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ED Management®

The monthly update on Emergency Department Management

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July 2001

Follow new pediatric guidelines or risk inappropriate care, liability

Many emergency departments are not in compliance

A child comes to the ED with abdominal pain and bruises on the legs and buttocks. A CT scan of the abdomen is negative for appendicitis, and his white blood cell count is normal. Child abuse is suspected immediately, and the boy is taken into protective custody.

The child is later found to have Henoch-Schonlein purpura, which is seen only in children between 4 and 10 years old, says **Barbara Weintraub**, RN, MPH, MSN, pediatric critical care nurse practitioner at Northwest Community Hospital in Arlington Heights, IL.

"These children can go on to have nephritis, nephrotic syndrome, and renal failure if the condition is not recognized and treated appropriately," she adds.

To avoid scenarios like this, you'll need to comply with new guidelines for pediatric care. *Care of Children in the Emergency Department: Guidelines for Preparedness* was jointly published by the Dallas-based American College of Emergency Physicians (ACEP) and the Elk Grove Village, IL-based American Academy of Pediatrics (AAP). **(For information on obtaining a complete copy of the guidelines, see resource box, p. 74.)**

If you don't follow the guidelines, you face potential risk management problems, warns **Marianne Gausche-Hill**, MD, FACEP, FAAP, director of emergency medical services at Harbor-University of California at Los Angeles Medical Center in Torrance.

Executive Summary

If you don't comply with new guidelines for pediatric emergency care jointly developed by the American College of Emergency Physicians and American Academy of Pediatrics, you risk adverse outcomes and lawsuits.

- When transferring a critically ill or injured child, use transport services with specific pediatric training.
- Have a physician and nursing coordinator ensure compliance with the guidelines.
- Ensure that staff are trained in pediatric resuscitation, and provide age-specific competencies for neonates, infants, children, and adolescents.

"Certainly, not abiding by published guidelines creates potential liability," Gausche-Hill says. "For example, there would be no defense for not having the equipment necessary to care for children of all ages."

When national organizations publish guidelines, they tend to be interpreted in legal circles as standards, explains Weintraub. "You need to sit up and take notice of these guidelines," she urges. "Unfortunately, quality-of-care issues become litigation issues when the outcome is not good."

Following the guidelines will improve patient satisfaction and decrease poor outcomes, adds Weintraub. "This can help ensure consistent, quality, family-centered care for our smallest, most vulnerable patients," she says. "Parents expect that the care we give them will be specific to their child's needs, and this is often not the case today."

Even if there is no adverse outcome, parents will not be happy if pediatric care is lacking in your ED, stresses Weintraub. She offers the following example: An

Resources

The American College of Emergency Physicians (ACEP)/ American Academy of Pediatrics (AAP) policy statement, "Care of Children in the Emergency Department: Guidelines for Preparedness" (published in the April 2001 issues of *Pediatrics and Annals of Emergency Medicine*), is among the AAP policy statements that can be downloaded free from the web site: www.aap.org. (Click on "Policy Statements." Under heading "C," click on "Care of children in the emergency department: Guidelines for preparedness.") The policy statement also can be purchased for $1.95 per copy, including shipping and handling. To order, contact:

- AAP Publications Department, P.O. Box 747, Elk Grove Village, IL 60009-0747. Telephone: (800) 433-9016 Ext. 4776 or (847) 981-7924. Fax: (847) 228-1281. E-mail: pubs@aap.org.

The Emergency Nursing Pediatric Course (ENPC) is a 16-hour course. For a list of ENPC courses in your area, go to the ENA web site (www.ena.org), click consecutively on "Programs and Meetings," "Continuing Education," and "ENPC Schedule." For more information, contact:

- ENA, Department of Trauma and Pediatric Services, 915 Lee St., Des Plaines, IL 60016. Telephone: (800) 900-9659. E-mail: jmika@ena.org.

A Pediatric Advanced Life Support Course (PALS) is offered by the American Heart Association (AHA). The course focuses on advanced medical assessment and interventions used to treat pediatric victims of respiratory and/or cardiovascular emergency and stroke.

- To contact AHA staff at a local level, call (888) 352-3824 or send an e-mail to cprecc@heart.org. For more information about the course, go to the AHA site for Emergency Cardiovascular Care Programs (www.cpr-ecc.org). Click on "About Courses," "Healthcare Provider Course Descriptions," and then "PALS provider."

The Advanced Pediatric Life Support Course (APLS) is offered by ACEP and the AAP. To find a course in your area, go to the AAP web site (www.aap.org). Click consecutively on "Professional Education," "Life Support Programs," "APLS: The Pediatric Emergency Medicine Course," and then "Find an APLS Course or Course Director." Or contact:

- American Academy of Pediatrics, 141 N.W. Point Blvd., Elk Grove Village, IL 60007-1098. Telephone: (847) 434-4000 ext. 4795. Fax: (847) 228-1350. E-mail: lifesupport@aap.org.

- A free Pediatric Resource Kit available from Emergency Medical Services for Children covers illness and injury prevention, patient care training and safety, equipment guidelines, public policy, and special populations. The kit can be downloaded from the EMS-C web site (www.ems-c.org) by clicking on "Products and Resources" and then "EMS-C Resources." A free CD-ROM version is available by contacting EMS-C Clearinghouse at (703) 902-1203 or send an e-mail to emsc@circsol.com.

COMING IN FUTURE MONTHS

- How to deal with abusive colleagues
- Update on emergency services legislation
- Strategies for staff training to prevent assaults
- Effective ways to address patient complaints

11-year-old boy presents with chest tightness. "This is a red flag for cardiac disease in the adult world, so he receives a chest X-ray and an ECG, both of which are read as normal, and the child is discharged," she says.

However, chest tightness in a child is more commonly respiratory-related, says Weintraub. "When the child returns later that afternoon to a pediatric ED with continued chest tightness, it is recognized that although wheezing couldn't be heard, it was most likely due to decreased air entry," she says.

He receives an albuterol nebulizer treatment, with immediate relief of the chest tightness. "Although the parents are delighted that their child is better, they perceive that they wouldn't have needed two visits had the ED staff at the first visit known kids better," she says.

Here are ways to comply with the guidelines:

• Find out if transport services are trained adequately.

Identifying the transport services with pediatric training is essential before you transfer seriously/critically ill and injured children, warns **Nancy Eckle**, RN, MSN, program manager for emergency services at Children's Hospital in Columbus, OH.

You may be tempted to send a child with the first available transport service, she explains. "However, if the transport team is not trained in the care of children, changes in condition and needed interventions may not be recognized," Eckle says.

When assessing the team's training, Eckle recommends asking the following questions:

— What pediatric competency has been established for the team members?

— What is the experience/background of the team?

— Do team members have pediatric specific training and ongoing education?

— What pediatric courses are taken by the team?

— Are team members all verified in pediatric life support courses?

• Designate a "coordinator" for pediatric emergency care.

The guidelines recommend that you have physician and nursing coordinators who will ensure that appropriate policies and procedures are in place, equipment and supplies appropriate for children are available, and a quality or performance improvement plan is in place. **(See Guidelines for Administration and Coordination of the ED for the Care of Children, p. 76, and Facility Recognition Criteria for the Emergency Department Approved for Pediatrics, enclosed in this issue.)**

The "coordinator" role can be a separate position or it can be an added role for a nurse manager or medical director, says Gausche-Hill. **(See Job Description for Coordinator of Pediatric Emergency Services, enclosed in this issue.)**

"These individuals ensure that the recommendations made in the guidelines would be appropriately addressed in the ED's policies and procedures manual," she explains.

This recommendation, when followed, ensures that there is an identified person with a pediatric focus and expertise who can evaluate care issues, says Eckle. "That person is focused on the needs of pediatric patients in the ED, including staff education needs, equipment needs, and quality improvement," she adds.

At Northwest Community Hospital, the nursing coordinator recommends equipment and training needs, conducts inservices, and monitors pediatric quality improvement activities, Weintraub reports.

"This individual ensures that the nursing care received by a pediatric patient anywhere within the emergency care continuum is research-based and family-centered," she says.

• Ensure that all staff members have appropriate pediatric training.

All emergency care providers must be able to evaluate and intervene for a child with an emergent condition, stresses Eckle. "Not being able to recognize an emergency condition and take the appropriate steps to stabilize the patient can cost the child his/her life," she warns.

Age-specific competencies should include neonates, infants, children, and adolescents, she urges. **(See Guidelines for Physicians and other Practitioners Staffing the ED, p. 77.)**

A report from Illinois Emergency Medical Services for Children (EMS-C) found that while 91% of ED physicians had taken an Advanced Cardiac Life Support (ACLS) course for adult resuscitation, only

Sources

For more information about the guidelines, contact:

- **Nancy Eckle**, RN, MSN, Emergency Services, Children's Hospital, 700 Children's Drive, Columbus, OH 43205. Telephone: (614) 722-4353. Fax: (614) 722-6890. E-mail: EckleN@chi.osu.edu.
- **Marianne Gausche-Hil**l, MD, FACEP, FAAP, Harbor-UCLA Medical Center, 1000 W. Carson St., Box 21, Torrance, CA 90509. Telephone: (310) 222-3501. Fax: (310) 782-1763. E-mail: mgausche@emedharbor.edu.
- **Barbara Weintraub**, RN, MPH, MSN, Northwest Community Hospital, 800 W. Central Road, Arlington Heights, IL 60005. Telephone: (847) 618-5432. Fax: (847) 618-4169. E-mail: bweintraub@nch.org.

63% had completed a pediatric equivalent such as Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS). Similarly, 90% of ED nurses had completed an ACLS course, but only 35% had completed a formal pediatric resuscitation course.[1] EMS-C is a Washington, DC-based national program to ensure that state-of-the-art emergency medical care is available for ill or injured children.

Weintraub recommends the Emergency Nursing Pediatric Course (ENPC) from the Des Plaines, IL-based Emergency Nurses Association as the "baseline" course for nurses. "It covers assessment, triage, and specific pediatric emergency conditions, as well as treatment of these conditions," she says. "It also addresses grieving, transport of ill children, trauma, and child abuse." **(See resource box for information**

Guidelines for Administration and Coordination of the ED for the Care of Children (Excerpt)

A. A Physician Coordinator for Pediatric Emergency Medicine is appointed by the ED Medical Director.
   1. The Physician Coordinator has the following qualifications:
      a. The Physician Coordinator meets the qualifications for credentialing by the Hospital as a specialist in emergency medicine, pediatric emergency medicine, or pediatrics.
      b. The Physician Coordinator has special interest, knowledge, and skill in emergency medical care of children as demonstrated by training, clinical experience, or focused continuing medical education.
      c. The Physician Coordinator may be a staff physician who is currently assigned other roles in the ED, such as the Medical Director of the ED, or may be shared through formal consultation agreements with professional resources from a hospital capable of providing definitive pediatric care.
   2. The Physician Coordinator is responsible for the following:
      a. Ensure adequate skill and knowledge of staff physicians in emergency care and resuscitation of infants and children.
      b. Oversee ED pediatric quality improvement (QI), performance improvement (PI), and clinical care protocols.
      c. Assist with development and periodic review of ED medications, equipment, supplies, policies, and procedures.
      d. Serve as liaison to appropriate in-hospital and out-of-hospital pediatric care committees in the community (if they exist).
      e. Serve as liaison to a definitive care hospital, which includes a regional pediatric referral hospital and trauma center; EMS agencies; primary care providers; health insurers; and any other medical resources needed to integrate services for the continuum of care of the patient.
      f. Facilitate pediatric emergency education for ED health care providers and out-of-hospital providers affiliated with the ED.

B. A Nursing Coordinator for Pediatric Emergency Care is appointed.
   1. The Nursing Coordinator has the following qualifications:
      The Nursing Coordinator demonstrates special interest, knowledge, and skill in emergency care and resuscitation of infants and children as demonstrated by training, clinical experience, or focused continuing nursing education.
   2. The Nursing Coordinator is responsible for the following:
      a. Coordinate pediatric QI, PI, and clinical care protocols with the Physician Coordinator.
      b. Serve as liaison to appropriate in-hospital and out-of-hospital pediatric care committees.
      c. Serve as liaison to inpatient nursing as well as to a definitive care hospital, a regional pediatric referral hospital and trauma center, EMS agencies, primary care providers, health insurers, and any other medical resources needed to integrate services for the continuum of care of the patient.
      d. Facilitate ED nursing continuing education in pediatrics and provide orientation for new staff members.
      e. Provide assistance and support for pediatric education of out-of-hospital providers affiliated with the ED.
      f. Assist in development and periodic review of policies and procedures for pediatric care.
      g. Stock and monitor pediatric equipment and medication availability.

Source: American College of Emergency Physicians and the American Academy of Pediatrics. Excerpt of Care of Children in the Emergency Department: Guidelines for Preparedness. *Ann Emerg Med* 2001; 37:423-427.

Guidelines for Physicians and Other Practitioners Staffing the ED

• Physicians staffing the ED have the necessary skill, knowledge, and training to provide emergency evaluation and treatment of children of all ages who may be brought to the ED, consistent with the services provided by the hospital.

• Nurses and other practitioners have the necessary skill, knowledge, and training to provide nursing care to children of all ages who may be brought to the ED, consistent with the services offered by the hospital.

• Competency evaluations completed by the staff are age-specific and include neonates, infants, children, and adolescents.

Source: American College of Emergency Physicians and the American Academy of Pediatrics. Excerpt of Care of Children in the Emergency Department: Guidelines for Preparedness. *Ann Emerg Med* 2001; 37:423-427.

about pediatric courses, p. 74.) Weintraub also recommends that ED nurses take PALS, but notes that this course is more focused on the resuscitative aspect of pediatric care.

Research shows that in the vast majority of pediatric cases, if the assessment and treatment follow established guidelines, resuscitative measures will not be needed, she says. "Research also indicates that when children do require full resuscitation, the outcomes are even more dismal than for adults," she adds.[2]

All ED physicians should be PALS-certified and also should consider a neonatal resuscitation program (NRP) certification, offered jointly by the AAP and the Dallas-based American Heart Association, adds Weintraub.

At Northwest's ED, nurses are required to take ENPC, PALS, the Emergency Nurses Association's Trauma Nursing Core Course (TNCC), and 20 hours of pediatric-specific continuing education per year, says Weintraub.

"We also offer a pediatric-specific IV skills lecture," she notes. "Even veteran ED nurses have indicated that this lecture has taught them new strategies."

References

1. Illinois Department of Public Health. *Illinois EMSC Needs Assessment Summary* 1994-1995. Springfield, IL; 1996.

2. American College of Emergency Physicians and the American Academy of Pediatrics. Care of children in the emergency department: guidelines for preparedness. *Ann Emerg Med* 2001; 37:423-427. ■

Educate patients, cut return asthma visits

Would you like to cut your return visit rate for asthma patients in half? That's what the ED at New Britain (CT) General Hospital achieved after a successful asthma education program was implemented.

"The rate of readmission to the ED within 72 hours decreased by 50%," reports **Patti LaMonica**, RN, MSN, the ED's nurse manager, who developed the asthma education procedure.

A significant number of ED visits could be prevented with appropriate education, according to **Lisa Molitor**, MSN, ARNP, CEN, CCRN, ED nurse practitioner at Shands at Alachua General Hospital in Gainesville, FL. "There are large numbers of poorly educated asthmatics who use the ED," she notes.

Because asthma patients have frequent exacerbations and remissions, the ED is often the "port of entry" to the health care system, says **Karen Huss**, RN, DNSc, CANP, FAAN, associate professor at Johns Hopkins University School of Nursing in Baltimore, MD. In fact, their asthma may first be diagnosed in the ED, says Huss.

"This presents a wonderful opportunity to educate patients with asthma about their disease and how to control it," she adds. **(See Asthma in Adults and Asthma Patient Education Protocol, both inserted in this issue.)**

More 'wheeze free' days

There are many recent changes in the treatment and long-term management of asthma that patients may not be aware of, says Molitor. "With the right combination of medications, most patients with asthma can enjoy many more "wheeze free" days than we used to think possible," she explains.

Executive Summary

An effective asthma education program can reduce return visits to the ED and adverse outcomes.

- The program should be tracked to ensure that every asthma patient receives education.
- ED nurses should work collaboratively with respiratory therapists.
- Patients should be called shortly after their ED visit to ensure they understand their discharge instructions and have made follow-up appointments.

For example, knowing how to use a peak flow meter can prevent ED visits, says Molitor. "Dips in the peak flow number signal the early onset of an asthma attack, so steps can be taken to prevent the second inflammatory phase from starting," she adds.

Here are effective ways to reduce return visits by asthma patients:

• Track the percentage of patients who are educated.

Louis Graff, MD, FACEP, FACP, associate director of the ED at New Britain (CT) General Hospital, recommends monitoring the percentage of patients receiving asthma education. When the program was implemented, the ED and the pulmonary department started a joint quality improvement project**,** he explains.

Monthly QI meetings

Monthly quality improvement committee meetings were held, and the head of respiratory therapy gave the statistics on how many asthma patients received patient education.

"We kept track each month of the percent of asthma patients getting education until it was nearly 100%," Graff reports. "We also focused on components of the education, such as how many patients were given pre-peak flows and post-peak flows."

• Collaborate with respiratory therapists.

At New Britain General, the respiratory therapist collaborates with the patient's ED nurse, says Graff. "That way, either individual can perform some of the tasks as needed," he says.

The respiratory therapist is called for every asthma patient, who is educated on the use of the metered dose inhaler, spacer, and peak flow meter. Next, the patient watches a video and is asked to demonstrate how to use the devices, says LaMonica. Upon discharge, the patient is given the video to take home, along with a packet of educational materials.

• Offer community services.

At New Britain, the ED held a free inservice in the hospital cafeteria for local asthmatics, including a lecture given by a pulmonologist and giveaways of free spacers and peak flow meters. Nurses, nutritionists, pharmacists, and exercise therapists also were there to answer questions, she adds.

The event was promoted with posters in the ED and local newspaper and radio ads. "It was a very low-budget event, but we had over 100 patients attend," says LaMonica.

• Address environmental factors.

Huss notes that individuals under the age of 50 presenting to the ED with asthma have a high incidence of allergy to indoor allergens, house dust mites, cats, and cockroaches.[1]

"Therefore, referral to an allergy/immunology specialist may be appropriate for this group of patients," she notes.

ED staff should educate asthma patients on avoidance of environmental irritants such as tobacco smoke and indoor/outdoor air pollution, says Huss.

• Give patients follow-up telephone calls.

LaMonica recommends calling asthma patients two days after the ED visit to make sure they were following the instructions they were given. "I ask them to explain to me their discharge instructions, and I check to make sure it's correct," she says.

Patients often have inhalers that run out, but fail to address this until they have an attack weeks later and wind up in the ED, LaMonica notes. "The follow-up call reminds the patient to make sure they don't run out of their inhaler and also triggers them to make their follow-up appointment with a primary care physician or a clinic," she says.

Reference

1. Gelber LE, Seltzer LH, Bouzoukis JK, et al. Sensitization and exposure to indoor allergens as risk factors for asthma among patients presenting to hospital. *Am Rev Respir Dis* 1993; 147:573-578. ■

Sources

For more information about educating asthma patients in the ED, contact:

- **Louis Graff**, MD, FACEP, FACP, Department of Emergency Medicine, New Britain General Hospital, 100 Grand St., New Britain, CT 06050. Telephone: (860) 224-5675 Fax: (860) 224-5774. E-mail: louisgraff@home.com.
- **Karen Huss**, RN, DNSc, CANP, FAAN, Johns Hopkins University, School of Nursing, 525 N. Wolfe St., Room 416, Baltimore, MD 21205. Telephone: (410) 614-5296. Fax: (410) 955-7463. E-mail: khuss@son.jhmi.edu.
- **Patti LaMonica**, RN, MSN, Emergency Department, New Britain General Hospital, 100 Grand St., New Britain, CT 06050. Telephone: (860) 224-5771. Fax: (860) 224-5774. E-mail: PLamonic@nbgh.org.
- **Lisa Molitor**, ARNP, RNC, MSN, CEN, CCRN, 8404 SW 28th Place, Gainesville, FL 32607. E-mail: Lmolitorge@aol.com.

Don't miss payments during observation

You may be missing out on reimbursement under ambulatory payment classifications (APCs), warns **Shawn Keenen**, ED manager at Monongalia General Hospital in Morgantown, WV. "We certainly need to take advantage of every break we can, to ensure we get as much reimbursement as possible," he says.

There is currently no separate reimbursement for observation itself, but you can get paid for procedures performed during observation, stresses Keenen. "ED managers are generally not aware of all the procedures that can be billed," he says.

Intramuscular injections reap up to $45

Keenen notes that regular intramuscular injections given by nurses are being reimbursed up to $45, depending on what is being given. "Conceivably, you could charge for several morphine injections for pain control for the same patient," he adds.

Here are effective ways to receive reimbursement for procedures performed while a patient is under observation:

• Educate coders about APCs.

Historically, many EDs bundled their procedures with the visit levels and didn't assign these codes separately, says **Candace E. Shaeffer**, RN, MBA, vice president of coding/quality management for Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

"The ED coders or nurses may be unfamiliar with CPT coding and APCs and may not be aware that a certain code can and should be separately billed," Shaeffer explains.

She suggests holding an inservice provided by an internal expert or a consultant. "Some nurse managers have gained expertise in coding and APCs," Shaeffer says. "An outpatient coder may also be a good resource."

• Know which procedures can be billed separately.

ED staff might not know that when a patient has a procedure performed in observation, that procedure may be billed and reimbursed even if the observation visit is not, says Shaeffer.

No site-of-service limitations restrict payment based on where a procedure is performed, she says. "However, hospitals usually have policies about what procedures are performed in what area."

Discuss this with your hospital's CFO or a reimbursement specialist to make sure you understand which procedures can be billed separately, Shaeffer adds. "Do this to gain a thorough understanding of outpatient reimbursement and APCs so you can optimize reimbursement in your ED," she says.

Many procedures can be billed separately, including injections, IV medication administration, and even application of different types of prefabricated splints, such as air casts or knee braces, Keenen notes.

Develop an appropriate list by reviewing the list of APCs, and consider your hospital policy and scope of services typically performed in observation, Shaeffer suggests. (For a list of procedures and codes with corresponding APCs, go to HCFA's web site, www.hcfa.gov/medlearn. Under "quick reference guides," click on "outpatient prospective payment system" and then "interim final rule.")

Form can help ID procedures

Monongalia General's ED uses a form that identifies procedures which can be reimbursed separately, such as injections. "The sheet can also help the biller/coder to identify procedures the physician did that the nurse assisted with, such as suturing, thoracentesis, or thrombolytic administration," says Keenen. Those procedures can be billed for the physician side, he explains. **(See Emergency Department Nursing Intervention Sheet, enclosed in this issue.)**

• Perform a review of the ED chargemaster.

If the ED or observation charge ticket or chargemaster is incomplete, the nurses or coders might not be able to assign a particular procedure code. She recommends performing a chargemaster review and analysis to make sure the codes and fees are current and

Executive Summary

Under ambulatory payment classifications (APCs), there is no separate reimbursement for observation itself, but you can get paid for procedures performed during observation.

- Educate nurses and physicians about which procedures can be billed separately, including injections and IV medication administration.
- Use coders who are specially trained for ED visits.
- Review the ED chargemaster to make sure the list of procedures is complete.

that the chargemaster has codes for all of the procedures performed in the ED.

"This will require some coding and reimbursement expertise. But an ED nurse manager could collaborate with the person responsible for chargemaster maintenance to complete this project," says Shaeffer.

Once the chargemaster is updated, also update the charge ticket, if the ED is using one of these for facility charges, she advises.

• Have specially trained coders for the ED.

At Monongalia, the ED has its own coders who were trained by Medical Management Resources in Jacksonville, FL, reports Keenen. "The average coder is geared toward inpatient coding," he says. "The ED coder must be experienced in ED coding, which is a different thing totally."

Nursing and physician notes both important

Because the ED visit is coded in two sections: the professional fee and the facility fee or nursing charge, the coder must be able to read both the nursing notes and the physician notes, and extract all the items that can be coded and billed, Keenen says.

The ED coder regularly speaks to physicians about their documentation, he says. "Improved documentation can increase the level of care and, therefore, the APC level which we bill," Keenen adds. (For more information on reimbursement for observation services, see *ED Management*, May 2001, p. 49. For information on reducing costs of observation services, see *ED Management*, June 2001, p. 64.) ■

Sources

For more information about reimbursement under APCs, contact:

- **Shawn Keenen**, Emergency Department, Monongalia General Hospital, 1200 J.D. Anderson Drive, Morgantown, WV 26508. Telephone: (304) 598-1900. Fax: (304) 598-1457. E-mail: KeenenS@monhealthsys.org.
- **Candace E. Shaeffer**, RN, MBA, Vice President of Coding/Quality Management, Lynx Medical Systems, 15325 SE 30th Place, Suite 200, Bellevue, WA 98007. Telephone: (800) 767-5969 ext. 2039 or (425) 641-4451. Fax: (425) 641-5596. E-mail: candaces@lynxmed.com.

EMTALA Q & A

This column is an ongoing series that will address reader questions about the Emergency Medical Treatment and Active Labor Act (EMTALA). If you have a question you'd like answered, contact Staci Kusterbeck, Editor, ED Management, *280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciKusterbeck@aol.com.*

(Editor's note: A response to a question addressed in the May 2001 issue of ED Management *generated significant debate among readers and EMTALA experts. Below, we explore this controversial topic further.)*

Question: During the night, police officers frequently bring individuals to the hospital for screening of blood alcohol levels. Our lab is staffed with only one person and is locked, which makes it difficult to access. If the officer brings the person to the ED for the blood draw, are we required to do a medical screening examination (MSE)?

Answer: "The primary issue is whether or not the individual's presence at the ED constitutes a request for examination or treatment that triggers the hospital's duty under EMTALA to provide an MSE," contends **Robert A. Bitterman,** MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC.

The law holds that the request for the MSE can come from anyone, not just the patient, he stresses. "Thus, the police officer's request for blood alcohol testing may itself be sufficient to constitute a request," he says.

Also, he notes that the Health Care Financing Administration (HCFA) views alcohol intoxication to be a "sufficiently severe medical symptom to warrant the label 'emergency medical condition'" [59 *Fed Reg* 32107 (1994)] .

Thus, an intoxicated individual has an emergency medical condition until the hospital proves otherwise, concludes Bitterman. "Furthermore, while legally debatable, the Health Care Financing Administration believes that anyone coming to the ED for tests must be provided an MSE unless the patient voluntarily withdraws the request for the examination," he says.

Police bring people to the ED to obtain a blood alcohol level because they believe the individual to be intoxicated, but they don't know for sure, says Bitterman. "Many emergency conditions mimic alcohol intoxication, including hypoglycemia, cerebral hypoxia, head injury, metabolic abnormalities, or other toxins," he warns.

Neither the hospital nor the police should automatically presume alcohol intoxication to be the cause of the patient's condition, Bitterman emphasizes. "The emergency physician should perform an MSE in these cases," he says.

However, the patient can refuse the offered MSE by the ED physician and request only that blood be drawn and provided to the police officer, says Bitterman. "But only competent individuals can refuse the MSE, so the ED physician [not a nurse or registration clerk] must first ascertain that the patient is competent to refuse," he underscores.

If the individual is clinically too intoxicated to make an informed decision, then the physician must keep that person in the ED until he or she is competent enough to make rational decisions, Bitterman adds.

He warns that these are clearly high-risk individuals. "To not offer them an examination or determine if they are competent to refuse an exam is a major risk management mistake," he says. "If you offer them an exam and they refuse, and are competent to do so, then EMTALA no longer applies and you can proceed to draw the blood."

Finally, Bitterman rejects the notion that EMTALA does not apply if the individual does not have an emergency medical condition. "The law requires the hospital to provide an MSE to anyone presenting requesting examination or treatment for a 'medical condition'; it does not say for an 'emergency medical condition,'" he explains. "Only after the hospital performs the MSE and the MSE determines the patient does not have an emergency medical condition, then and only then does EMTALA not apply further."

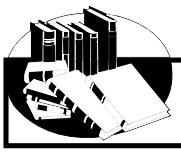
Bitterman acknowledges that if the patient denies requesting or refuses the MSE, then you do not have to supply one. However, you should offer one and document the patient's refusal and competence to refuse, he cautions.

"Alcohol-related incidents are an extremely common source of litigation against hospitals," says Bitterman. "Common sense should prevail." ■

Sources

For more information about EMTALA, contact:

- Robert A. Bitterman, MD, JD, FACEP, Department of Emergency Medicine, Carolinas Medical Center, P.O. Box 32861, Charlotte, NC 28232-2861. Telephone: (704) 355-5291. Fax: (704) 355-8356. E-mail: rbitterman@carolinas.org.
- 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.



JOURNAL REVIEW

Buelow M. **Noise level measurements in four Phoenix emergency departments**. *J Emerg Nurs* 2001; 27:23-26.

When four EDs in the Phoenix, AZ, area were tested for noise levels, it was found that all of them were at hazardous levels for staff and patients, says this study. The researcher compared noise levels in the four EDs with decibel level standards established by the Washington, DC-based National Institute for Occupational Safety and Health. The recording unit was placed near the clerk's desk.

All of the noise levels were higher than the 50-decibel level that is considered acceptable for a work environment, and many levels were high enough to cause feelings of annoyance.

"These noise levels are sufficient to cause deleterious psychological and secondary physical effects on staff members," writes the researcher. He suggests taking the following steps to reduce noise:

- using sound-absorbing materials such as carpeting, acoustic ceiling tiles, padded partitions, or solid doors;
- contacting your local telephone company to disconnect telephone ringers and substitute a flashing light or gentle gong sound;
- setting cardiac monitors carefully to reduce the number of false alarms sounding;
- giving staff members cell phones to replace overhead paging;
- holding inservice sessions on the importance of noise control.

EDs should make sound control part of their department's culture, recommends the researcher. "We must not allow other priorities to push noise management out of our awareness," he writes. ■

CE/CME questions

[For more information about participating in the continuing education program, please contact American Health Consultants, Customer Service, PO Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcpub.com. Web: www.ahcpub.com.)

19. Which of the following is recommended by new guidelines for pediatric care, *Care of Children in the Emergency Department: Guidelines for Preparedness*, which was jointly published by the American College of Emergency Physicians and the American Academy of Pediatrics?

A. The guidelines may legally be interpreted as standard of care, so there are liability risks if you don't comply.

B. A critically ill or injured child should be sent with the first available transport team.

C. Physician and nursing coordinators for pediatric emergency care must be separate positions, not added roles for existing job positions.

D. There are no increased liability risks for noncompliance with the guidelines, because they are not mandated by law.

20. Which of the following is recommended regarding staff education about pediatric emergency care, according to Barbara Weintraub, RN, MPH, MSN, pediatric critical care nurse practitioner at Northwest Community Hospital?

A. The minimum recommendation for ED nurses is the Emergency Nurses Association's Emergency Nursing Pediatric Course.

B. Only nurses who see a high volume of pediatric patients should take Pediatric Advanced Life Support (PALS) courses.

C. Resuscitation outcomes are generally better in children than adults.

D. If PALS courses are taken, pediatric-specific continuing education is not needed.

21. Which of the following is true regarding EMTALA requirements and patients being brought to the ED for screening of blood alcohol levels, according to Robert A. Bitterman, MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center?

A. No medical screening examination is needed, because intoxication is not an emergency medical condition.

B. The request for a medical screening examination must come from the patient.

C. Police officer's request for blood alcohol testing may be considered a request for a medical screening examination.

D. Because the patient is not coming to the ED voluntarily, no medical screening examination is needed.

22. Which of the following is accurate regarding education of asthma patients in the ED, according to Patti LaMonica, RN, MSN, ED nurse manager at New Britain (CT) General Hospital?

A. There is no evidence that return asthma visits can be prevented with education.

B. The ED is not an appropriate setting for education of asthma patients.

C. Education efforts from the ED and respiratory therapists should be separate.

D. Consistent education can significantly reduce return visits.

23. Which of the following is true, regarding payments under ambulatory payment classifications (APCs) for procedures performed during observation, according to Candace E. Shaeffer, RN, MBA, vice president of coding/quality management for Lynx Medical Systems?

A. Procedures performed during observation cannot be separately billed.

B. Under APCs, there are site-of-service limitations that restrict payment based on where a procedure is performed.

C. When a patient has a procedure performed in observation, that procedure may be billed and reimbursed even if the observation visit is not.

D. Injections are the only procedures that may be billed separately.

24. Which of the following is true regarding EDs and noise levels, according to a study recently published in *Journal of Emergency Nursing*?

A. None of the EDs tested had noise levels at hazardous levels.

B. All of the EDs tested had noise levels at hazardous levels.

C. A 100-decibel level is considered acceptable for a work environment.

D. Noise levels of 100 decibels are not high enough to cause feelings of annoyance. ■

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Editor: Staci Kusterbeck.

Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@ahcpub.com).

Editorial Group Head: Valerie Loner, (404) 262-5475, (valerie.loner@ahcpub.com).

Managing Editor: Joy Daughtery Dickinson, (229) 377-8044, (joy.dickinson@ahcpub.com).

Production Editor: Caralyn Davis.

Editorial Questions

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

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CE/CME objectives

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

1. Identify four recommendations for pediatric emergency care from new guidelines from the American College of Emergency Physicians and the American Academy of Pediatrics. (See "Is your staff ready to care for critically ill children? Act now to comply with new pediatric guidelines" in this issue.)
2. List three recommendations for staff education regarding pediatric emergency care. (See "Is your staff ready to care for critically ill children? Act now to comply with new pediatric guidelines.")
3. Cite EMTALA requirements for patients brought by police to the ED for screening of blood alcohol levels. (See "EMTALA Q&A.")
4. Identify what an ED must do when transferring a patient to another ED in the same hospital system. (See "EMTALA Q&A.")
5. List three procedures that can be billed separately when performed while a patient is under observation. (See "Don't miss out on payments.")
6. Identify three ways to reduce noise in the ED. (See "Journal Review.") ■

Asthma in Adults

AfterCare® Instructions

What You Should Know:

• Asthma (as-ma) is an illness that causes the air passages in the lungs to be irritated, make mucus, and to swell. The airways may also become smaller. You may have trouble breathing, a tight feeling in your chest, or wheezing. Wheezing is a loud noise that you hear when you breathe in or out. An asthma attack happens when your airways narrow which makes it hard for you to breathe. Asthma attacks are also called flare-ups, exacerbations (eks-as-sir-ba-shuns), or episodes (ep-uh-sodes).

• There is no cure for asthma, but it can be treated. With time and working with caregivers, you will learn how to care for your asthma. Medicines can control the airway swelling. Avoid things that bother your airways, such as tobacco smoke. Your asthma may change with time. You may get new allergies, or your asthma may get better or worse. Caregivers may need to change your treatment plan if your asthma changes. Asthma can be managed, and you should be able to live a normal life.

Instructions:

• If you are given a prescription for medicine, use it as ordered by your doctor.

• Avoid pollen, dust, animal dander, molds, smoke, and other things that cause attacks at home and at work.
— You may have fewer attacks if you lessen the amount of dust in your home.
— It may help to replace your pillows or mattress with materials that do not cause allergies.

• If you are not on a fluid restriction, drink 8-10 glasses of water each day. This will help thin sputum so that it can be coughed-up more easily.

• Discuss an exercise routine with your doctor.

• If animal dander is the cause of asthma, you may need to get rid of those pets.

Call If:

• You have wheezing and shortness of breath even if you are taking medicine to prevent attacks.

• You develop a temperature over _____F (_____C).

• You have muscle aches, chest pain, and thickening of sputum.

• Your sputum changes from clear or white to yellow, green, grey, or bloody.

• You have any problems that may be related to the medicine you are taking (such as a rash, itching, swelling, or trouble breathing).

Return Immediately If:

• Your usual medicines do not stop your wheezing, difficulty breathing, or coughing.

• You have increased difficulty breathing.

Illinois Emergency Medical Services for Children (EMSC)

Facility Recognition Criteria For The Emergency Department Approved for Pediatrics (EDAP)

1. Professional Staff: Physicians

1.1 Qualifications

1. Twenty-four hour coverage of the emergency department shall be provided by at least one physician responsible for the care of critically ill or injured children as evidenced by **one** of the following:
   A. certification in Emergency Medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) **or** residency-trained/board-eligible in Emergency Medicine and in the first cycle of the board certification process;
   B. certification in Pediatric Emergency Medicine by the American Board of Pediatrics/ABEM (ABP/ABEM) **or** residency-trained/board-eligible in pediatric emergency medicine and in the first cycle of the board certification process;
   C. certification in one of the following boards **and current** American Heart Association (AHA)/American Academy of Pediatrics (AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians (ACEP)/AAP Advanced Pediatric Life Support (APLS) or equivalent course:
      - family practice by the American Board of Family Practice (ABFP) or American Osteopathic Board of Family Practice (AOBFP);
      - certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP);
      - residency-trained/board-eligible in either family practice or pediatrics and in the first cycle of the board-certification process;

   D. a physician who has received a waiver from the Illinois Department of Public Health based on meeting one of the criteria below:
      - an emergency department physician who already has received a waiver per the *Trauma Center Rules & Regulations* (Section 515.2030, e 1 B; Section 515.2040, f 1 B);
      - completion of 12 months of internship followed by at least 7,000 hours of hospital-based emergency medicine that includes pediatric patients over the last 60-month period (including 2,800 hours within one 24-month period), verified in writing by the hospital(s) at which the internship and subsequent hours were completed and current AHA-AAP PALS or ACEP-AAP APLS recognition;
      - completion of professional activities spent in the practice of pediatric emergency medicine (PEM), over the last 60-month period and totaling a minimum of 6,000 hours, clearly focused in the care of patients in the pediatric age group (≤ 21 years of age) in the emergency department and demonstrated by the following:
        1) Of the 6,000 hours, 2,800 hours must have been accrued in a 24-month (maximum) consecutive period of time;
        2) A minimum of 4,000 of the 6,000 hours must have been spent in the clinical practice of PEM. (If practiced in a general ED, only time spent exclusively in pediatric practice can be used for credit);
        3) The remaining 2,000 hours may be spent in either clinical care or a mixture of related nonclinical activities clearly focused on PEM including administration, teaching, pre-hospital care, quality improvement, research, or other academic activities.

1.2 Continuing Medical Education

All full- or part-time emergency physicians shall have documentation of a minimum of 16 hours of continuing medical education (American Medical Association [AMA] Category I or II) in pediatric emergency topics within a two-year period.

1.3 Coverage

At least one physician satisfying 1.1 shall be on duty in the emergency department 24 hours a day.

(Continued)

1.4 Consultation

Telephone consultation with a physician who is board-certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation can be with an on-staff physician or in accordance with the Illinois EMSC *Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline.*

1.5 Physician Backup

A "backup" physician whose qualifications and training are equivalent to that of 1.1 shall be available to the EDAP within one hour to assist with critical situations or disasters.

1.6 On-Call Physicians

Protocols shall be available that address maximum response time for on-call physicians.

2. Professional Staff: Mid-Level Providers. (Mid-level provider is defined as a nurse practitioner or physician assistant who works under the supervision of a licensed physician who satisfies criteria 1.1a and 1.1b.)

2.1 Qualifications

A. Nurse practitioners shall have:
   1. completed a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program;
   2. an Illinois advanced practice license within one year of hire;
   3. credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient.

B. Physician assistants shall have:
   1. current Illinois licensure (permanent or temporary);
   2. credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient.

C. All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS Course, the ACEP-AAP APLS Course, or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC).

2.2 Continuing Medical Education

A. All full- or part-time nurse practitioners shall have documentation of a minimum of 16 hours of approved continuing education units (CEUs) in pediatric emergency topics within a two-year period.

B. All full- or part-time physician assistants shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I) in pediatric emergency topics within a two-year period. Credit for CME must be approved by the Accreditation Council on Continuing Medical Education (ACCME), American Osteopathic Association Council on Continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP), or American Academy of Physician Assistants (AAPA).

3. Professional Staff: Nursing

3.1 Qualifications

A. At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care.
   - AHA-AAP PALS provider course;
   - ACEP-AAP APLS provider course;
   - ENA ENPC.

B. All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months of employment.

(Continued)

3.2 Continuing Education

All nurses assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education hours within a two-year period. Continuing education may include, but is not limited to CEU offerings, case presentations, competency testing, teaching courses related to pediatrics and/or publications. **These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric-specific.**

4. Policies and Procedures

4.1 Interfacility Transfer

Transfer agreement(s) with emergency pediatric centers (EPCs) and policies/procedures concerning transfer of critically ill and injured patients to EPCs. Incorporating the components of the Illinois EMSC *Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline* into the emergency department transfer policy/procedure will meet this requirement.

4.2 Suspected Child Abuse

Policies/procedures addressing the identification, evaluation, treatment, and referral of victims of suspected child abuse in accordance with state mandates.

4.3 Treatment Protocols

Protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients (i.e., trauma, respiratory distress, seizures).

4.4 Latex-Free Policy

Policy addressing availability of latex-free equipment and supplies.

5. Quality Improvement

5.1 Multidisciplinary Committee

Pediatric emergency medical care shall be included in the EDAP's emergency department or section quality improvement (QI) program and reported to the hospital QI committee.

Multidisciplinary continuous QI (CQI) activities shall be established with documented CQI monitors addressing pediatric care within the emergency department with identified clinical indicators and/or outcomes for care. These activities shall include children from birth up to and including 16 years of age and shall consist of, but are not limited to, all pediatric emergency department deaths, resuscitations, and interfacility transfers.

5.2 Pediatric CQI Liaison

A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated and supported by the hospital as the pediatric liaison. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience.

The responsibilities of the pediatric liaison shall include:

5.2.1 — ensure and document pediatric continuing education of all emergency department professional staff (Criteria 1.1, 1.2, 2.1, 2.2, 3.1 and 3.2);

5.2.2 — maintain a data summary and work in conjunction with the multidisciplinary CQI committee to coordinate criteria-based review and follow-up of sample pediatric emergency department visits (Criteria 5.1);

5.2.3 — coordinate review of pre-hospital provider transported pediatric cases and provide feedback to the emergency medical services (EMS) system coordinator and the EMS Regional Advisory Board.

5.2.4 — a written CQI report and attendance at the EMS Regional CQI subcommittee shall be supported by the hospital. One representative from the CQI subcommittee shall report to the EMS Regional Advisory Board.

5.2.5 — CQI information shall be made available to the Illinois Department of Public Health upon request.

Source: Illinois Department of Public Health, Springfield, IL. Excerpt from *Facility Recognition Application Packet.*

SUBJECT: ASTHMA PATIENT EDUCATION PROTOCOL (Supplemental Education)

MANUAL CODE: 3.0250

The following protocol addresses the education of patients with a medical diagnosis of asthma who are treated and discharged from the Emergency Department. This education may be provided by the Respiratory Therapist, RN, and/or MD as supplemental teaching as determined by the patient's needs and equipment availability.

ASSESSMENT

1. Assess the patient's learning needs (See Education Protocol).
2. Assess the patient's use of inhalers, including how long the patient has used them and whether the patient uses a spacer.
3. Assess whether the patient uses a peak flow meter.

IMPLEMENTATION

1. Review the patient's ability to use the inhaler (MDI) and provide additional instructions as needed.

   NOTE: The last respiratory treatment may be provided utilizing an MDI.

2. Obtain an Asthma Education Pack (located in both the asthma cabinet and the Walk-in Utility Room) which is available in both English and Spanish. The Pack contains the following: spacer, peak flow meter, and written asthma instructions with a video cassette.
3. Review the patient's ability to use a spacer and provide additional instructions when indicated.
4. Review the patient's ability to use a peak flow meter and provide additional instructions when indicated.
5. Place the TV/VCR in the patient's room and have the patient view the asthma video (provided in the Asthma Pack) prior to discharge.
6. Provide additional written instruction sheets specific to the patient's needs (e.g. applicable medications), located in the asthma cabinet next to the ED medication room.
7. Document the education and equipment provided to the patient and/or significant other and the patient's and/or significant other's response to education on the patient's medical record.
8. Check the box "Asthma Pack" located on the green ED charge card when applicable.

E.D. POLICY/PROCEDURE MANUAL

SUBJECT: ASTHMA PATIENT EDUCATION PROTOCOL (Supplemental Education)

MANUAL CODE: 3.0250
Page 2 of 2

The Respiratory Therapist will provide asthma patients' records to the ED Nurse Manager for telephone follow-up.

EVALUATION

The patient will correctly state and/or demonstrate the information and appropriate use of equipment.

CROSS REFERENCE: Nursing Protocol Manual, "Education of Patients," Manual Code: 3.0250.

Written: 6/95
Revised: 12/1/97

Source: New Britain (CT) General Hospital.

MONONGALIA GENERAL HOSPITAL
1200 J.D. ANDERSON DRIVE
MORGANTOWN, WV 26505

EMERGENCY DEPARTMENT
NURSING INTERVENTION SHEET

ER-202

Nursing Interventions	Pts
Triage Includes Initial VS and WTs (on peds)	
1. Adult	25
2. Peds	30
3. Pulse Oximetry	30
4. Pulse oximeter continuous	40
5. Cardiac Monitors	30
6. Visual Acuity	40
7. Reassess pt	45
8. Retake vital signs	35
9. Orthostatic Check	50
10. Discharge Instruction-Simple	30
11. Discharge Instruction- Complex	45
Oxygen Admin per hr x___	
1. Nasal Cannula	40
2. Simple Mask	30
3. Non re-breathing –venti- mask	35
Wound Care:	
1. Irrigation <15 min	30
2. Irrigation >15 min <30 min	70
3. Irrigation >30 min	100
1. Dressing-simple	30
2. Dressing-wet/dry	45
3. Dressing-complex	75
4. Suture Removal	35
1. Splint application- wrist	50
2. Splint application- ankle	60
3. Splint application- knee	100
4. Dislocations	40
1. Crutch (adjust/teach)	50
2. Sling, ACE wrap, etc. (apply/teach)	40
Medications:	
1. Oral- per trip x _____	45
2. Sub Q/IM/event	50
3. Rectal- X _____	50
4. Eye/ear instillation each	50
5. IV push/piggyback	50
Topical Med Application;	
1. (Nitro paste, LET, etc.)	45

Nursing Interventions	Pts
IV Start- each attempt	
1. Adult X ____	100
2. Peds x _____	125
3. DC IV Site	45
4. IV Cont. infusion- no med x _____ hrs	50
5. IV cont. inf. W meds x _____ hrs	75
6. Administer blood x _____ unit	150
7. Porta-cath Access	150
Venipuncture (specimen Collection):	
1. Adult x _____	50
2. Peds x _____	75
3. AG Sugar x _____	40
4. Dip Urine/Clean Catch	40
5. Blood Culture	75
1. ED Staff to lab x _____	50
2. Arrange Outpt. Testing	55
3. D/C pt via w/c to POV	45
4. Assist pt to ED via W/C	45
5. ED staff with pt for tests per 15 min x _____	45
6. Pt transfer with ED staff to another hosp	300
Admission/Transport	
Pt transport by ED Staff	
1. To Xray	45
2. To Floor	65
3. Other tests	50
Arrange:	
1. Transfers (nsrg home,home)	75
2. Taxi/Bus	65
3. Transfer to another hosp	100
Perform:	
1. Ear irrigation	80
2. Eye irrigation	70
3. Fill foley cath	60
4. Enema X _____	100
5. Foley Cath/Straight cath - adult	80
6. Cath Peds	50
7. Peds U-Bag	45
8. Irrigate Cath	40
9. Oral suctioning x _____	50
10. Tracheal suctioning x _____	50
11. Animal bite protocol	75
12. Prep Body for Morgue	100

Nursing Interventions	Pts
11. NG Tube Insertion	100
12. NG Lavage/15 min x _____	100
13. Restraints/30 minutes	100
14. Pts who require 1:1 or who are confused/combative/pyschotic/per 15 min X _____	100
15. Peds<6 (no adult)	100
16. Abuse exam, peds/adult	150
Assist with:	
1. Peds exam	100
2. Gyn Exam (no specimen)	75
3. Gyn Exam (specimen)	100
4. Suture setup	35
5. Suture assist	65
6. Rape Examination	250
7. Lumbar Puncture	90
8. Chest tube insertion	200
9. Needle decompression	80
10. Thoracentesis	80
11. Paracentesis	80
12. Nasal Packing	60
13. Rectal Exam	75
14. Frequent Elimination	50
1. Fetal Heart tones	50
2. Newborn Care	100
3. Prepare pt for OR	200
4. Bed linen change X _____	40
1. Cardiac Arrest <15 min	200
2. Cardiac arrest each addl. 15 min x _____	150
3. Ventilator pt x _____ hrs	100
4. Cardioversion/event	300
5. Intubation	200
6. External Pacer	250
7. Defib/time	150
8. Conscious Sedation	300
9. Thrombolytic Administration	350
10. Critically Ill pt observation x ____ ½ hr	150
11. Committal of patient for drug/alcohol rehab	300

99281(0-50) 99282 (51-100) 99283 (101-150) 99284 (151-200) 99285 (201-300) 99291 (301-400)

Prepared by: **Date:**

MG-ER-202 [REV. 7/00]

Source: Monongalia General Hospital, Morgantown, WV.

NORTHWEST COMMUNITY HOSPITAL
JOB DESCRIPTION

Title: Coordinator, Pediatric Emergency Services
Department: Nursing Services

GENERAL SUMMARY:

Responsible for planning, organizing, directing, and evaluation of all activities relating to the emergency care of the pediatric patient within the organization.

REPRESENTATIVE FUNCTIONS:

1. Coordinates pediatric QI, PI, and clinical care protocols with the Medical Director of the Pediatric Emergency Department.
2. Serves as liaison to appropriate in-hospital and out-of-hospital pediatric care committees. serves as liaison to inpatient nursing, as well as to a definitive care hospital, a regional pediatric referral hospital and trauma center, EMS agencies, primary care providers, health insurers, and any other medical resources needed to integrate services for the continuum of care of the patient.
3. Facilitate ED nursing continuing education in pediatric emergency care, including coordination of ENPC, PALS and other pediatric emergency care courses.
4. Assist with the orientation of new nurses in both the main emergency department and the pediatric emergency department.
5. Provide assistance and support for pediatric education of out-of-hospital providers affiliated with the ED.
6. Assist in the development and periodic review of policies and procedures for pediatric care.
7. Make recommendations on and monitor availability of pediatric emergency equipment and medications.
8. Ensure consistency of practice regarding pediatric emergency care protocols, equipment, and standards across the organization.
9. Interviews, hires, disciplines, and discharges (when necessary) personnel for the Pediatric Emergency Department. Regularly evaluates the performance of personnel according to the guidelines of the hospital's performance management system.
10. Stays clinically current through the provision of direct patient care as needed.
11. Adheres to the hospital's guest relations policy.
12. Directs the preparation of Pediatric Emergency Department records as well as recurring and special reports and analyses, ensuring that they are accurate, timely, and complete. Reviews and interprets reports and analyses.
13. Develops and prepares marketing plans in conjunction with the Marketing Communications Department.
14. Supports and facilitates the Shared Governance Councils.

SPECIAL SKILLS AND ABILITIES REQUIRED:

1. The organizational and supervisor skills to plan, organize and direct Pediatric Emergency Department activities that meet the expectations of patients, physicians, paramedics, and the community.
2. The analytical skills necessary to evaluate personnel and program effectiveness, to project and plan program goals, and to prepare analytical reports.
3. The interpersonal skills necessary to interact with all levels of hospital personnel, physicians, patients, and paramedics.
4. The written and verbal skills necessary to communicate in a clear, concise manner.
5. Extensive experience and education in the emergency care of children.

KNOWLEDGE, PRACTICAL EXPERIENCE AND LICENSURE/REGISTRATION REQUIRED:

1. Graduate of an accredited school of nursing; bachelor's degree in nursing required. Advanced degree in pediatric acute or critical care.
2. Current RN licensure in the state of Illinois.
3. Minimum four years Emergency Department and pediatric experience required.
4. Current CPR, PALS, ENPC, NRP, TNS, and ECRN required; ACLS recommended.
5. Instructor status in PALS and ENPC within six months of hire.
6. Minimum of two years previous experience teaching nurses and pre-hospital personnel.

PHYSICAL REQUIREMENTS:

1. Moderate physical effort. May require frequent periods of standing or walking. May require lifting or moving of lightweight material, occasional moving or lifting of average weight material, or rarely lifting or moving of heavy weight material.
2. Flow of work and character of duties involves normal mental and visual attention.

WORKING CONDITIONS:

1. Good working conditions. Seldom exposed to disagreeable working conditions or hazards.

Source: Northwest Community Hospital, Arlington Heights, IL.

American Health Consultants
Education and Training Fax-back Survey

We would like to learn more about training and education needs for you and your staff. Please circle the number corresponding to your level of interest in the following topics:

	No Interest		Some Interest		Much Interest
HIPAA privacy rules	1	2	3	4	5
Stark II	1	2	3	4	5
EMTALA	1	2	3	4	5
Aftermath of ergonomics	1	2	3	4	5
OSHA compliance	1	2	3	4	5
Post-exposure prophylaxis	1	2	3	4	5
Influenza update	1	2	3	4	5
Antibiotic resistance	1	2	3	4	5
Adverse drug reactions	1	2	3	4	5
Drug interactions	1	2	3	4	5
Medication errors	1	2	3	4	5
Herb-drug interactions	1	2	3	4	5
Nosocomial infections	1	2	3	4	5
Patient falls	1	2	3	4	5
Basic information for frontline workers	1	2	3	4	5
Needlesticks	1	2	3	4	5
Latex sensitivity	1	2	3	4	5
TB compliance	1	2	3	4	5
Restraints and the violent patient	1	2	3	4	5
Pain management	1	2	3	4	5

	No Interest		Some Interest		Much Interest
Palliative care	1	2	3	4	5
End-of-life care	1	2	3	4	5
Assisted suicide	1	2	3	4	5
Genetic testing	1	2	3	4	5
Organizational ethics	1	2	3	4	5
Human research protection	1	2	3	4	5
Informed consent documentation	1	2	3	4	5
New accreditation standards	1	2	3	4	5
Observation units (23-hour care or recovery beds)	1	2	3	4	5
ED diversion	1	2	3	4	5
Avoiding lawsuits: What to say when something goes wrong	1	2	3	4	5
Improving documentation for nurses and physicians	1	2	3	4	5
Nursing shortage	1	2	3	4	5
Bioterrorism	1	2	3	4	5
Disaster planning and mass casualties	1	2	3	4	5
Safety and security	1	2	3	4	5

What training format is preferred for you and your staff? Rate the following methods using the scale below:

	Least Preferred				Most Preferred
On-site speakers	1	2	3	4	5
Travel off-site to live conferences	1	2	3	4	5
Subscription-based newsletters/journals	1	2	3	4	5
Outside-sponsored teleconferences	1	2	3	4	5
Outside-sponsored videoconferences	1	2	3	4	5
Web-based conferences	1	2	3	4	5
Resource books	1	2	3	4	5
Other _____	1	2	3	4	5

What is your title?_____

To what American Health Consultants newsletter(s) do you subscribe? _____

_____

Thank you for your assistance.

Please fax your completed form to (800) 850-1232 by August 1, 2001.