Catalano.

Every individual must have a competency for the particular infusion pump being used, she says. "Ensure that each person has been instructed on the differences in the amount of fluid and medication doses for various-age patients, including infant, child, adolescent, adult, and geriatric patients," she adds.

There should be competency-based, age-specific, and unit-specific education, says Catalano. "Education should be dependent on the most frequent fluids and medications given in your ED via an infusion pump," she adds.

At Tallahassee Memorial, mandatory staff inservices for use of infusion pumps are held, including hands-on instruction. "Each nurse has to demonstrate her ability to set up a PCA pump," says Bruns.

• Use the buddy system.

Catalano suggests having infusion pumps set on a buddy system. "Two individuals check the pump to be

Resources

The Joint Commission's *Sentinel Event Alert*, "Infusion Pumps: Preventing Future Adverse Events," identifies the most common human and mechanical errors associated with infusion pumps and provides recommended steps to avoid such errors. It can be found on-line at www.jcaho.org. (Click on "Patient Safety/Sentinel Events," "Sentinel Event Alert," and then "Sentinel Event Alert" again. Scroll down to the Nov. 30, 2000, issue.) You can sign up to receive *Sentinel Event Alert* via e-mail by going to the *Sentinel Event Alert* home page. To get the latest copy of *Sentinel Event Alert* by fax, call the Joint Commission's fax-on-demand line at (630) 792-3885, and press 4.

The U.S. Pharmacopeia has published an alert on free-flow IV pumps that can be accessed free of charge on the organization's web site (www.usp.org). Click on "Practitioner Reporting," "Practitioners' Reporting News," and then "Med Error Reports." Scroll down and click on "Alert! Free-Flow IV Pumps." MedMARx is an Internet-accessible national database for hospitals to report medication errors, available through the U.S. Pharmacopeia. For more information, contact:

- U.S. Pharmacopeia, 12601 Twinbrook Parkway, Rockville, MD 20852. Telephone: (800) 227-8772 ext. 8546 or (301) 881-0666. Fax: (301) 816-8532. E-mail: smw@usp.org. Web: www.usp.org.

The Institute for Healthcare Improvement (IHI) has published a guide titled *Breakthrough Series: Reducing Adverse Drug Events*. The guide includes strategies for improving ordering systems, the dispensing process, administration of medications, and basic prevention strategies. The guide costs $49.95, plus $7 shipping and handling. To order, contact:

- Institute for Healthcare Improvement, 375 Longwood Ave., Fourth Floor, Boston, MA 02215. Telephone: (617) 754-4800. Fax: (617) 754-4848. E-mail: info@ihi.org. Web: www.ihi.org.

The Institute for Safe Medication Practices (ISMP) provides education about adverse drug events and their prevention through the *ISMP Medication Safety Alert*, a biweekly resource sent by fax or e-mail for a $135 annual subscription fee. A previous issue focusing on infusion pumps is available free of charge on the web site, www.ismp.org. (Click on "ISMP Medication Safety Alert!"; the April 22, 1998, issue; and then on "IV pump set free-flow: When is enough enough?") To order a subscription, contact:

- ISMP, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Telephone: (215) 947-7797. Fax: (215) 914-1492. E-mail: ismpinfo@ismp.org. Web: www.ismp.org.

ECRI, a nonprofit health services research agency, publishes *Health Devices*, which gives evaluations and brand name ratings. The May 2001 issue contains evaluations of patient-controlled analgesic (PCA) infusion pumps. A single issue costs $75 for member of ECRI's Health Devices System and $275 for nonmembers. The April-May 1998 issue of *Health Devices* contains evaluations of infusion pump analyzers and general-purpose infusion pumps. The cost of this double issue is $95 for members and $335 for nonmembers. There is no shipping charge for single-issue orders. *Healthcare Product Comparison System* is a purchasing guide without ratings. The December 2000 issue includes reports on ambulatory and general-purpose infusion pumps, and the January 2001 issue covers PCA infusion pumps. Each report costs $175, with no shipping charge. To order any of these products, contact:

- Brian Duffin, Membership Services, ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462. Telephone: (610) 825-6000, ext. 5414. Fax: (610) 834-1275. E-mail: bduffin@ecri.org. Web: www.ecri.org.

Sources

For more information on infusion pumps, contact:

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sure the right amount of fluid and medication will be infused," she explains.

At Tallahassee Memorial, the ED's policies require all PCA pump medication set-ups to be verified and co-signed on the Emergency Center chart by a second RN, says Bruns. **(See policies for the Use of the PCA Plus II for Analgesia and Medication Administration, enclosed in this issue.)**

"Two nurses verify the medication vial and the pump settings with the physician's order," she says. "This verification/co-signature requirement is also true for heparin drips and insulin drips."

Consult with risk management

• Learn from previous incidents.

Check with your hospital's risk management department to find out if there have been any reports of infusion pump-related errors, Catalano advises. "If so, find out if a root-cause analysis was done and what was learned," she suggests.

• Implement policies to increase safety.

New policies involving medication administration have been instituted at Tallahassee Memorial Hospital within the past year, says Bruns. The policies include standardized order forms or order sets, a two-nurse verification system, and a lower "lock-out" setting to possibly prevent respiratory depression.

"These policies have had a direct bearing on the care and safety of patients," she says.

• Be involved in product evaluation.

When your facility is examining a change in infusion pumps, make sure the ED is represented on the new product evaluation team, advises Catalano. "Everyone should be comfortable with the choice made. Learn all you can about the infusion pump your facility uses." ■

Experts: Cut costs of ED observation

(Editor's note: This is the second of a two-part series on ED observation services. Last month, we covered ways to increase reimbursement. This month, we cover ways to make your observation unit cost-effective.)

If you want to keep your observation unit open, you'll need to look at new strategies, says **Patricia Hall**, RN, MSN, CEN, service leader for emergency services at Howard Young Health Care in Woodruff, WI.

"The advent of APCs has made it difficult for observation units to be financially sound," she adds. Although there is not currently a separate APC for observation, the Baltimore, MD-based Health Care Financing Administration is expected to add a separate APC this year (For more details, go to the Society of Chest Pain Centers and Providers web site: www.scpcp.org, and click on "HCFA discussion on observation services.")

Taking these steps can help cut your unit's costs:

• Create a "hybrid" unit.

The observation unit at William Beaumont Hospital in Royal Oak, MI, began as a hybrid "observation/scheduled-procedure" unit, says **Michael A. Ross**, MD, FACEP, director of the emergency observation unit and chest pain center.

There was a problem with low census in the afternoon, he explains. "We would drop down to one or two patients, which is prohibitive from a nursing staffing standpoint."

The eight-bed unit was separate from the ED, so it wasn't possible to decrease the nursing staff to a single nurse, adds Ross. The solution was to allocate a set number of beds for observation patients and for scheduled-procedure patients.

Executive Summary

Keeping an observation unit operating with current reimbursement might depend on successful implementation of cost-reduction strategies.

- A "hybrid" model with scheduled-procedure patients in addition to observation patients allows you to staff with fewer nurses per patient.
- Observe patients with only one specific acute problem who are likely to be discharged within 18 hours.
- By offering stress testing in close proximity to the observation unit, length of stay is reduced, and the hospital can provide stress testing to inpatients on weekends.

Guide for Which Patients to Observe (Excerpt)

Indications for observation

1. Focused goal of patient care. The physician's notes should document what the reason for observation is. Generally, there should be only one specific problem that requires acute management. When multiple problems require management, the likelihood of admission is much higher. The three broad categories of observation are:

a. diagnostic evaluation of a critical syndrome, such as chest pain, abdominal pain, etc.;

b. short-term treatment of an emergency condition, such as dehydration, asthma, renal colic, etc.;

c. management of psychosocial needs, such as psychiatric, social worker, or continuing-care evaluation and management of selected problems.

2. Limited intensity of service. This is judged clinically by the Emergency Center (EC) physician. Patients not meeting this criterion should be managed in the EC or admitted to the hospital (i.e., patients who require one-on-one nursing care).

3. Limited severity of illness. This also is judged clinically by the EC physician (i.e., patients who are in extremis or clinically unstable). Following low severity of illness/intensity of service (SI/IS) criteria enables the Observation Unit to be run effectively.

4. Clinical condition appropriate for observation. In general, the observed condition should have a high (70-80%) probability of discharge within 18 hours.

It should also be a condition for which initial discharge from the EC is not likely (i.e., an otherwise admitted condition).

In addition to the list of "Observation Unit Clinical Conditions" included in this packet, the physician covering the unit may elect to observe other conditions if they meet the above criteria. This group will be monitored.

Contraindications to observation

1. High severity of illness. Patients requiring more nursing care than can be offered in the unit. For example, patients with unstable vital signs, or unstable cardiac, pulmonary, or neurological condition. These patients should be managed in the initial EC treatment area until deemed to be stable for at least one hour.

2. High intensity of service. Patients who are too unstable or ill to be observed. For example, difficult intoxicated or suicidal psychiatric patients, patients requiring frequent vital signs or treatments.

3. Patients requiring admission. If inpatient admission is apparent in the initial treatment area, the patient should not enter for "observation." This type of patient is defined as a "hold" if they are simply waiting for a bed.

4. Age less than 13 years old. These patients will be managed on the inpatient pediatric floor. Pediatric patients over the age of 13 who are transferred to the observation unit should not have significant underlying illness or co-morbidities, which may require increased nursing care (high SI criteria).

5. Obstetric patients over 20 weeks pregnant. These patients should be managed on the Labor and Delivery (L&D) unit according to EC policy. If they have already been evaluated on L&D and sent back to EC, or cleared by their private obstetrician for management of a non-obstetrical condition (i.e., asthma), they may be managed in the Observation Unit.

6. Anticipated observation length of stay less than three hours or over 18 hours. The work of transferring, admitting, and discharging the patient is not efficiently spent if the patient stays for less than three hours. A regular audit of such admissions will be performed. Since most observed cases are discharged in 10–15 hours, cases that will clearly require more than 18 hours of care are unlikely to benefit from the unit.

7. Nursing home placement. Patients must first have the feasibility of their observation placement plan approved by the continuing care or admissions transfer office nurse. This group often fails placement in a timely manner.

Source: Excerpt from Emergency Center Observation Unit Guidelines, William Beaumont Hospital, Royal Oak, MI.

"Combining these two services enabled us to always have enough patients and maximize the use of that space," says Ross.

As the observation service grew to 21 beds, the ED was able to maintain an adequate census of observation patients. "We found we no longer needed to be a hybrid unit," says Ross. "Over time, we weaned out the scheduled-procedure patients. We identified an inpatient location that could accommodate those patients and displaced them to that setting."

• Address staffing issues.

Initially, the observation unit at William Beaumont had an all-nursing staff doing primary care with a case ratio of one nurse per four patients, says **Pat Zientek**, RN, the emergency center's administrative nurse manager. But the current ratio is one nurse per five patients.

"Increasing the ratio was important to decrease cost," she notes. "Two less-costly technicians were introduced per shift who were cross-trained for the unit secretary duties."

Sources

For more information about reducing the costs of observation units, contact:

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The "hybrid" model allows you to staff with an average hourly patient/nurse ratio of 3.7 compared with the ratio of 2.5 for a regular observation unit, says Ross. "This reduces the cost by 0.13 nurse FTE per patient."[1]

• Avoid prolonged observation.

Patients who "succeed" in observation will be discharged long before 24 hours, says Ross. "The concept of a 24-hour observation unit is antiquated," he argues. "Most patients define themselves by 18 hours. If they cannot go home by then, they have a very high probability of needing hospitalization."

The ED observation unit requires that a disposition be made in 18 hours, unless the physician documents a clear and compelling reason to continue observing the patient, says Ross. **(See Patient Observation Record, Physicians Order Sheet for EC Observation Unit, Observation Unit Chest Pain Tracking Sheet, and Observation Unit Nursing and Physician Assessment Sheet, inserted in this issue.)**

• Only observe appropriate patients.

At Howard Young Health Care, the ED has become more selective with the patients placed on observation status, notes Hall. "If their condition appears to be more complicated with potential co-morbidities, we are opting for admission. This seems to be exactly contrary to how we used to think. But honestly, they traditionally have ended up staying more than 23 hours anyway."

At William Beaumont's ED, only specific conditions can be sent to the unit, based on specific inclusion/exclusion criteria. "The physician or nurse covering the unit is empowered to refuse a patient based on failure to meet these criteria,' says Ross. **(See Indications and Contraindications for Admission to the EC Observation Unit, p. 65.)**

The ED uses written guidelines for 32 conditions, along with general principles on which patients are appropriate for observation, says Ross.

"You must be managing only one specific acute problem, and it must be a problem of limited severity of illness that has a 70-80% probability of being discharged within 18 hours," he explains.

The guidelines are converted into orders specific for 80% of the conditions sent to the unit, says Ross. "This helps to maintain consistency," he says.

• Offer stress testing in close proximity.

Previously, 25% of the patient volume was transported to the eighth floor for stress testing, which necessitated a 15-minute trip each way of 'nonproductive time,' says Zientek. "To decrease the time off the unit, we have installed a stress lab directly adjacent to the unit, with a one- or two-minute trip each way."

The satellite stress-testing lab reduced the length of stay of chest pain patients by a couple of hours, says Ross.

"This allows the hospital to do stress testing on weekends for chest pain patients and get inpatients out sooner," he explains.

Reference

1. Ross MA, Naylor S, Compton S, et al. Maximizing use of the emergency department observation unit: A novel hybrid design. *Ann Emerg Med* 2001; 37:267-274. ■

Here's how to prevent assaults on staff

If a staff member is assaulted in your ED, it can have far-reaching effects long after the incident is over, warns **Tracy G. Sanson**, MD, FACEP, assistant medical director for the department of emergency medicine at Brandon (FL) Regional Medical Center.

"A violent incident can change the way your ED operates for a long time," she says. "The memories of an event may last for months or years, affecting staff morale and retention rates. The stress of the threat of violence can affect productivity and employee health, including substance abuse and suicide."

Occupational health and safety laws say employees must be provided with a safe working environment and safe systems of work, Sanson notes.

"Employers should prepare a plan to identify, assess, and control potentially threatening or violent situations and incidents at work," she adds. **(See**

Executive Summary

ED personnel experience the majority of all hospital assaults, and these attacks can have long-term effects on morale and productivity.

- OSHA regulations require you to provide staff with a safe working environment.
- You should have a plan to address security personnel issues, responses to specific scenarios, restraint techniques, and violence prevention.
- Strategies include flagging violence-prone individuals, using patient liaisons in the waiting areas, and ensuring that ED security officers have been trained to work in hospitals.

checklist for specific steps to take before and after assaults, p. 68.)

ED personnel experience the majority of all hospital assaults, warns **Tom Scaletta**, MD, FAAEM, chairperson of the department of emergency medicine at West Suburban Hospital Medical Center in Oak Park, IL.[1] In a national survey, 62% of residents admitted fearing assault in the ED, and 43% of university-based EDs report at least one physical assault of a staff member monthly, he adds.[2,3]

Here are effective strategies to prevent assaults on ED staff:

• Develop an ED security plan.

Scaletta suggests developing an ED security plan that addresses the following issues:

— security personnel hiring, training/certification, weapons-carrying policy, and responsibilities;

— alerting/response protocols (i.e., hostage situation, overt violence, pre-violence);

— restraint techniques/participants;

— arrest vs. eviction rules for disruptive patients/visitors;

— violence prevention means (i.e., zero tolerance for violence, checking IDs, metal detectors); and

— reporting requirements (form completion, committee review).

• Educate staff in violence-prevention techniques.

Staff should be trained to identify predictors of violence in individuals, develop de-escalation skills, and "get out of the way of unstoppable trouble," says Scaletta. **(See resource box for courses to take, p. 69.)**

"Flagging violence-prone individuals on subsequent ED visits helps alert staff to be ready for anything," he says. "Of course, this information should not be used to mistreat the person in a retributive way."

• Avoid lack of communication and unprofessional behavior.

Use patient liaisons in the waiting areas to explain how the system works, why waiting might be necessary, and what is happening in the clinical area, says Scaletta.

He offers the following anecdote to illustrate the importance of avoiding behavior that can escalate violence: After a surgical resident was overtly rude to a patient in police custody, he repaired a laceration and did not immediately dispose of the suture kit. "The arrestee was able to use a free hand to grab a scalpel and threaten the resident during morning rounds," he says.

Luckily, no one was hurt, and the staff learned an important lesson from the frightening incident, says Scaletta. "Treat patients and visitors with respect, and remain professional at all times," he underscores.

• Implement additional security measures.

Safety measures to consider include portable panic buttons, visitor control policies, locked-entry and total lock-down capability, video cameras, and metal detectors, says **Diane Presley**, RN, MSN, director of nursing for emergency services/critical care at Seton Medical Center in Austin, TX.

Seton's ED recently installed doors with a lock-down capability, and most of the ED hallways are videotaped, Presley reports. "There is locked entry only, so there is ease of access for patients and visitors to come out of the department," she says. "The trauma center is always locked, and the ED locks down from 10 p.m. until 6 a.m. or if there is a incident such as a disaster of internal or external nature."

• Ensure adequate training of ED security.

Your ED's security guards might not be as effective as they could be if they haven't been trained to work in hospitals, Presley cautions. "Training should include violence management, plus investigation and detection

Sources

For more information on preventing assaults, contact:

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of uncommon weapons," she says. The Lombard, IL-based International Association of Hospital Security and Safety has a certification course for hospital security officers, she notes.

• Encourage staff to report all incidents.

All involved staff should complete a report after an assault occurs, says Scaletta. **(See sample reporting form, inserted in this issue.)**

Use This 'Before and After' Checklist

Before an incident occurs:

- ☐ Develop a plan or written policy to address violence in the workplace.
- ☐ Clearly state that staff and patient safety are a priority.
- ☐ Communicate this policy and appropriate behavior for all employees toward coworkers and hospital customers.
- ☐ Make it clear violence, incivility, direct or veiled threats of harm, and intimidating, belligerent, harassing, bullying, or other inappropriate and aggressive behavior will not be tolerated.
- ☐ Screen all employees, and check their references.
- ☐ Conduct exit interviews when employees retire, quit, or are transferred or terminated, to identify potential violence-related security or management problems.
- ☐ Invite local police into your firm to review the written violence prevention plan.
- ☐ Encourage the police to become more familiar with your facility. Learn what actions they take during incidents involving threats and violence.
- ☐ Have a security expert evaluate your written plan, and educate employees on violence prevention.
- ☐ Educate managers on the signs of a troubled employee. Watch for the following: a change in the employee's behavior or work pattern, tardiness, failure to complete projects, irritability, and hypersensitivity to criticism or negative information.
  Signs of a troubled home situation include frequent or threatening phone calls, the employee becoming upset after calls or visits from family members, a change in schedule requests, an increase in sick days, and any injury.
- ☐ Have a policy to address restraining orders initiated by staff. A major proportion of homicides in the workplace involve the extension of domestic violence into the workplace. You should know if an employee has a restraining order against anyone. The management, staff, and security ideally should have a photo of the person to prevent the person gaining access to the work site or the employee. The staff should know whom to call and actions to take if the person presents to the workplace. The goal is to let authorities remove the person without endangering the employee, other staff, and innocent bystanders.
- ☐ Have an internal emergency code to be used in crisis, and conduct mock crisis drills.
- ☐ Encourage staff to seek help when a situation seems to be escalating. Ask your employees to help identify potentially violent situations.

After an incident has occurred:

- ☐ Make an immediate investigation.
- ☐ Secure the work area where the incident occurred.
- ☐ Account for all staff and others.
- ☐ Ensure the physical safety of those remaining in the area.
- ☐ Ensure that no work area is left short-staffed while others assist the victim or secure the area.
- ☐ Focus on fact-finding to prevent recurrence, and not on fault-finding.
- ☐ Determine what action needs to be taken.
- ☐ When a threat has been made or an incident has occurred, evaluate the situation and, if warranted, notify the potential victims and/or police.
- ☐ Conduct immediate debriefings. Include all affected employees in a debriefing to discuss the cause of the violence, explore explanations, develop a plan of action, and identify those needing further counseling.
- ☐ Support the prosecution of the offenders. File charges in every case of assault.
- ☐ Provide information and counseling services to those involved and their families.
- ☐ Provide accurate communication to outside agencies, media, and law enforcement.
- ☐ Determine what could be done differently in the future.

Source: Tracy G. Sanson, MD, FACEP, Assistant Medical Director, Department of Emergency Medicine, Brandon (FL) Regional Medical Center.

He recommends reviewing security calls for violent or disruptive patients and visitors. "When there was a verbal threat of harm and certainly when there was an assault reported by security, the involved staff member should be asked to fill out a data collection form, even in retrospect," he says.

Tracking assaults helps because the process allows the reviewer (or review committee) to look for commonalities, says Scaletta. "Maybe a certain staff is always 'getting into it' with difficult patients/visitors and this person needs some interpersonal skill building."

You might discover there are opportunities to call security or the local police earlier, or learn about a security staffing problem that needs objective evidence to be overcome, says Scaletta.

References

1. Pane G, Winiarski A, Salness K. Aggression directed toward emergency department staff at a university teaching hospital. *Ann Emerg Med* 1991; 20:283-286.
2. Anglin D, Kyriacou D, Hutson HR. Residents' perspectives on violence and personal safety in the emergency department. *Ann Emerg Med* 1994; 23:1,082-1,084.
3. Lavoie FW, Carter GL, Danzl DF, et al. Emergency department violence in United States teaching hospitals. *Ann Emerg Med* 1988; 17:1,227-1,233. ■

Resources

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 that provide skills training for management of violent behavior. For more information, contact:

- REB, P.O. Box 845, Stoddard, NH 03464. Telephone: (603) 446-9393. Fax: (603) 446-9394. E-mail: rebtrng@monad.net. Web: www.rebtraining.com.

The Emergency Nurses Association (ENA) has a position statement titled *Violence in the Emergency Care Setting*. All ENA position statements can be accessed from the web site: www.ena.org. (Click on "Programs and Meetings" and then "Position Statements"; then scroll down to "Violence in the Emergency Care Setting.") Single copies of position statements are available at no charge. To obtain copies, contact:

- ENA, 915 Lee St., Des Plaines, IL 60016. Telephone: (800) 243-8362 or (847) 460-4000. Fax: (847) 460-4001. Web: www.ena.org.

Question: Does the recent court ruling that says patients in nonhospital ambulances are covered by the Emergency Medical Treatment and Active Labor Act (EMTALA) conflict with the regulations as defined by the Health Care Financing Administration?

Answer: Under EMTALA, a patient is considered to have "come to the ED" if that patient is in a hospital-owned ambulance or on hospital property, says **Janet Richmond**, an attorney for the Sacramento-based California Healthcare Association. However, a recent court ruling from the Ninth U.S. Circuit Court of Appeals, based in San Francisco, has expanded this definition to include communication by a nonhospital-owned ambulance with a hospital.

"The court case says that the issue is not whether the ambulance is owned by the hospital, but whether the ambulance called the hospital and the hospital was in communication with that ambulance," she explains. "So this ruling conflicts with the definition under EMTALA."

At this time, HCFA is unlikely to enforce the EMTALA statute consistent with this court ruling, Richmond says. "That having been said, in the real world, hospitals don't turn away ambulances whether they are owned by the hospital or not, whether they communicate with the hospital or not, unless they are on diversion," she adds.

However, a hospital might find itself in litigation that could include a cause of action stemming from an EMTALA violation if it turns away a nonhospital-owned ambulance after it communicates with the hospital, if the hospital is not on diversion, says Richmond.

The ambulance also would have to be located in a state that is covered by the Ninth Circuit Court of Appeals, says Richmond. These states are Hawaii, Alaska, Arizona, Washington, Idaho, Nevada, California, Montana, Wyoming, and Oregon.

After the case was heard in the Ninth Circuit, the hospital involved, Queens Medical Center in Honolulu, asked for a rehearing, and it was denied,

Sources

For more information about EMTALA, contact:

- **Gloria Frank**, JD, EMTALA Solutions, P.O. Box 1340, Ellicott City, MD 21041. Telephone: (800) 972-7916. Fax: (410) 480-9116. E-mail: emtala@home.com. Web: www.gloriafrank.com.
- **Stephen Frew**, JD, Frew Consulting Group, 6072 Brynwood Drive, Rockford, IL 61114. Telephone: (815) 654-2123. Fax: (815) 654-2162. E-mail: sfrew@medlaw.com.

Richmond adds. "So the only other option they have is to appeal it to the U.S. Supreme Court."

Richmond notes that it is not known whether Queens Medical Center plans to appeal the Ninth Circuit decision to the Supreme Court. She points out, however, that the General Accounting Office (GAO) is examining EMTALA at the request of Congress. The GAO is looking at such issues as whether EMTALA has strayed from the original intent, and what the costs are to the health care system.

Question: What are guidelines for on-call physician response times to the ED for emergent and urgent conditions?

Answer: Always check your state law and insurance carrier contracts, recommends **Gloria Frank**, JD, owner of EMTALA Solutions, an Ellicott City, MD-based consulting firm, and former lead enforcement official on EMTALA for HCFA. She notes that HCFA does not specify a time frame but insists that hospitals establish time frames in written policies.

There should be separate time frames for responding by phone and physically presenting to the ED, says Frank. "Also, policies should delineate consequences for failure to abide by time frames," she says. ED staff should know what to do if the physician doesn't show up. For example, at what time do they call someone else?

Generally HCFA looks for response times for both STAT and routine conditions, says **Stephen Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance.

"In plans of correction following citations, my experience is that they require a maximum of 30 minutes for STAT calls for private on-call physicians, differentiating from in-house capability, 60 minutes for routine calls in urban areas, and sometimes 90 minutes in rural areas where physicians are widely scattered," he says.

Frew cautions that although most calls for specialists are in the classic definition ranges of emergent and urgent, HCFA will look at a duty to respond for evaluation or stabilizing care, regardless of the category that the patient is placed in for triage reference. Also, "Response is 'in person,' not by phone," he says.

Question: There is only one hospital in town or within 30 miles. Must offsite facilities do more than dial 911 for transfer of patients to hospital?

Answer: Yes, according to Frank. She notes that HCFA addressed this issue in a *Federal Register* document by saying: "We agree that EMS personnel can play a valuable role in transporting patients to appropriate sources of emergency care. A hospital may not, however, meet its EMTALA obligations merely by summoning EMS personnel. EMS may be used appropriately in conjunction with an appropriate hospital response to treat and move an individual who is already on hospital property." [65 *Fed Reg* 18434, 18523 (2000).]

At the least, you should document communications with the main hospital and document the screening performed by the qualified medical person designated in accordance with the new regulations to handle emergencies, says Frank.

"A department must designate a qualified medical person only if it regularly is staffed by doctors, nurses, or licensed practical nurses," she adds.

If the offsite facility is hospital-owned and operating as a designated provider-based remote department of the hospital, it must have designated personnel and policies for medical screening, policies on patient stabilization, and policies on transfer to the main hospital ED, says Frew.

"The regulations require that these must contain requirements for direct contact from the remote site to the main ED for direction of care," Frew adds. ■

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *Experts: Cut costs of ED observation, Here's a guide for which patients to observe* and *Here's how to prevent assaults on staff* in this issue.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *Are you putting patients in danger? Heed warning on infusion pumps* and *EMTALA Q&A* in this issue.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

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CE questions

13. Which types of infusion pumps should not be used, says the Joint Commission on Accreditation of Healthcare Organizations' *Sentinel Event Alert*?

A. all infusion pumps

B. pumps that do not provide protection from the free-flow of intravenous fluid/medication into the patient

C. pumps with a lockup mechanism

D. PCA infusion pumps

14. Which of the following is true regarding infusion pumps, according to Cindy Bruns, RN, BSN, CEN, quality management coordinator for the Emergency Center at Tallahassee Memorial Hospital?

A. Adverse outcomes occur mainly because of tampering by patient and visitors.

B. Dosages can be set incorrectly.

C. Pumps are only dangerous if they do not have protection against free-flow.

D. All types of infusion pumps are equally hazardous.

15. Which of the following patients is an appropriate candidate for observation, according to Michael A. Ross, MD, FACEP, director of the emergency observation unit and chest pain center at William Beaumont Hospital?

A. a patient with only one specific acute problem who is likely to be discharged within 18 hours

B. a patient with several acute problems

C. an obstetric patient more than 20 weeks pregnant

D. a patient who is definitely going to be admitted

16. Which of the following is an effective way to reduce costs of operating an ED observation unit, according to Ross?

A. providing 24-hour observation

B. observing patients with potential co-morbidities

C. creating a hybrid unit with scheduled-procedure patients

D. having observation patients go to other departments for stress testing

17. Which of the following is true regarding ED personnel and hospital assaults, says Tom Scaletta, MD, FAAEM, chairperson of the department of emergency medicine at West Suburban Hospital Medical Center?

A. Only a small percentage of residents reported fearing assaults.

B. Tracking actual assaults is rarely helpful in preventing future assaults.

C. Assaults on ED personnel are declining.

D. ED personnel experience the majority of all hospital assaults.

18. Which of the following is true regarding on-call physician response times and EMTALA requirements?

A. HCFA requires a maximum of 30 minutes for routine calls in urban areas.

B. EMTALA does not address on-call physician response times.

C. HCFA does not specify a time frame, but it insists that hospitals establish time frames in written policies.

D. Time frames for responding by phone and physically presenting to the ED should be the same. ■

ED Management
The monthly update on Emergency Department Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this salary survey and the overall state of employment in your field.

Instructions: Circle the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be held strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?
   A. Chair
   B. Director of emergency services
   C. Director of nursing services
   D. Medical director
   E. Nurse manager

2. Please indicate your highest degree.
   A. BA
   B. BS
   C. BSN
   D. MA
   E. MBA
   F. MD
   G. MS
   H. MSN
   I. PhD
   J. RN

3. Including your past and present employers, how long have you worked in positions with the same or similar responsibilities as your current position(s)?
   A. less than 1 year
   B. 1 to 3 years
   C. 4 to 6 years
   D. 7 to 9 years
   E. 10 to 12 years
   F. 13 to 15 years
   G. 16 to 18 years
   H. 19 to 21 years
   I. 22 to 24 years
   J. 25 or more years

4. Including your present and past employers, how long have you worked in the health care field?
   A. less than 1 year
   B. 1 to 3 years
   C. 4 to 6 years
   D. 7 to 9 years
   E. 10 to 12 years
   F. 13 to 15 years
   G. 16 to 18 years
   H. 19 to 21 years
   I. 22 to 24 years
   J. 25 or more years

5. What is your age?
   A. 20 to 25 years
   B. 26 to 30 years
   C. 31 to 35 years
   D. 36 to 40 years
   E. 41 to 45 years
   F. 46 to 50 years
   G. 51 to 55 years
   H. 56 to 60 years
   I. 61 to 65 years
   J. 66 years or older

6. What is your sex?
   A. male
   B. female

7. What is your annual gross income from your primary health care position. Please exclude additional income from teaching, consulting, bonuses, etc. To answer this question, circle the correct salary.
   A. less than $35,000
   B. $35,000 to $39,999
   C. $40,000 to $44,999
   D. $45,000 to $49,999
   E. $50,000 to $54,999
   F. $55,000 to $59,999
   G. $60,000 to $64,999
   H. $65,000 to $69,999
   I. $70,000 to $74,999
   J. $75,000 to $79,999
   K. $80,000 to $84,999
   L. $85,000 to $89,999
   M. $90,000 to $94,999
   N. $95,000 to $99,999
   O. $100,000 to $104,999
   P. $105,000 to $109,999
   Q. $110,000 to $114,999
   R. $115,000 to $119,999
   S. $120,000 to $124,999
   T. $125,000 to $129,999
   U. $130,000 to $134,999
   V. $135,000 to $139,999
   W. $140,000 to $144,999
   X. $145,000 to $149,999
   Y. $150,000 to $154,999
   Z. $155,000 to $159,999
   AA. $160,000 or more

8. On average, how many hours a week do you actually work? (Regular hours plus overtime, regardless of whether you're paid extra for it.)

A. less than 20 hours/week	D. 41 - 45 hours/week	G. 56 - 60 hours/week
B. 20 - 30 hours/week	E. 46 - 50 hours/week	H. 61 - 65 hours/week
C. 31 - 40 hours/week	F. 51 - 55 hours/week	I. more than 65 hours/week

9. In the past 12 months, how has your salary or income increased or decreased?

A. salary or income has decreased	C. 1% - 3% increase	F. 11% - 15% increase
B. no change	D. 4% - 6% increase	G. 16% - 20% increase
	E. 7% - 10% increase	H. 21% or more increase

10. In the past 12 months, how has the number of employees in your company or department changed?

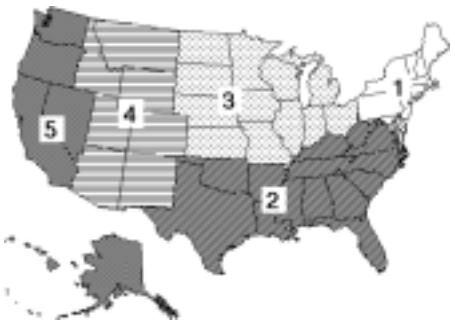
A. increased	B. decreased	C. no change

Please rate the following benefits according to how important they are in determining your job satisfaction. Use the following scale, and be sure to mark the benefit's importance only if your employer currently provides that benefit to you. If your employer does not currently provide that benefit, or if your company has no benefits, skip these questions.

	Extremely important	Not important		Extremely important	Not important
11. medical coverage	1	5	18. pension plan	1	5
12. dental coverage	1	5	19. profit-sharing plan	1	5
13. eyecare coverage	1	5	20. annual or semi-annual bonus	1	5
14. life insurance	1	5	21. elder care	1	5
15. 401k or other plan	1	5	22. maternal/paternal leave	1	5
16. child care	1	5	23. some freedom to choose work schedule	1	5
17. tuition reimbursement (including CE credits)	1	5	24. exercise facilities or health club membership	1	5

25. Using the map provided here, please indicate where your employer is located.

A. region 1	E. region 5
B. region 2	F. Canada
C. region 3	G. other
D. region 4	



26. Which of the following best describes the location of your work?
    A. urban (within a large city)
    B. suburban (in a community within a metropolitan area dominated by a large city)
    C. medium-sized community
    D. rural

27. Which of the following best describes the ownership or control of your employer?

A. college or university	D. nonprofit (church-operated, volunteer, etc.)
B. federal government (VA, military, and federal agencies)	E. for profit (individual, private practice, corporation, etc.)
C. state, county, or city government	

28. Which of the following best categorizes the work environment of your employer? Choose only one answer.

A. academic	C. city or county	E. college health service	G. hospital
B. agency health department	D. clinic	F. consulting	H. private practice

29. If you work in a hospital, what is its size? (If you don't work in a hospital, please circle J.)

A. < 100 beds	D. 301 - 400 beds	G. 601 - 800 beds	J. I don't work in a hospital
B. 101 - 200 beds	E. 401 - 500 beds	H. 801 - 1,000 beds	
C. 201 - 300 beds	F. 501 - 600 beds	I. > 1,000 beds	

Deadline for responses: Aug. 1, 2001

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.

USE OF THE PCA PLUS II FOR ANALGESIA

PURPOSE: To allow the patient and/or nurse to administer an analgesic drug utilizing the PCA Plus II.

MANDATORY REQUIREMENTS:

1. The physician's order must include drug, dosage and lockout interval (in PCA mode). The four hour limit may be omitted. When a verbal or telephone order for PCA pump set-up or PCA pump setting changes is received, the nurse MUST write this order on a PCA Order Sheet (and not on a regular physician's order sheet).
2. Absolutely no other narcotics, sedatives or any other medications with sedative effects are to be given to the patient unless approved by the physician who ordered the PCA pump or by the Pain Management Consultant (PMC) if the pump was ordered by them. This also includes medications given for procedures being performed on the patient (Endoscopy, insertion of a chest tube, etc.). (Refer to the Pain Management Service PCA Order Set.) Until the PCA is discontinued, document on the MAR and in the kardex that the PMC ordered the PCA.
3. **When the PCA pump is initiated, the RN MUST document the pump's PMID number (the 6 digit number on the silver sticker) in a focus nursing note in the patient's chart.** If for some reason the PCA pump is changed out and a different pump is used, the PMID number of the new pump MUST also be documented in a nursing focus note.
4. At the beginning of each shift, the nurse must document in the nursing notes the pump settings and type of pain medication being used. Every eight hours, the nurse must document on the MAR the amount of pain medication used.
5. **Pump settings and type of pain medication being used MUST be verified by a second licensed nurse prior to initiating PCA therapy, with any change in pump settings, with each medication vial change or when a patient is received in transfer from another unit. Both the nurse who is initiating PCA therapy, changing pump settings, changing the medication vial or receiving the patient in transfer and the nurse who is double checking to be certain that the correct medication is in the pump and that the pump is set correctly for the medication and prescribed dosage will initial the MAR or other document used for documenting medication administration. At all times, the physician's order or the MAR will be used by both nurses to verify the pump settings and medication are correct.**
6. **When a patient with a PCA pump is transferred from one unit to another, the nurse receiving the patient in transfer will document in a focus nursing note the amount of narcotic left in the medication vial at the time the patient arrives on the new unit.**

GENERAL INFORMATION:

1. The initials "PCA" are an abbreviation for "patient controlled analgesia". The PCA Plus II pump is most often referred to as the "PCA pump".
2. Refer to the Patient Care Standard for "Pain Management".
3. The PCA Plus II may be used as an alternative delivery mechanism when frequent IV bolus pain medication is anticipated, even when the patient is not allowed to self-administer the medication.
4. Only an RN can initiate a PCA infusion or change pump settings. RNs and LPNs may change the empty medication vial, document the amount of medication used during the shift, verify pump settings, witness drug wastage and discontinue a PCA pump.

5. Identify the patient and instruct in use of PCA. Give patient the information pamphlet entitled "To Help You Rest Easy..." **Both the patient and family should be instructed that only the patient is allowed to give doses of pain medication.** Assess understanding and answer any questions the patient and/or family may ask. Document teaching on the Patient/Family Education Record.
6. PCA narcotics may cause drowsiness and respiratory depression. Careful assessment of level of consciousness, vital signs and especially respiratory status should be made during infusion. (Refer to the Patient Care Standard for "Pain Management".)
7. The PCA line should not be interrupted unless absolutely necessary. If necessary to use, the lower portion of tubing should be well flushed prior to and after use. Provide for alternative pain relief by consulting with the physician if the PCA must be interrupted for an extended period of time.
8. A maintenance IV infusion must be maintained for duration of the PCA therapy with type of fluid and rate specified by physician order.
9. The PCA medication vial must be changed at least every 24 hours. Change out the old injector and tubing with new every 72 hours.
10. Keep the pump plugged in except during transport or ambulation.

EQUIPMENT:

PCA Plus II pump
Medication as ordered in pre-filled injector vial
PCA Tubing Set
IV Fluid and Tubing
Venous Access Device
PCA pump key

PROCEDURE for PCA Plus II Pump Set-Up (by an RN only):

1. Verify the physician's orders for medication, dosage (mg.), lock out interval (minutes in PCA mode), 4 hour limit if applicable (mg.) and loading dose if applicable.
2. Set up PCA Plus II pump and injector vial.
   A. Injector Vial:
      1. Sign out narcotic on the Controlled Drug Administration Record (CDAR) as though the entire amount will be administered (30 ml.).
      2. Assemble PCA vial, injector and PCA tubing following instructions on the package.
      3. Hold the vial/injector with the male luer connector in the upright position. Exert slight pressure on the vial to prime the tubing. Close the slide clamp on the PCA tubing. Maintain the sterility of the tubing during priming procedure. **(CAUTION: Disconnect the PCA set from patient before priming tubing.)**
   B. PCA Plus II Pump:
      1. Open security door.
      2. Activate drive release mechanism by pinching levers and moving to uppermost position.
      3. Load injector vial assembly **making sure to turn vial so that the color strip showing the medication name and strength is facing outward**. This information must be visible through the PCA door. Insure the vial is firmly placed in the vial holder

4. Move drive assembly to lowest position making sure that the flange on the injector "clicks" into position. Proper loading of the syringe will turn the unit on and activate it. Open the slide clamp on the PCA tubing.
5. Pump is turned on by either inserting or removing vial or by pressing the [ON] key on the keypad.
6. Start-up sequence will be performed by the pump. After this sequence, user is prompted to begin purge cycle. Press [NO] to omit purge cycle. **(CAUTION: If purge cycle is used, disconnect the PCA set from the patient before starting purge cycle.** Stop purging after flow is seen at the end of PCA set.)

3. Initiate PCA Plus II Pump:
   - A. Plug pump into electrical outlet.
   - B. Program the PCA Plus II pump:
     1. Select drug and concentration to be administered using [YES], [NO] keys on keypad. Follow prompts.
     2. Program Loading Dose, if ordered.
     3. Select Mode of Delivery (PCA, CONTINUOUS, PCA + CONTINUOUS) as ordered.
     4. Select dose to be delivered in mgs.
     5. Set Lockout Interval if using PCA or PCA + CONTINUOUS Mode.
     6. Set Continuous rate if ordered.
     7. Set 4 hour limit in mgs., if ordered.
     8. Press [HISTORY] to confirm settings.
     9. Close and lock security door.
     10. **Prior to administering the first dose of medication, a second licensed nurse MUST verify the pump settings and medication. The RN initiating the PCA pump and the nurse double checking the pump settings and medication will initial the MAR or other document used for documenting medication administration. Both nurses will take either the MAR or the physician's order to the patient's bedside and use it to verify that the pump settings and medication are correct.**
     11. **The RN MUST document the pump's PMID number (the 6 digit number on the silver sticker) in a focus nursing note in the patient's chart.**
   - C. Connect primed IV tubing to the Y-adapter on the PCA tubing. Open roller clamp on tubing and flush medication from PCA tubing below Y-adapter. Maintain sterility of tubing during priming procedure.
   - D. Connect PCA tubing to the IV access device and initiate IV fluid at the prescribed rate. Press [RESET/START] key on the keypad.

PROCEDURE to Initiate PCA Plus II for Nurse IV Bolusing (initial set up by an RN only):

1. Determine mechanism of delivery ("Loading Dose" or "PCA Dosing").
   - A. For "Loading Dose":
     1. Plug pump into electrical outlet.
     2. Program the pump:
        - a. Select drug and concentration to be administered using [YES], [NO] keys on the keypad. Follow prompts.

b. Program Loading Dose. **Prior to administering a dose of medication, a second licensed nurse MUST verify the pump settings and medication. The RN initiating the PCA pump and the nurse double checking the pump settings and medication will initial the MAR or other document used for documenting medication administration. Both nurses will take either the MAR or the physician's order to the patient's bedside and use it to verify that the pump settings and medication are correct.**

c. The RN MUST document the pump's PMID number (the 6 digit number on the silver sticker) in a focus nursing note in the patient's chart.

3. Turn off machine.
4. Close and lock security door.
5. Repeat as needed according to the physician order.

B. For "PCA Dosing":

1. Plug pump into electrical outlet.
2. Program the pump:
   a. Select drug and concentration to be administered using [YES], [NO] keys on the keypad. Follow prompts.
   b. Program Loading Dose for first dose, if desired.
   c. Select Mode of Delivery (PCA)
   d. Select dose to be delivered in mgs.
   e. Select lockout interval based on the physician order. For example, for the order "Morphine Sulfate 2mg IV Q1H PRN", the lockout interval could be 60 minutes.
   f. Indicate [NO] for 4 hour dose limit.
   g. Confirm settings.
   h. Close and lock security door.
   i. Prior to administering the first dose of medication, a second licensed nurse MUST verify the pump settings and medication. The RN initiating the PCA pump and the nurse double checking the pump settings and medication will initial the MAR or other document used for documenting medication administration. Both nurses will take either the MAR or the physician's order to the patient's bedside and use it to verify that the pump settings and medication are correct.
   j. The RN MUST document the pump's PMID number (the 6 digit number on the silver sticker) in a focus nursing note in the patient's chart.
3. If first dose not given as a loading dose, press button.
4. Press Patient Control Button as needed according to the physician order.
5. Remove Patient Control Button from room and place in a secure area in between doses. (This will prevent accidental dosing.)
6. Document PRN administration on the MAR.

PROCEDURE for PCA Plus II Pump Maintenance (by an RN or LPN):

1. On initial shift rounds, check the PCA Plus II pump for ordered settings and medication. Document in the nursing notes.
2. Monitor the following while the patient is using the PCA Plus II pump:
   - A. Number of mg's. used every 8 hours.
   - B. Sedation level of the patient every 4 hours.
   - C. Comfort or relief level every 4 hours.
   - D. Vital signs every 4 hours.
3. At the end of the shift assess the total number of mg's. used and clear the pump. Unlock and open door. Press [REVIEW/CHANGE]. "Clear dose history and total delivered?" Press [YES]. Follow prompts.
4. Document:
   - A. Vital signs on the Graphic Record.
   - B. Level of sedation, level of comfort and PCA Plus II pump settings on initial shift assessment and any changes from that assessment in the nursing notes.
   - C. Number of mg's. used every shift on the MAR.
   - D. Wasting of Medication:
     1. Complete CDAR as though signing out a narcotic (date, time, patient name and number).
     2. Under physician write "waste" when changing the vial or write "D/C" when discontinuing the PCA Plus II pump.
     3. Sign along with a co-signature by a second nurse for the amount wasted. Fill in drug and strength as well as amount given and wasted.
     4. In the balance forward place a dash (-) as the balance is unchanged.
   - E. Discontinuation of PCA therapy in the nursing notes.

PROCEDURE for Adding a New Vial to the PCA Plus II Pump (by an RN or LPN)

1. Assess pump for the need for a new vial of medication or check physician orders for a change in medication. The PCA Plus II pump will alarm when the syringe is empty. The alarm can be silenced for 5 minutes temporarily by pushing the [SILENCE/NO] key.
2. Obtain a new vial of medication from the narcotic lock-up and sign out the medication on the Controlled Drug Administration Record (CDAR) as though the entire amount will be administered.
3. Close slide clamp on PCA side which is attached to vial/injector.
4. Remove the cap from the new vial.
5. Unlock the PCA Plus II pump and turn it [OFF]. (Pump will retain settings and history for 60 minutes of previous use.) Remove the old vial, with injector intact, by grasping the vial at the top and gently pulling forward.
6. Remove vial/injector assembly from infusion pump. Rotate vial counterclockwise until injector is removed from stopper.
7. While maintaining sterility, connect new vial to injector by rotating vial clockwise about 3 turns or until stopper is pierced by metal cannula. To purge air from new vial, disconnect PCA set from injector. Advance injector allowing solution to purge air from inverted vial. Reattach PCA set to injector.

USE OF THE PCA PLUS II FOR ANALGESIA
Page 6

8. Load injector vial assembly and insure it is firmly placed in the vial holder. Move drive assembly to lowest position making sure that the flange on the injector "clicks" into position. Confirm settings using the [HISTORY] key.
9. Close and lock the security door. Open slide clamp. Press [RESET/START].
10. **Before the patient can resume dosing, a second licensed nurse MUST verify the pump settings and medication. Both the nurse changing the medication vial and the nurse double checking the pump settings and medication will initial the MAR or other document used for documenting medication administration. Both nurses will take either the MAR or the physician's order to the patient's bedside and use it to verify that the pump setting and medication are correct.**
11. Document any waste of medication on the CDAR with a co-signature. (See #4D under Procedure for PCA Plus II Pump Maintenance.)

PROCEDURE for Discarding of Wasted Medication (by an RN or LPN)

1. If changing to a different medication, discontinuing PCA therapy or changing out the old injector and tubing:
   A. While in the presence of another licensed nurse:
      1. Accurately measure and verify the amount of medication to be wasted.
      2. Completely empty medication from vial by pushing injector/plunger up to top of vial.
      3. Discard medication.
      4. Discard empty vial/injector into sharps container.
   B. Document any waste of medication on the CDAR with a co-signature. (See #4D under Procedure for PCA Plus II Pump Maintenance.)
2. If changing out a vial with the same medication as used in the previous vial:
   A. While in the presence of another licensed nurse:
      1. Estimate and verify amount of medication remaining in vial.
      2. As this vial does not have injector/plunger, discard vial with medication intact into sharps container.
   B. Document any waste of medication on the CDAR with a co-signature. (See #4D under Procedure for PCA Plus II Pump Maintenance.)

Approved: 5/87
Revised: 2/94; 1/95; 4/95; 6/95; 11/96; 2/97; 11/97; 1/99; 4/99
Revised: 4/00; 5/00; 8/00; 3/01
Reviewed: 12/92
(p-pca.wpd)

Source: Tallahassee (FL) Memorial Hospital.

MEDICATION ADMINISTRATION

1. Before any medications are administered, the patient's identification will be verified by checking the patient identification bracelet and checking that against the information on the MAR. Refer to Administrative Policy No. 40-68: "Patient Identification."

2. All medications should be checked for the following:
   A. Correct patient name, drug, dosage, route and expiration date.
   B. The MAR corresponds with the medication dispensed by the Pharmacy or from floor stock.
   C. The MAR clearly identifies the date and time for administration.
   D. Any parameters or instructions that should be followed related to the medication administration (hold for BP, on call, QOD, etc.).

3. Standard precautions should be followed during any medication administration:
   A. Safety devices such as needleless or blunt cannula components of an IV system will be used. The use of traditional needle/syringe systems is not acceptable when a safe system alternative is available.
   B. Do not remove a needle/cannula from the syringe, bend, break or otherwise manipulate by hand.
   C. Never recap a used needle/cannula using both hands. Use either a one-handed "scoop" technique or a recapping device to hold the sheath.
   D. Any ampule, vial, needle, blunt cannula, and syringe with a needle/cannula should be placed directly into the nearest sharps disposal container after use. Any syringe without a needle/cannula, if not contaminated with blood or body fluids, may be discarded into regular (non-biomedical) trash.

4. All medications and IV infusions are documented on the MAR or special flowsheets with the nurse's initials. If a medication is held or refused, the nurse should put an asterisk (*) by the medication and time on the MAR. Medications that are held, refused or any PRNs given should also be accompanied by a nursing note explaining the reason for giving or not giving, dosage (if a range is given), any complications and the patient's response to the medication. If there are parameters with the order, the reason for not giving a medication should be noted on the MAR.

5. If a patient has been placed on NPO or HOLD for a procedure, check with the physician which medications, if any, should be given. It is especially important to clarify insulin orders.

6. All IV fluids and medications will be labeled with the date and time of **expiration** by the Pharmacy, the nurse preparing them or the manufacturer.

7. Medication Orders:
   A. The pink carbon of the original order will be forwarded to the Pharmacy. The white carbon is given to the nurse administering medications for that patient. Any new PRN medications that need to be filled immediately will be circled on the pharmacy carbon.
   B. When physician order sets are used, 3 copies are needed. The first copy is for the permanent patient record, the second copy is to be sent to Pharmacy and the third copy is for the nurse.
   C. The time and "C.P." for carbon pulled will be noted on the left hand margin of the original order before the carbon is pulled. The Pharmacy copy of the orders will be sent to the Pharmacy via the tube system. The nursing copy is given to the nurse.
   D. STAT and NOW orders will be called to the attention of the nurse responsible for the patient's medications by the staff member transcribing the orders. These orders are to be circled and the order sheet checked for legibility and complete patient information before being placed in a red envelope and tubed to the main Pharmacy unless there is a unit dose satellite or stock medication available.
   E. All new medication orders are written on a blank MAR or on the existing MAR using standard dosing times except for the first dose of antibiotics which will be given within two hours of being ordered. The RN verifies the handwritten order with the physician's order and initials it in the initial box.

8. Allergies to foods or medications identified on admission will be entered under the Allergy section of Powerchart, written on the MAR and placed on "allergy" tape along with the patient's name and attached to the front of the chart. Any new allergies identified during the hospital stay should be added to the Allergy section of Powerchart, the MAR and the chart.

9. The patient's height and weight will be entered into the Weights and Measurements section of Powerchart on admission and updated any time there is a weight change of 10 pounds or more.

10. Standard Dosing Times:
   A.

QD	-	0800
BID	-	0800, 2000
TID	-	0800, 1400, 2000
QID	-	0800, 1200, 1600, 2000
qPM	-	1800
qHS	-	2200
AC	-	varies according to unit; should be 30 minute before meals.
PC	-	varies according to unit; should be 30 minute after meals.

B. COUMADIN: Given at 1600 to allow for the return of lab values and reporting to the physician as indicated. At the time Coumadin is administered, the nurse will enter the current PT/INR value on to the MAR or make an entry that no PT/INR was ordered. This must be addressed with each dose.

C. DIGOXIN: Given at 1200 to allow for the return of lab values and reporting to the physician as indicated. The patient's heart rate will be measured before administration and recorded on the MAR.

D. LASIX: Given at 0800 if ordered daily and at 0800 and 1600 if ordered BID.

11. Administration of HEPARIN:

Prior to administering heparin, the medication and dosage MUST be verified by a second nurse. Both the nurse who is giving the heparin and the nurse who is double checking to be certain that the correct medication and dosage have been drawn up will initial the appropriate medication administration document. At all times, the physician's order, the MAR or the appropriate nomogram will be used by both nurses to verify that medication and dosage are correct.

A. When administering a heparin infusion or bolus as directed by a weight based order set, documentation will occur on the Heparin Flow Sheet and Nomogram. The RN administering the medication or changing pump settings will initial in the "RN" column. The nurse double checking the drug calculations, pump settings and medication will initial in the "Co-sign" column.

B. When administering subcutaneous, intravenous bolus or a continuous non-weight based infusion of heparin, documentation will occur on the MAR. The nurse administering the medication will initial next to the administration time. The nurse double checking the medication and dosage (as well as pump settings with an infusion) will initial and indicate that it is a double check on the line below.

C. When administering dilute heparin flushes into an intravenous line, documentation will occur on the MAR. The nurse flushing the line will initial next to the administration time. The nurse double checking the heparin strength and dosage will initial and indicate that it is a double check on the line below.

12. Administration of INSULIN:

Prior to administering insulin, the medication and dosage MUST be verified by a second nurse. Both the nurse who is giving the insulin and the nurse who is double checking to be certain that the correct medication and dosage have been drawn up will initial the appropriate medication administration document. At all times, the physician's order or the MAR will be used by both nurses to verify that medication and dosage are correct.

A. When administering an insulin infusion, documentation will occur on the Diabetic Flow Sheet Record. The nurse administering the medication or changing pump settings will initial in the "Given Initials" column. The nurse double checking the pump settings and medication will initial in the "Checked Initials" column.

B. When administering subcutaneous or intravenous insulin (not associated with a continuous infusion), documentation will occur on the Diabetic Flow Sheet Record. The nurse administering the medication will initial in the "Given Initials" column. The nurse double checking the medication and dosage will initial in the "Checked Initials" column.

C. If the patient is self-administering insulin, two nurses are to double check the medication prior to it being taken into the patient's room. After the patient draws the insulin dose up, the nurse will double check the dosage. The nurse double checking both the medication and dosage will initial in the "Given Initials" column and the nurse double checking only the medication will initial in the "Checked Initials" column.

13. I.V. POTASSIUM:

A. Peripheral Infusion: IV potassium administration will not exceed a dilution of 10 mEq/100 ml. and will not be given over less than one hour.

B. Central Line Infusion: Non-monitored areas - IV potassium administration can not exceed a rate greater than 10 mEq per hour and a dilution of greater than 10 mEq/100 ml. Monitored areas - IV potassium administration can not exceed a rate greater than 20 mEq per hour. If there is a specific physician's order to exceed 20 mEq per hour, the patient should be in an intensive care unit (ICU) or intermediate care unit (IMCU).

14. If an adverse or allergic drug reaction is suspected, the drug is to be stopped or held until reported to the physician. If an adverse or allergic drug reaction is confirmed, document the patient's symptoms with any interventions taken in the nursing notes and complete an incident report. Refer to Administrative Policy No. 10-8: "Incidents: Definitions/Reporting Requirements/Duties of the Risk Manager".

15. Courtesy Medication: A dose of courtesy medication for family members in deaths and other traumatic occasions will be dispensed to the nursing unit from Pharmacy following the receipt of a prescription. If additional doses are needed, a prescription must be written for outpatient use, to be filled at a later date at a commercial pharmacy.

16. Routine medications should be administered within one hour of the scheduled time (i.e., if the medication is scheduled for 0800, it should be given between 0700 and 0900). The exact time a medication is given is to be noted on the MAR.

17. If a patient vomits shortly after receiving oral medications or if the IV infiltrates while receiving medication, the nurse will observe the emesis or amount of medication absorbed and call the physician for further instructions as needed. A focus nursing note should be made in the chart about redosing.

18. The nurse must verify that medication can be opened or crushed for oral or gastric tube administration before giving.

19. A patient may self-administer medications or use medications brought from home while hospitalized only under special circumstances. Refer to Administrative Policy No. 40-2: "Medications Brought into the Hospital by Patients".

20. An order to "list meds patient is on" or "continue home meds" does not constitute an order to give the medications. Obtain a list of the medications and confer with the physician for specific orders to administer the medications.

21. A new order for a medication will cancel the previous orders for that medication unless otherwise stated.

22. All orders to hold a medication must specify a time period or the medication will be discontinued.

23. Patients receiving medications for the conversion of an **unstable** cardiac arrhythmia (Verapamil, Lidocaine, Inderal, Cardizem, etc.) must have continuous ECG monitoring during administration.

24. Medication carts will be attended or locked at all times.

25. A multidose vial **without** preservatives will be labeled with the date, time and initials of the person opening it and discarded within 24 hours.

26. A multidose vial **with** preservatives is to be discarded by the manufacturer's expiration date. Do not date, time or initial these vials when opened.

27. A multidose vial **containing a lyophilized powder** requiring reconstitution will be labeled with date, time of preparation, discard/expiration date (stated in hours or days according to manufacturer), initials of person preparing as well as diluent and final concentration. Storage conditions (room temperature or refrigeration) will be stated on the vial by the manufacturer.

28. Standard dilutions for all medications have been established. A list is maintained in the Pharmacy for reference. If the diluent or final concentration needs to be altered, the nurse and pharmacist should discuss alternatives.

MEDICATION ADMINISTRATION
Page 6

29. For patients on continuous infusions of vasoactive/antiarrhythmic drugs:
    A. Infusion pumps will be used for all vasoactive/antiarrhythmic drugs.
    B. The infusion rate will be calculated and documented in the patient record every shift.
    C. Patients on vasoactive/antiarrhythmic infusions may be placed on general nursing units according to the following chart:

MEDICATION	IMCU or DIALYSIS	CPCU (3N)	GENERAL UNITS
Activase	Only low dose when used by IV Therapy to declot lines.		
Amiodarone	Yes	Yes	No
Cardizem	Yes	Yes	No
Dobutamine	Yes	Yes	*Yes
Dopamine	Yes	#Yes	#Yes
Lidocaine	Yes	Yes	No
Nipride	Yes	No	No
Nitroglycerine	Yes	No	No
Pitressin	Yes	No	No
Primacor	Yes	Yes	*Yes
Pronestyl	Yes	Yes	No

* = Only if patient is a No CRT
# = Only if renal dose; may go to general unit after drug initiation in ICU, IMCU or CPCU.

Approved: 8/93
Revised: 10/93; 1/95; 1/96; 2/97; 7/97; 10/97; 11/98; 11/99
Revised: 4/00 (Combined GENMED1 & GENMED2); 5/00; 12/00; 3/01
(m-medadm.wpd)

Source: Tallahassee (FL) Memorial Hospital.

PATIENT OBSERVATION RECORD
EMERGENCY CENTER OBSERVATION UNIT
WILLIAM BEAUMONT HOSPITAL - ROYAL OAK

PRIVATE PHYSICIAN - ***TIME CONTACTED*** -
REASON FOR OBSERVATION - (EC Obs Unit DX)

VITAL SIGNS (CIRCLE) - PER ROUTINE Q _____HOUR

ACTIVITY (CIRCLE) - AD LIB / BRP / BEDREST / WITH ASSISTANCE
RESPIRATORY - O2:

DIET (CIRCLE) - REGULAR / CARDIAC / _____cal ADA / _____gm SODIUM /_____LIQUID

TMS (CIRCLE) - NO / YES (PATIENTS ON TMS MAY BE TRANSPORTED TO EC OBS UNIT WITHOUT AN RN)

EC OBSERVATION PLAN OF CARE:

- ESTIMATED LENGTH OF STAY (GOAL=3-18 HRS): _____
- RE-EVALUATE FOR DISCHARGE: _____

SENDING ECP SIGNATURE & ID#: _____

***DICTATION MUST BE COMPLETE BEFORE TRANSFER TO Observation Unit**

Source: William Beaumont Hospital, Royal Oak, MI.

Beaumont
William Beaumont Hospital

INJECTION SITE CODES

A - LEFT DORSOGLUTEAL	B - RIGHT DORSOGLUTEAL
C - LEFT VENTROGLUTEAL	D - RIGHT VENTROGLUTEAL
E - LEFT THIGH	F - RIGHT THIGH
G - LEFT ARM	H - RIGHT ARM
I - LEFT ABDOMEN	J - RIGHT ABDOMEN

PHYSICIANS ORDER SHEET - EC OBSERVATION UNIT

ATTENTION PHYSICIAN: This preprinted form is available to facilitate patient care.
Order items by checking the box in front of the item and / or completing the blanks where necessary.
If additional items are needed, add them on the standard Doctors Order sheet (Form 280).

REASON FOR OBSERVATION : / EC OBSERVATION PLAN OF CARE

1. Initial Obs Unit ECP : Time Contacted :
2. Private Physician : Time Contacted :
3. • Print ECP Dictation ASAP
4. Allergies:
5. • Vital Signs per Routine
6. Activity : ☐ BRP ☐ Other _____
7. Respiratory : ☐ O2 per guidelines
8. Diet : ☐ Regular ☐ Cardiac ☐ _____ cal ADA
   ☐ _____gm NA ☐ _____ liquid
9. TMS : ☐ NO ☐ YES (Patients on TMS may be transported to EC Obs unit without an RN)
10. ☐ Home medications - transcribe onto med sheet. ECP to review and order
11. CPR Status Order : ☐ Full CPR (Call CPR Team)
    ☐ No CPR (CPR team will not be called, no chest compressions will be initiated by unit staff in the event of cardiopulmonary arrest)

_____ Page No. _____
Attending Physician Signature

MEDICATION ORDERS AND ADMINISTRATION RECORD

	Date	Date
12. ☐ IV 0.9NS @ _____ ml/hr **OR** ☐ Heparin Lock	0000 1200 0000 1200	0000 1200 0000 1200
13. ☐ Prochlorperazine (Compazine) 5 mg IV Push Q 6h PRN nausea **OR** ☐ Trimethobenzamide (Tigan) 200 mg IM Q 6h PRN nausea	0000 1200 0000 1200	0000 1200 0000 1200
14. ☐ Acetaminophen (Tylenol) 975 mg PO Q 6h PRN pain or fever (maximum 4gm/24hrs)	0000 1200	0000 1200
15. ☐ Ibuprofen (Motrin) 600 mg PO Q 6h PRN pain or fever	0000 1200	0000 1200
16. ☐ Maalox 30cc PO PRN indigestion	0000 1200	0000 1200
17. ☐ Temazepam (Restoril)15 mg PO QHS PRN sleep	0000 1200	0000 1200

Sending ECP Signature	Dr. Page No.	Date	Time	Name & ID #	Name & ID #

Noted by Unit Secretary	Date	Time	Noted by R.N.	Date	Time

7679A FEB 99 WP Medical Record

Source: William Beaumont Hospital, Royal Oak, MI.

Beaumont
William Beaumont Hospital

PATIENT ID STAMP

EC OBSERVATION UNIT CHEST PAIN TRACKING SHEET

	Time 0 = triage time (ECG, CKMB, Myo)*	4 hours (ECG, CKMB, Myo)	4hr – 0hr ** CKMB / Myo diff.	8 hours – *if needed* (CK, TnT, ECG)***
Time				
ECG				
CK (M<230, F<150)				
CK-MB (< 10ng/ml)				
CK-MB index (< 4.0%)				
Myoglobin (< 110ng/ml)				
Troponin T (<0.2ng/ml)				

*** If** 4 hour labs are sent, **call lab** to add Myoglobin to initial EC blood.
******4hr – 0hr diff. = Myoglobin and CKMB change over 4 hours = Time 0 hr (EC) – 4 hr level
******* 8 hour testing indicated if: **(a) 4 hr test missed, (b) any Myoglobin elevated,**
(c) Myoglobin or CKMB are NORMAL but DOUBLES over 4 hours.

4 HOUR ECG: _____

Stress test (circle one): TIME DONE _____

GXT / GXT-MPI / PERSANTINE / GXT-Echo / Dobut.-Echo / NONE

Stress test results (circle one):

NORMAL / ABNORMAL / EQUIVOCAL - INDETERMINANT

FINAL Observation Unit diagnosis (circle one):

- MI
- Unstable angina
- Musculoskeletal chest pain
- Gastritis – esophagitis
- Anxiety disorder
- Other (write in) _____

NOT A PERMANENT PART OF THE MEDICAL RECORD

7680 X MAY 99

Source: William Beaumont Hospital, Royal Oak, MI.

Beaumont
William Beaumont Hospital

EC OBSERVATION UNIT NURSING AND PHYSICIAN ASSESSMENT SHEET

Chief Complaint :

HPI (O,P,Q,R,S,T, Details) -

Past Medical History :

☐ Yes ☐ No Diabetes (Insulin Dependent DM / Non Insulin Dependent DM)
☐ Yes ☐ No High Cholesterol or Lipids
☐ Yes ☐ No Hypertension (High Blood Pressure)
☐ Yes ☐ No Heart Problems
(Angina / Heart Attack(MI) / Bypass Surgery / Angioplasty / Valve Disease)
☐ Yes ☐ No Lung Problems (Asthma / Emphysema / COPD)
☐ Yes ☐ No Kidney Problems (Kidney Stones / Kidney Failure / Kidney Infections)
☐ Yes ☐ No Seizure (Epilepsy)
☐ Yes ☐ No Stroke / TIA
☐ Yes ☐ No Cancer
☐ Yes ☐ No Other Problems _____

Past Surgical History (Operation, Year)

Allergies (Drug, Reaction)

Medications - Please record in the space below any Medications, the **dose**, and **how often** you take it.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Family History - Do you have any illnesses or diseases that run in your immediate family as noted below?

☐ Yes ☐ No Family history of heart attack / angina
☐ Yes ☐ No Seizures
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Stroke
☐ Yes ☐ No Other disease (Please specify) _____

6062 APR 99 Medical Record

Beaumont
William Beaumont Hospital

EC OBSERVATION UNIT NURSING AND PHYSICIAN ASSESSMENT SHEET

Social History:

☐ Yes ☐ No Do you smoke?
If so, how many packs a day? _____
How many years have you smoked? _____
☐ Yes ☐ No Do you drink alcohol?
If so, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
☐ Yes ☐ No Do you use any illegal drugs?

Review of Systems : Have you had any problems related to the following areas?

☐ Yes ☐ No Recent weight loss or weight gain
Weight _____ Height _____
☐ Yes ☐ No Fevers, chills, night sweats
☐ Yes ☐ No Eye problems, vision problems
☐ Yes ☐ No Sore throat, difficulty swallowing
☐ Yes ☐ No Jaw pain, teeth pain, cavities
☐ Yes ☐ No Neck pain, neck swelling
☐ Yes ☐ No Chest pain, heart palpitations, heart pain, chest aching, chest discomfort or pressure
☐ Yes ☐ No Difficulty breathing, short of breath, frequent cough, or cough up blood
☐ Yes ☐ No Abdominal pain, foods upset your stomach
☐ Yes ☐ No Frequent vomiting or vomiting blood
☐ Yes ☐ No Diarrhea, constipation, black stools
☐ Yes ☐ No Pain with urinating, urinating often
☐ Yes ☐ No Testicular pain or swelling
☐ Yes ☐ No Menstrual problems, vaginal discharge
Date of last menstrual period _____
☐ Yes ☐ No Muscle pains, joint pain or swelling
☐ Yes ☐ No Nervous problems, psychiatric problems
☐ Yes ☐ No Allergies, skin rashes
☐ Yes ☐ No Blood disorder, clotting problems, easy bruising
☐ Yes ☐ No Headaches, confusion, slurred speech, weak, numb or paralyzed limb
☐ Yes ☐ No Dizziness, difficulty walking
☐ Yes ☐ No Back pain, back injury
☐ Yes ☐ No Deafness, ringing in ears, buzzing in ears
☐ Yes ☐ No Sleepiness, difficulty arousing

Nurse Signature _____

Reviewing ECP Signature _____

6062 APR 99 Medical Record

Source: William Beaumont Hospital, Royal Oak, MI.

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.