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The monthly update on Emergency Department Management

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## Inside



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- Emergency Contraception: Important Information for Survivors of Sexual Assault
- Ultrasound Examination List Template
- *Bioterrorism Watch*

**JUNE 2002**

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# Do sex assault victims receive adequate care? If not, you risk fines, violations

*In many EDs, rape victims fall to 'the bottom of the list'*

A rape victim is brought to a New York City emergency department (ED), where she waits more than three hours before being examined. Poorly trained staff lose key evidence, including underwear and vaginal swabs. Tests for sexual transmitted diseases (STDs) aren't processed by the lab. A second dose of emergency contraception is never given. No plan is given for follow-up care. No one obtains contact information for this patient.

The assailant is a serial sex offender who attacked the woman the day after his release from prison, but no usable evidence is found in the hospital's rape kit. As a result, prosecutors cannot convict.

If this sounds like a fictitious worst-case scenario, think again. The above scenario occurred at a New York City hospital, which was cited for 23 violations and fined $46,000 by the state health department.

"I was actually glad to see that fine imposed," says **Linda E. Ledray**, RN, PhD, FAAN, director of the Sexual Assault Resource Service in Minneapolis. "I believe this is a clear statement that hospitals can no longer get by with providing substandard care."

The shocking incident puts a spotlight on inadequate care of rape victims in

## Stay on top of EMTALA with audio conference

*EMTALA rules continue to change — Are you up-to-date?*

Keep abreast of all the latest changes with EMTALA Update 2002, an audio conference sponsored by American Health Consultants. The conference, scheduled for Tuesday, June 4, 2002, from 2:30 - 3:30 p.m. Eastern time, will be presented by Charlotte S. Yeh, MD, FACEP, and Nancy J. Brent, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Company. Brent is a Chicago-based attorney, with extensive experience as a speaker on the Emergency Medical Treatment and Labor Act (EMTALA) and related health care issues.

The conference will outline a new report that puts a national spotlight on inadequate emergency department (ED) on-call coverage. There is a growing

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*Continued from cover*

trend of specialists refusing to take call for the ED, partly due to increased liability risks for medical malpractice and violations of EMTALA. If you don't take steps to ensure appropriate on-call coverage for your ED, you're at risk for violations and adverse outcomes. This program also will update you on any legislative efforts to compel managed care plans to reimburse hospitals for EMTALA-related services.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the EMTALA Update 2002 audio conference for just $249 for American Health Consultants subscribers and $299 for nonsubscribers, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. For more information, or to register, call American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, go on-line at www.ahcpub.com, or e-mail customerservice@ahcpub.com. ■

the ED, according to Ledray.

"Too often, victims are not being tested for STDs and are not being treated prophylactically," she says. "Crisis intervention needs are also being overlooked."

Here are common problems that occur in EDs as identified by sexual assault nurse examiners (SANEs), along with strategies to improve care:

**• Rape victims are asked the same questions repeatedly.**

Avoid having the patient repeat the story over and over, advises **Lianne Ritch**, RN, nurse clinician and SANE coordinator for the Sexual Assault Service at British Columbia Women's Hospital in Vancouver, Canada.

For example, the triage nurse's role is to assess whether urgent care is needed, and he or she doesn't need to know all the details about the assault, she says. "People tend to ask a lot of things that are irrelevant and don't impact the patient's care," adds Ritch.

She gives the following examples of questions that aren't appropriate to ask at triage: What were you doing before the assault? Did he use a condom? How many drinks did you have? Did you know him? Did you fight back or scream?

**• Patients' concerns are not addressed.**

Ritch points to research indicating that rape victims appreciate having control over their care.[1]

She recommends asking the patient, "How can we help you? What are you most concerned about?" "Then we can address that concern right away, which relieves a lot of anxiety and fear," Ritch says.

For example, if a patient is worried about pregnancy, you can explain that emergency contraception is available, says Ritch. "Often, our agenda is focused on forensic and legal issues. But the patient's health is their primary concern," she says. "That's why they have come to us."

Your protocols must address patient concerns about injuries, STDs, and pregnancy, emphasizes **Eileen M. Allen**, RN, BSN, DABFN, SANE program coordinator for Monmouth County, NJ**.**

**• The patient is examined in an inappropriate space.**

You'll need a room large enough for a comfortable interview, and adequate space for law enforcement, medical staff, and advocates for the victim, says **Kathy Hendershot**, RN, director of clinical operations for the ED at Methodist Hospital in Indianapolis.

The ED uses a room large enough to seat at least four people simultaneously, she says. "We hold this room for sexual assault exams and interviews only. It is never used for anything else," adds Hendershot.

The room doesn't need to be in the ED and may even have a separate entrance from the ED triage area, but close proximity is preferable, says Hendershot. "Currently we are entertaining the thought of relocat-

## Executive Summary

Failure to collect evidence, inadequate care, and delays resulted in a New York City hospital being fined for providing inadequate care to a rape victim. These problems are common in the emergency department.

- Avoid asking sexual assault victims the same questions repeatedly.
- Determine the patient's primary concern and address it immediately.
- Examine patients in a private area with adequate space.

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ing our sexual assault treatment area from our ED to a place of less traffic," she notes.

**• Emergency contraception is not offered.**

According to several studies, EDs often fail to offer rape victims emergency contraception.[2-4] "This is likely not unusual," says Ledray. "We just don't realize how bad it is," she says.

To address this, Ledray added a sheet explaining this option to the clothing kits provided to all rape victims in her state. **(See Emergency Contraception: Important Information for Survivors of Sexual Assault, in this issue.)**

Ensure that every rape victim is told about emergency contraception, says Ledray. "If they want emergency contraception, you should have the medication available to give to the rape victim," she adds.

**• There is a lack of privacy.**

A rape victim actually might leave the ED if she has have to disclose information in front of other patients, warns Ritch.

Allen acknowledges you'll need to find creative ways to provide privacy in a crowded ED. For example, patients can be escorted to a small conference room near the ED to await the nurse examiner, advocate, and police officer after triage. "A sign can be added to the door indicating that the room is occupied, to limit unnecessary intrusions," adds Allen.

At Methodist Hospital, the ED's triage policy requires a victim of sexual assault to be taken immediately to a private room, says Hendershot. If a general exam room is not available, the staff makes it a high priority to find another private space, such as a consultant room, office space, or assessment room, says Hendershot.

Forensic sexual assault interviews and examinations never should take place in a curtained cubicle, Allen adds. If a separate dedicated room is not available, she suggests using a walled exam room equipped with a gynecological examination table, evidence collection kits, and other necessary materials.

**• Evidence is not collected properly.**

When untrained staff with little experience and lack of proper equipment attempt to collect evidence, errors occur, says **Diana Faugno**, BSN, RN, CPN, FAAFS, district director of forensic health services for the sexual assault response team in Escondido, CA.

"Both the ED nurse and physician wind up reading the long instructions on how to collect evidence, in front of the victim," says Faugno. "This is a disaster waiting to happen."

She suggests the following to avoid this:

• have staff review evidence collection instructions on a quarterly basis;

• ask the crime lab to give an annual presentation about evidence collection kits;

• hang up posters about the top problem areas for improper evidence collection;

• ask the hospital's risk management department to give an inservice on exposure to lawsuits for failure to collect evidence.

**• Rape victims are not considered a priority.**

More than 90% of all rape victims do not sustain serious physical injuries, but most present with significant emotional trauma, says Allen.

"Every survivor who seeks assistance at a hospital deserves to receive prompt attention from health care

## Resources

A free Sexual Assault Nurse Examiner (SANE) guide is available for download at no charge at the Sexual Assault Resource Service web site (www.sane-sart.com). The guide is designed for nurses who evaluate sexual assault victims. Or if you are interested in learning more about SANE/Sexual Assault Response Team (SART) programs in your state, you can go to the map on the site. Click on "If you are interested in learning more about SANE-SART Programs in your state, you can go to the map and find a contact from a program in your area."

## Sources

For more information about caring for sexual assault patients in the ED, contact:


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providers with specialized training to meet their physical and psychological needs," she underscores.

Unfortunately, sexual assault victims often wait hours to be seen since the typical patient is hemodynamically stable, says Hendershot. "The priority for ED staff would be trauma cases, heart attacks, and other life-and-death issues," she says. "Sexual assault cases are often put at the bottom of the list."

You should have a protocol for these patients to facilitate the examination, documentation, and collection of evidence, says Hendershot. "The body is the crime scene, so evidence should be collected as soon as possible," she adds.

**• Basic essentials are not provided.**

During the evidence collection process, clothing and other items may be taken from patients, says Allen.

She adds that victims at the county's exam sites are supplied with new sweat suits, socks, and underwear, along with 'patient comfort' kits containing a toothbrush, toothpaste, soap, lotion, and a hairbrush, all donated by local rape care advocacy programs.

"These items help to ensure that each survivor has an opportunity to clean up and is fully clothed when leaving the exam site," says Allen.

### References


1. Ericksen J, Dudley C, McIntosh G, et al. Client's experiences with a specialized sexual assault service. *J Emerg Nurs* 2002; 28:86-90.

2. Doughton S. Contraception after the act. *Tacoma News Tribune*, Aug. 20, 2001: accessed at search.tribnet.com/archive/archive30/0820s11.html.

3. Catholics for a Free Choice. Catholic Health Restrictions Updated. Washington, DC: Catholics for a Free Choice; 1999.

4. Clara Bell Duvall Reproductive Freedom Project. Emergency Contraception Services for Rape Victims in Pennsylvania Hospitals. Philadelphia, PA: Clara Bell Duvall Reproductive Freedom Project: accessed at www.aclupa.org/duvall/ecinPA.html. ■


# SANE programs have benefits you can't ignore

When a rape victim came to an emergency department (ED) for treatment, she didn't expect to spend seven hours waiting to be seen, but that's exactly what happened. "Because the victim didn't have severe physical injuries, she was left to wait while patients with more serious problems were seen and cared for," says **Eileen M. Allen**, RN, BSN, DABFN, sexual assault nurse examiner (SANE) program coordinator for Monmouth County, NJ.

The woman became increasingly upset during the long wait. "At the end of the ordeal, the victim was reluctant to go forward with the investigative process," adds Allen. "She said that she had 'had enough.'"

The above scenario is unfortunately all too common, but a SANE program can ensure that it doesn't occur in your ED, says Allen.

Without SANE programs, survivors of rape may be re-victimized when they come to the ED for help, says Allen.

In addition to long waits, patients may perceive a lack of compassion from ED nurses and a lack of supportive response from law enforcement community, she says.

**Diana Faugno**, BSN, RN, CPN, FAAFS, district director of forensic health services for the sexual assault response team in Escondido, CA, urges you to determine if there are SANE programs in your area, and take steps to establish one if there are not. She suggests enlisting the help of local law enforcement to establish a referral system.

You may not have your own SANE, but you must have access to one, urges **Linda E. Ledray**, RN, PhD, FAAN, director of the sexual assault resource service in Minneapolis. "Training all your ED nurses does not work, and I do not recommend this model," she says.

Ledray suggests working together with other hospitals within a three-hour radius to implement regional centers where SANEs are on call for many EDs, or developing a mobile SANE unit.

Small community EDs should send several staff members to be trained as SANEs, says Faugno. "You can establish relationships with others for peer review and to keep updated on current information," she says.

She suggests taking the following steps:

• photograph or videotape the examination so it can be reviewed by your peers in another county or group;

• review documentation of actual cases without names or identification;

• join a professional organization to keep abreast of national issues;

• ask an outside reviewer to give recommendations for specific cases.

Here are benefits of SANE programs:

**1. Patients are treated faster.**

A recent study showed that rape victims were treated more quickly by SANEs than by ED physicians, and with fewer interruptions.[1]

**2. It's a current standard of care.**

SANE programs are the current standard of care for victims of sexual assault, according to Faugno.

**3. The patient is treated by dedicated staff.**

Sexual assault examinations typically last two to five hours, notes Faugno. "With a SANE program, the patient is treated by staff who have a desire to do this work, and the ED staff is not asked to 'fit this in,'" she says.

**4. There is better evidence collection.**

SANE programs have greatly improved the quality of evidence obtained during the forensic examination, says Allen. Ledray points to her own study, which showed that 48% of the time, non-SANE evidence collectors did not maintain chain of custody, while SANEs did so 100% of the time.[2]

There is more time for thorough evidence collection, adds **Kathy Hendershot**, RN, director of clinical operations for the ED at Methodist Hospital in Indianapolis.

**5. Patients receive more consistent care.**

With the SANE program, everything is standardized, including documentation, training, collection, and method of treatment, says Hendershot.

**6. There is a higher conviction rate.**

"We work very closely with the prosecutor's office to improve our court presentation, and eventually, higher convictions," says Hendershot.

### References


1. Stermac LE, Stirpe TS. Efficacy of a 2-year-old sexual assault nurse examiner program in a Canadian hospital. *J Emerg Nurs* 2002; 28:18-23.

2. Ledray LE, Simmelink K. Efficacy of SANE evidence collection; a Minnesota study. *J Emerg Nurs* 1997; 23:75-77. ■


# Can you really collect copays? Experts say yes

*[Editor's note: In this first part of a two-part series on collecting copays, we discuss how much you can collect and how to do it. Next month, we give you three tips for collecting at the end of the visit.]*

Collecting copays in the emergency department (ED) is not feasible.

Copay collection can provide a significant boost to an ED's bottom line.

Which of the above statements is true? The answer may depend on the strategy you use, according to reimbursement experts interviewed by *ED Management*.

Many ED managers have given up trying to collect copays, but this is a definite mistake, according to **Michael J. Williams**, president of the Abaris Group, a Walnut Creek, CA-based consulting firm specializing in emergency services.


## Executive Summary

Copay collections during the emergency department (ED) visit can provide significant additional revenue, since only 35% of copays are paid after the ED visit.

- Collecting copays is not a violation of the Emergency Medical Treatment and Labor Act (EMTALA).
- Use promissory notes, ATMs, and self-addressed stamped envelopes to facilitate payment.
- EDs can obtain $25,000 to $100,000 per month from collecting copays.


"Copay collection strategies are a critical tool needed to round out the revenue cycle for EDs," he insists.

According to Williams, you're missing out by not collecting copays, since they are part of the payment assumptions built into payer contracts. "Hospitals often have inadequate or no systems in place to collect the fees we have negotiated in our contracts, namely the copays," he says.

Copays are generally $25-$50 for all managed care patients, and there is the potential to collect up to $800 at the beginning of the year when Medicare patients have not yet met their deductible, says Williams. "Only 35% of copays are paid after the ED visit," he adds.

If you increase this to 65%, you'll increase revenues by $150,000 per year, assuming you collect from 15,000 managed care patients with an average copay of $35, says Williams.

Some EDs are collecting $25,000 to $100,000 per month in copays that otherwise would be written off, or additional costs would be incurred by mailing bills in an attempt to collect, he adds.

### EDs wary of asking for money

Too often, ED managers shy away from collecting copays, fearing violations of the Emergency Medical Treatment and Labor Act (EMTALA), according to **Thom Mayer**, MD, FACEP, chairman of the department of emergency medicine at Inova Fairfax Hospital in Falls Church, VA.

"However, the hospital attorneys would be the first ones to tell you there is nothing wrong with doing this," Mayer says, adding that his ED has had significant success in collection of copays.

Williams notes that copays should be only collected after the patient has been fully medically screened.

Some EDs report unsuccessful experience with copay collection. "This is something we have struggled with," says **Richard Eckert**, MD, medical director of emergency services at University Hospital in Augusta, GA.

Instead of doing a medical screening examination at triage, patients are taken directly to treatment rooms where a physician sees them and a disposition is made, says Eckert. "The chart may be made with the financial data before the patient is seen, but since we have the policy that all are being seen and fully evaluated, this does not violate any EMTALA concerns," he adds.

The complete chart is made either before or during the medical evaluation process, he says. No copay questions are asked upfront.

He adds that the ED tried to implement a copay collection process at discharge. "This required additional personnel that we did not have to spare," says Eckert. "Also, very rarely could we collect anything. The patient response was almost always 'Bill me.'"

Here are things to consider about collecting copays:

**• Use "tools" to encourage payment.**

Williams recommends use of the following to encourage a patient to pay at or near the time of service:

— Promissory notes. These are contracts signed by the patient or financially responsible provided at discharge.

— Self-addressed envelopes. If patients don't have their copay, Williams recommends providing self-addressed stamped envelopes with the patient's account number on it. "If the ED has a financial incentive for point-of-service collections, this payment gets credited to them," he says. "Staff are usually highly motivated to pursue this."

— ATMs and/or credit card machines. A strategically located ATM machine in the ED is a powerful incentive for patients to settle their copays, suggests Williams.

"This can be a freestanding machine or a little credit card machine at the desk. It's hard for a patient to ignore or avoid this payment option if they have their ATM or credit card with them," he says.

**• Determine which group will receive revenue.**

At Inova Fairfax's ED, the copay revenue is collected entirely by the hospital, reports Mayer. "We have had some talk of a 50/50 split between the physician group and the hospital," he adds. "But while it is a fair amount of money, it is something the hospital is doing with the registrar people who are hospital staff members."

**• Evaluate costs.**

Eckert recommends evaluating costs if you plan to set up a copay collection system up front.

"The added cost of collecting far exceeded our ability to collect," he says. "We found that it was simpler to concentrate on moving patients quickly and safely through the ED."

Although most physician offices collect copays up front, you cannot do this in the ED unless a medical screening examination has been performed, he notes.

If you decide to do this, an appropriate medical person would have to be used, says Eckert, and then if no medical emergency were found, the patient would be refused further use of resources until they paid upfront.

"This means that you would have to send away both well-insured who didn't have a copay on them that day, as well as the indigent who doesn't pay his bills anyhow, or you would have a two-tiered system, which would be illegal," he says.

This would create a public relations nightmare for the facility and a lot of angry people within your ED, says Eckert. "I do not think that many hospitals are going to allow you to refuse further care to a paying customer," he adds. ■

### Sources

For more information about copay collection, contact:

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# Act now to improve your ultrasound program

When a surgeon was called to the emergency department (ED) to take a patient to the operating room for cholecystitis, he complained that he didn't trust the accuracy of the ultrasound scans.

"When I showed him the images of the inflamed gallbladder and the stones in it, and then the videotape of it, his demeanor changed completely," says **Michael Blaivas**, MD, RDMS, director of emergency ultrasound at North Shore University Hospital in Manhasset, NY.

The surgeon smiled and agreed to take the patient for

## Executive Summary

Emergency department ultrasound programs may be shut down if an effective quality assurance program is not in place.

- Videotape every exam so it can be reviewed later.
- Obtain confirmatory tests if you're unsure of results.
- Have a dedicated person responsible for quality assurance.

surgery after a second course of antibiotics, he reports.

The above anecdote illustrates the importance of demonstrating a quality ED ultrasound program, says Blaivas. **(For more information on documentation of ED ultrasound, see related story on p. 68.)**

"Complaints are often used to undermine or shut down an ED ultrasound program," he stresses.

The more organized you appear, the better you can defend against any attacks, adds Blaivas. "Be prepared for complaints, and show that you have a dynamic system that fixes errors and continually improves," he says.

An effective quality assurance (QA) program can make or break the survival of your ultrasound program, according **to Christopher DiOrio**, DO, emergency ultrasound coordinator at Medical College of Georgia in Augusta. "No test is 100% sensitive or specific, so it is important to have a system designed to handle the minority of missed cases," he adds.

Here are ways to improve your ultrasound program:

**• Videotape all ultrasound examinations.**

Blaivas advises you to videotape all examinations, instead of only printing a few still images.

"Videotaping allows the physician to review the scan at a later time to see if any additional findings were present, or if anything was missed," he says.

He acknowledges that many ED physicians are reluctant to do this, fearing mistakes will be discovered subsequently. "But you can't practice to cover up any possible errors. You can learn from these errors," he says, adding that the tape is probably protected from discovery in the event of a lawsuit since it's part of QA.

Videotapes allow you to see where the novice ultrasonographer makes mistakes and help him or her to make corrections, he says.

**• Each ultrasound performed by a noncredentialled physician must be reviewed by a credentialled staff member.**

It would be optimum to do this using real-time video, says DiOrio. "However, this is probably logistically impossible since this would take much too long," he explains. "In light of this, we use still images of key portions of the exam."

For example, the goal may be to rule out an ectopic pregnancy, says DiOrio. "We usually can ascertain this adequately with an intravaginal two-view approach, clearly pictured on still copies for QA review," he adds.

DiOrio cautions that if a decision needs to be made immediately, and if a credentialled ultrasound faculty member is not available, then a confirmatory test needs to be obtained such as a repeat ultrasound, computerized tomography, or serial exams.

He also warns against basing medical decisions on ultrasound alone if you are not certain of the images obtained. Just as additional tests may be needed to rule out a heart attack, a single ultrasound may not be enough to adequately evaluate other disease processes, says DiOrio.

**• Have a dedicated individual responsible for ultrasound QA.**

A single individual should be responsible for managing all QA data and investigating any negative outcomes, says Blaivis. "This should not be left up to individual physicians any more than other departments would leave QA for electrocardiograms or chest X-ray readings up to individuals," he adds.

Blaivas advises against assigning QA to someone who has no interest in it. "Ideally it would be a volunteer position, attracting someone who is really interested in emergency ultrasound," he says.

It's a mistake to allow someone from radiology do QA for the ED, adds Blaivas. "They have no true understanding of emergency practice, nor will they have the welfare of any department other than their own in mind," he says. "This is just the reality of business." ■

## Sources

For more information about emergency department ultrasound, contact:

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# Does your documentation satisfy irate colleagues?

When a general surgeon with a reputation for being aggressive and hotheaded came down to the emergency department (ED) at North Shore, he furiously complained about a patient in his care.

"The patient was seen in our ED one month prior for abdominal pain," recalls **Michael Blaivas**, MD, RDMS, director of emergency ultrasound at North Shore University Hospital in Manhasset, NY. "He was found to have a large gallstone, with the rest of the gallbladder examination being normal."

The patient improved during his course in the ED and preferred to be discharged so he could see his own surgeon at a different hospital, adds Blaivas. Three weeks later, the patient had surgery that did not find a gallstone, but he later returned to the ED with fever and abdominal pain. "On abdominal CT, an abscess was found by the patient's liver," says Blaivas.

The surgeon claimed that the ED had incorrectly diagnosed a gallstone and also missed the previous liver abscess. "Luckily, I had a copy of our formal report with pictures which clearly showed a large gallstone in the neck of the gallbladder with the rest of the gallbladder being normal," says Blaivas.

Blaivas informed the surgeon that the ED does not check the entire liver on a gallbladder scan. He adds, "In any case, it was obvious from clinical history, my ultrasound, and current findings that the stone was dropped into the abdomen accidentally, as can happen during the operation, and was missed."

As a result, the patient now was back with an abscess, explained Blaivas. "The surgeon who originally promised a full investigation and said he would make sure we did not scan again was never heard from again on this topic," he reports. "It is hard to deny well-documented evidence when you hold a copy in your hand."

Poor documentation makes you look like a "fly-by-night" operation, he warns.

Here are effective ways to document your ultrasound exams:

**• Every exam must be documented.**

This documentation should include written or dictated notes and key images attached to the chart, according to **Robert Jones**, DO, RDMS, FACEP, assistant professor of emergency medicine at Case Western University, and faculty of the emergency medicine residency program at MetroHealth Medical Center, both in Cleveland.

"Some physicians feel that they can 'unofficially' do the ultrasound and not record it," he says. "This is a big mistake."

For example, some clinicians think that if they don't see an abdominal aortic aneurysm (AAA) they can just move to other diagnoses without documenting the exam, says Jones. "Unfortunately, patients will most likely remember that the ultrasound was done and mention it to consultants or their doctor," he says. "There will be no respect for ED ultrasound if it is a hidden exam."

Blaivas points to the following scenario: An 80-year-old patient comes in with abdominal pain, and there is concern about an AAA, so an ultrasound of the aorta is performed.

The test is negative, but a month later the patient goes to their private physician and asks for a report saying the aorta is normal caliber and the patient in not in danger from it. The radiology department has no record of the exam.

The private physician then spends half a day making calls about the ultrasound and suggests to the patient he is mistaken. "Eventually the ED is called, the patient's chart is pulled, but no record of the normal scan exists, and everything has to be repeated. This sounds comical, but I have seen this happen over and over," says Blaivas.

Radiologists often complain that EDs are not documenting properly, says Blaivas. "This seems to be one of the last tactics left to the radiologists that would like to see ED ultrasound squashed," he says.

"Administrators know that poor record keeping is dangerous and looks bad."

Armed with good documentation, Blaivas has headed off several radiology complaints, he says. When Blaivas performs an exam, he generates a formal report and hard copy images, stapled to his billing/report sheet. "A copy goes into my file for future reference and a copy, plus the original goes into the medical record," he says.

**• Use templates.**

Jones uses templates for various "limited" ultrasounds, which allow him to use checkboxes or hand write information. Pertinent images are affixed to the

## Sources

For more information about documentation of ultrasound examinations, contact:

- **Robert Jones**, DO, RDMS, FACEP, Department of Emergency Medicine, MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, OH 44109. E-mail: rjones@metrohealth.org.

back of the sheet and become part of the permanent medical record. **(See Ultrasound Examination List Template inserted in this issue.)**

He also comments on the ultrasound's impact on clinical management so other physicians can understand his goals. Jones gives the following example:

"A limited transabdominal/transvaginal ultrasound was performed to verify the presence of an intrauterine pregnancy. This exam was not performed to identify all sonographically detectable pathology, and the patient was made aware of this. The findings of the study include a single viable intrauterine pregnancy. There was a minimal amount of free fluid in the cul-de-sac."

**• Document success stories.**

It's especially important to document any instance when the ED's use of ultrasound saved a life or came through when radiology ultrasound failed, suggests Blaivas. "This may seem underhanded, but there will be no punches pulled on you when radiology wants to close you down," he says. ■

# EMTALA Q & A

***Question:*** Can a patient be transferred from an intensive care unit (ICU) of one hospital to the emergency department (ED) of another hospital, based on an accepting physician's request? What if the ED receiving the patient is holding patients waiting to be admitted?

***Answer:*** In part, the answer to this question lies with state regulations, since several states take the position that transfers to the ED from an ICU represent a transfer to a lower level of care or an abandonment of the patient, says **Stephen Frew**, JD, risk management consultant at Physicians Insurance Company of Wisconsin, based in Loves Park, IL.

Hospitals are required to comply with their state laws and regulations, to the extent that they do not conflict with EMTALA requirements, he explains. "This requirement then makes this type of transfer a violation in those states that have the rule," he says.

Frew recommends checking with your state hospital inspector to determine your state's regulations regarding transfers.

However, Frew adds that EMTALA does not specifically forbid transfers to the ED. In fact, he says recent citations suggest that if there is a long transfer or deterioration, the ED should provide a medical screening examination to the transfer patient before sending patients to the floor.

EMTALA requires that the receiving hospital accept the patient, but it does not specifically indicate who the accepting person is, says Frew. "Some states require an accepting physician in addition to the EMTALA requirement," he adds. "In the absence of state standards, EMTALA does not say where or how the patient must be accepted."

Frew emphasizes that EMTALA requires that the hospital provide necessary further care and stabilization of patients who are known to have an unstable or emergency medical condition.

"These terms are defined by law and are much broader than medical terminology," he notes. "It is relatively safe to state that all patients coming from an ICU in need of a higher level of care have an emergency medical condition and are unstable, as defined by EMTALA."

The Centers for Medicare & Medicaid Services (CMS) will look at whether the hospital promptly and appropriately provided necessary evaluation and stabilizing care to the transfer patient, says Frew.

"If that care is rendered, it is unlikely in most states that the hospital would be cited," he says.

***Question:*** We are a rural hospital and transfer most of our neurological, cardiac, and trauma patients. One of the hospitals makes us wait several hours for bed availability. If we have an acute myocardial infarction and an accepting doctor from the hospital, is there anything we can do to speed up the transfer process? Would it be an EMTALA violation if we sent the patient to the hospital ED?

***Answer:*** That depends on the stability of the patient, according to **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

For unstable patients, the receiving hospital has no excuse for delaying the transport of a patient to a facility

## Sources

For more information about the Emergency Medical Treatment and Labor Act (EMTALA), contact:

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- **Jonathan D. Lawrence**, MD, JD, FACEP, Emergency Department, St. Mary Medical Center, 1050 Linden Ave., Long Beach, CA 90813. Telephone: (562) 491-9090. E-mail: jdl28@cornell.edu.

for a higher level of care if a physician accepts the patient and the hospital has the equipment and personnel to treat the problem, says Lawrence.

"This is the kind of patient that typically will go straight to the OR [operating room], cath lab, or for other acute diagnostic or therapeutic intervention," he adds.

Lawrence stresses that the admitting office or other administrative personnel should have no veto or delaying power over this type of transfer. A case could be made that any non-medically based delay by the receiving hospital is tantamount to a refusal to accept, which may subject the receiving hospital to statutory punishments, he adds.

On the other hand, Lawrence adds that a stable patient (defined by EMTALA as one in which no reasonable expectation of deterioration is expected as a result of the transfer) may be held at the sending hospital for a reasonable length of time at the sending hospital while the receiving hospital checks on bed and personnel availability.

"There is no recognized time limit of 'reasonableness,'" he says. These patients will typically be admitted to a hospital bed without immediate therapeutic or diagnostic interventions, and it is not unreasonable to allow the receiving hospital to assess its resources and ability to care for the patient, says Lawrence.

Contrary to popular myth, there is no EMTALA prohibition of an ED-to-ED transfer, says Lawrence. "If the receiving hospital wishes to receive transferred patients, stable or unstable, into its ED, it may do so," he notes.

The so-called prohibition against ED-to-ED transfers is a business office rule, since Medicare and many insurance carriers will not pay for a second ED visit on the same day for the same problem, explains Lawrence. ■

## JOURNAL REVIEW

Hedges JR, Trout A, Magnusson R. **Satisfied patients exiting the emergency department (SPEED) study.** *Acad Emerg Med* 2002; 9:15-21.

If you want to improve patient satisfaction, focus on how patients *perceive* wait times instead of just decreasing delays, say researchers from Oregon Health Sciences University in Portland and Carlton College in Northfield, MN.

Using a computerized tracking system, the researchers tracked wait times of adult emergency department (ED) patients at an urban hospital. After a disposition decision was made by the ED physician, 126 patients were surveyed about overall satisfaction with the care they received and their perceptions of wait times.

The median wait time was 14 minutes for a room and 13 minutes until seen by a physician. However, overall satisfaction was linked more closely to the perception that the wait time was shorter than expected, rather than with the patients' estimate of the wait time or the actual wait time itself. The same was true for the total time in the ED.

Trying to shorten delays may be more costly than trying to change perception of the wait times, suggest the researchers. "We believe that although patient satisfaction may be adversely impacted by either a long wait to be placed in an ED evaluation room, a long wait until a physician sees the patient, or even the total time at the ED, other interpersonal factors more strongly predict overall satisfaction," they conclude.

They suggest the following to satisfy ED patients:

- focusing more on interpersonal relationships, beginning at triage;
- meeting patient expectations for information exchange;
- paying close attention to patient needs for privacy and respect;
- explaining the reason for delays to patients;
- keeping patients informed about potential delays due to processing of ancillary tests, obtaining consultations, and obtaining in-hospital beds;
- guiding the patient and significant others toward realistic wait times. ■

# Correction

In the February 2002 issue of *ED Management*, we reported that the Joint Commission on Accreditation of Healthcare Organizations requires that you have enough pharmaceuticals to treat 100 victims and your staff for at least three days. There is no such requirement. ■

# CE/CME questions

13. Which of the following is an effective way to manage sexual assault patients, according to Lianne Ritch, RN, nurse clinician and SANE coordinator for the Sexual Assault Service at British Columbia Women's Hospital?
    A. Ask the victim to repeat details of the assault so they can be documented.
    B. Don't offer emergency contraception unless the victim expresses concern about pregnancy.
    C. Address forensic issues first regardless of

patient concerns.

D. Ask the patient what her primary concern is.

14. Which of the following is accurate about use of sexual assault nurse examiner (SANE) programs according to current research?
    A. There is a greater chance of losing chain of custody during evidence collection.
    B. Patients are treated with fewer interruptions.
    C. This is not yet the standard of care for sexual assault patients.
    D. Examinations typically last under an hour.

15. Which of the following is accurate regarding copay collection in the ED, according to Michael J. Williams, president of the Abaris Group?
    A. Copay collection is a frequent source of patient complaints.
    B. The majority of copays are paid after the ED visit.
    C. Copay collection is not itself a violation of EMTALA.
    D. Having an ATM machine in the ED violates EMTALA.

16. Which of the following is recommended for quality assurance of ED ultrasound programs by Michael Blaivas, MD, RDMS, director of emergency ultrasound at North Shore University Hospital?
    A. Avoid videotaping of examinations.
    B. Have ultrasounds reviewed by a credentialed staff member.

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## CE/CME objectives

1. Name one effective way to improve care of sexual assault patients. (See *"Do sex assault victims get adequate care? If not, you risk fines, violations."*)
2. Describe one benefit of sexual assault nurse examiner (SANE) programs. (See *"SANE programs have benefits you can't ignore."*)
3. Name one recommendation for collection of copays in the ED (See *"Can you really collect copays? Experts say yes."*)
4. Identify one way to ensure quality assurance for ED ultrasound. (See "*Act now to improve your ultrasound program."*)
5. Cite one way to comply with Emergency Medical Treatment and Labor Act (EMTALA) regulations regarding transfer of ICU patients. (See *"EMTALA Q&A."*)
6. Give one recommendation to improve patient satisfaction. (See "*Journal Review."*) ■

C. Base medical decisions on ultrasound alone.
D. Having a radiologist handle quality assurance.

17. What does EMTALA require regarding transfer of intensive care unit (ICU) patients, according to Stephen Frew, JD, risk management consultant at Physicians Insurance Company of Wisconsin?
    A. Patients should not be transferred from the ICU to an ED.
    B. The accepting person must be a physician.
    C. Hospitals must provide further care and stabilization of patients before transfer.
    D. State laws supercede EMTALA requirements.

18. Which is true regarding patient satisfaction and wait times, according to a study published in *Academic Emergency Medicine*?
    A. Patient satisfaction depends mainly on the actual time spent waiting.
    B. Patient satisfaction depends mainly on the perception of wait time.
    C. Patient satisfaction was higher if patients waited under an hour.
    D. Patients were less satisfied if continually informed about delays.

# Emergency Contraception: Important Information for Survivors of Sexual Assault

Rape can happen to anyone, anywhere, at any time. No one deserves to be raped. It is not your fault.

While you are at the medical facility, a nurse or doctor will document and treat any injuries you have and may offer you medication to lower your risk of sexually transmitted infection. She/he also will do a special exam to collect physical evidence of the assault and assess your risk for unintended pregnancy.

Ask your doctor about Emergency Contraception (EC). Your doctor will tell you how EC can prevent pregnancy if you take it within 72 hours of sexual contact. EC is a high dose of ordinary birth control pills that can lower your chances of getting pregnant by 75-89%. EC is not an abortion medication.

If this medical facility does not offer or give you a referral for EC, call your local rape crisis center (listed in the yellow pages). Make sure you get a referral, fill your prescription, and take the first dose within 72 hours of sexual contact.

If you can't find a local center, try the following options:

- The MN Coalition Against Sexual Abuse at (800) 964-8847 can give you a referral during normal business hours.
- Call the Emergency Contraception Hotline at (888) NOT-2LATE.
- Call the MN Family Planning Hotline at (800) 78-FACTS

*Source*: Sexual Assault Resource Service, Minnesota, MN.

**OHIO CHAPTER ACEP**
**MEDICAL CENTER**
**FAST EXAM**
**TRAINING LOG**

***Patient ID***

***INDICATION**

- ❑ Penetrating Trauma
- ❑ Blunt Trauma

***FINDINGS**

**Perihepatic (Abnormal)**
- ❑ Hemoperitoneum
- ❑ Hemothorax
- ❑ Solid-Organ Injury
- ❑ Hemoretroperitoneum

❑ **Perihepatic (Normal)**

**Perisplenic (Abnormal)**
- ❑ Hemoperitoneum
- ❑ Hemothorax
- ❑ Solid-Organ Injury
- ❑ Hemoretroperitoneum

❑ **Perisplenic (Normal)**

**Pelvic (Abnormal)**
- ❑ Hemoperitoneum

❑ **Pelvic (Normal)**

**Pericardial (Abnormal)**
- ❑ Hemopericardium
- ❑ Pericardial Tamponade

❑ **Pericardial (Normal)**

SONOGRAPHIC INTERPRETATION:_____

CONFIRMATORY STUDY/RESULTS:
- ❑ CT Scan:_____
- ❑ Ultrasound:_____
- ❑ Laparotomy:_____
- ❑ DPL:_____
- ❑ Autopsy:_____

Physician-Sonographer:_____
Study Number:_____

*Source*: Ohio Chapter of the American College of Emergency Physicians, Columbus, OH.

| | |
|---|---|
| | |
| **Pericardial** | **Perihepatic** |

| | |
|---|---|
| **Perisplenic** | **Pelvic** |
| | |

*Source*: Ohio Chapter of the American College of Emergency Physicians, Columbus, OH.

BIOTERRORISM WATCH
Preparing for and responding to biological, chemical and nuclear disasters

# They don't call it bio*terror* for nothing: Fear is the foe when anthrax spores are found within hospital walls

*'We feel we were able to ward off a panic . . .'*

Clinicians nationwide were beset with hoax powder scares last year at the height of the anthrax attacks, but at one hospital, the threat turned out to be real. Positive cultures for *Bacillus anthracis* were found within hospital walls, setting off a wave of anxiety that threatened to descend into panic.

"There was a mounting level of anxiety among our health care workers," said **Maureen Schultz**, RN, infection control coordinator at Veterans Affairs (VA) Medical Center in Washington, DC. "It had to be dealt with before we could work out any other aspect of the situation."

The events began to unfold last October, when it was discovered that the anthrax letter sent to Sen. Tom Daschle (D-SD) might have contaminated other federal buildings through cross-contamination of mail processed at the Brentwood postal building in Washington, DC.

"It was several days before the contamination was discovered, and by that time, several downstream facilities, including our VA hospital, were contaminated," she said recently in Salt Lake City at the annual meeting of the Society for Healthcare Epidemiology of America (SHEA).[1] In light of the situation, it was recommended that mailrooms in federal buildings be cultured for anthrax.

"One of the things we found frustrating was that we were not given any guidance as to how we should screen the mail," Schultz said. "So we [took] cotton swabs and ran each swab over an approximately 10 to 50 square inch area."

Four of 34 environmental swabs taken in the hospital mailroom grew *B. anthracis*, with colony counts varying from one to 11. The anthrax was found on a canvas mail tote, a cardboard box that had been mailed, on the top of a mailroom speaker, and on a canvas mail cart.

## *The fear factor*

"Even before the contamination was discovered, [we] decided to take some action because of the growing concern among our employees," she said. "So [we] convened a group from the emergency response team, infection control, safety, and public affairs."

The focus of the response was to determine risk level, provide prophylaxis as needed, decontaminate the environment, and get accurate information to all 1,700 health care workers, patients, and visitors, Schultz said. In order to reduce the high level of anxiety, a series of educational sessions were held, information was posted on the hospital web page, press releases were distributed, and printed materials were given to staff, patients, and families. In addition, a series of "town-hall" meetings was held to fully air the concerns of employees.

"These were informal sessions that we had in our auditorium where many health care workers could come and interact on an informal basis," Schultz said.

The risk to hospital workers was determined to

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be low, and only eight staff members were started on prophylactic antibiotics. Those included five mailroom employees who were encouraged to take full 60-day regimens. Another three workers, considered at lower risk, were given 10-day regimens due to possible contact with contaminated mail. The mailroom and surrounding area were decontaminated by an outside contractor.

Overall, some 500 health care workers attended the education sessions, and each town-hall meeting drew more than 200 staff members. With the colony counts low and the contamination limited, the decision was made to limit prophylaxis to only the eight aforementioned employees. That approach was not well received by other health care workers who feared they could have been unknowingly exposed.

"We refused treatment to all other employees, and initially, this created a lot of anxiety among the health care workers, particularly in these large town-hall meetings," Schultz said. "They were demanding ciprofloxacin or doxycycline in case they had come in contact with something contaminated. But we did hold firm on this, and we did not provide prophylaxis to any other employees."

Still, at the SHEA meeting, the Centers for Disease Control and Prevention (CDC) conceded that many of its initial assumptions about anthrax turned out to be false, including the perception that mail handlers were not at risk for inhalational anthrax. Given that acknowledgment, *Bioterrorism Watch* asked Schultz if she would now reconsider the decision to limit antibiotic prophylaxis to a few workers. "Based on the information we have now, no. I don't think we would change that decision." There really was no evidence that any widespread contamination had occurred, she added.

A total of 34 workers reported to the occupational health service for clinical evaluation, but there were no reports of staff refusing to work, and patient care was not interrupted. The initial level of fear and anxiety among many of the workers eased off under the continuous education and communication effort.

"We feel we were able to ward off a panic situation by the actions that we took," she said.

## *NYC hospital faces similar situation*

A similar contamination incident was feared at Memorial Sloan Kettering Institute, a 431-bed cancer center in New York City. Some 1,200 health care workers at Sloan Kettering work in the same building as Gov. George Pataki's Manhattan office, which was reported to be the target of anthrax mailing. On Oct. 17, possible anthrax (positive by polymerase chain reaction test) was discovered in the governor's office. Pataki and staff vacated their part of the building, and infection control staff and hospital administration at Sloan Kettering developed a response plan to protect their workers.

The hospital employees worked on 10 floors of the 40-story building, including three floors that shared an air-ventilation system with the governor's offices. The response was honed to focus on mailroom staff and some 250 employees who worked on the three floors with shared air. With incomplete information on the scope of potential contamination of Pataki's offices, hospital clinicians decided to perform nasal cultures on the employees on the three floors, **Janet Eagan**, RN, an infection control professional at Sloan Kettering reported at the SHEA conference.[2] All of the 245 cultures taken were negative.

"I think the nasal swabs were more to allay fear," she said. "We wanted to do something that was proactive."

Public health investigators first used the nasal swab approach after the first anthrax case in Florida, but the CDC would later advise against routine use of the practice. The reliability of the swabs came into question, in part, because even those exposed may test negative as the nose clears of spores. At a Nov. 1, 2002, press briefing, the CDC advised against using nasal swabs "as a nonspecific probe to determine whether anthrax has ever been present in an environment."

Of course, clinicians at Sloan Kettering were dealing with a situation before that clarification was issued, but even then there were doubts about the wisdom of swabbing the workers.

"By the time we agreed to do the nasal swabs, I was kicking myself, thinking what on earth are we going to do with this information," **Ken Sepkowitz**, MD, epidemiologist at the hospital told SHEA attendees. "The nasal swabs was a screw-up, but with the information we had . . ."

With all the swabs negative, no antibiotics were administered. Additional efforts were needed to reassure the "worried well" that they were not at risk. Personnel from infection control, safety, security, and social work all met with the staff. Building management conducted an independent environmental survey of the building.

"E-mails went to all staff that all 245 employees tested had negative results," Eagan said.

"Communication is key. We believe that by having a hands-on approach — actually being there meeting with staff — prevented panic in employees that were very vulnerable."

Then word came that the original specimen from the governor's office had been found culture negative on retesting. The hospital had been through an intense false alarm drill, but overall had met the challenge, Eagan said.

"Decisions were made using incomplete information at a time-sensitive pace," she said. "Staff responded in a positive manner to the high visibility of administrative leadership, infectious disease, and infection control in numerous educational sessions and e-mail alerts."

### *References*


1. Gordin F, Schultz M, Benator D, et al. A coordinated response to contamination of the hospital environment with *Bacillus anthracis* spores. Abstract 129. Presented at the annual conference for the Society for Health Care Epidemiology of America. Salt Lake City; April 6-9, 2002.
2. Eagan J, Martin K, Prager L, et al. Infection control response to potential anthrax contamination of building with hospital workers. Abstract 130. Presented at the annual conference for the Society for Health Care Epidemiology of America. Salt Lake City; April 6-9, 2002. ■


# APIC: Smallpox plan uses outdated infection control

*Designating patient facilities a mistake*

The Centers for Disease Control and Prevention (CDC) has based its smallpox bioterrorism response plan on "outdated concepts," and entire sections need to be revised to reflect current epidemiologic strategies, the nation's leading group of infection control experts warned.

The Association for Professionals in Infection Control and Epidemiology (APIC) commented on the *CDC Interim Smallpox Response Plan and Guidelines*, which has been released as something of a work in progress.

"In general, we are concerned that the draft guidelines appear to be based on outdated strategies used to control this disease decades ago and do not appropriately integrate those infection control strategies and environmental controls utilized in our hospitals today," the APIC letter stated.

The CDC response plan calls for investigators to rapidly immunize a "ring" around the first cases. The ring concept uses isolation of confirmed and suspected smallpox cases followed by contact tracing, vaccination, and close surveillance of contacts. The ring approach was used to successfully eradicate smallpox from the world in 1980. But the ring concept was effective when the demographics of smallpox were very different, when few were infected, and the vast majority of people already were immune.

As part of the ring response, vaccine would be administered to people involved in the direct medical care, public health evaluation, or transportation of confirmed or suspected smallpox patients.

"Vaccination, like any preventive strategy, is more effective if given prior to exposure," APIC argued. "If health care workers are not immunized prior to case identification, these individuals [especially emergency department staff, direct caregivers, and laundry personnel] should be vaccinated immediately upon documentation of a case in their community. It is crucial that we not wait for a case to present in the facility before taking preventative action."

In addition, it may not be possible to distinguish between febrile response to vaccine or actual exposure in health care workers, APIC warned.

"Approximately 20% of vaccinated employees will develop fever and not be able to work if vaccine is given in response to a suspect or confirmed case," the association stated. "We need to develop strategies for dealing with staffing shortages whether they are due to febrile reaction to vaccination, true infection / disease, or refusal to care for patients in a smallpox emergency."

### *'Misuse of resources'*

APIC also questioned the CDC concept of a "Type C isolation facility" for smallpox patients. As proposed, the sites would be facilities that are at least 100 yards from any other occupied building, or those that have nonshared air-ventilation systems with filtered exhaust.

"We believe it would be a misuse of resources to design, build / retrofit, and maintain a designated facility that is not integrated with the existing health care system," APIC stated. "Using alternative structures rather than enhancing the current infrastructure is not a wise use of our limited resources."

Instead, existing facilities could substantially

benefit from dedicating resources to ensuring appropriate air handling and ventilation systems for existing clinics, emergency departments, and isolation rooms. "This would provide the added benefit of controlling more likely exposures to infectious droplet nuclei [tuberculosis, disseminated zoster, chicken pox, measles, etc.] in addition to minimizing or eliminating the likelihood of intrafacility transmission of smallpox," APIC stated.

The association expressed concern that health care delivery might be compromised in separate Type C facilities, particularly if they are not designed to provide services such as intensive care, ventilator support, dialysis, and laboratory resources. Rather then designate facilities for smallpox patients, each hospital should be prepared in advance to activate its program when the first case is identified, APIC argued.

"There needs to be a predetermined area [building or wing, etc.] that meets the 'Type C' facility requirements for isolation," APIC noted. "Part of a facility's planning would include a determination regarding the number of patients that could be housed in the designated area."

Some of the cleaning and disinfection recommendations in the document are out of date with current sterilization principles and practices. That includes "fogging" rooms to disinfect environmental surfaces, the association charged.

"CDC has not recommended the fogging of rooms for many years," APIC stated. "We strongly suggest the deletion of any archaic references to fogging." ■

# Stanford sets the standard for bioterrorism planning

*A separate piece: Stand-alone plan advised*

It's not enough merely to update the bioterrorism component of your current disaster preparedness plan, experts say; you must create a detailed bioterrorism response plan that stands on its own.

That's precisely the philosophy behind the Stanford (CA) Hospital and Clinics (SHC) & Lucile Packard Children's Hospital (LPCH) Bioterrorism Response Preparedness Plan, which is gaining widespread recognition as a model for such plans. In fact, several Kaiser Permanente facilities in California already have adopted the plan.

"You need a separate [bioterrorism] plan," asserts **Eric A. Weiss**, MD, assistant professor of emergency medicine at Stanford, associate director of trauma at Stanford Hospital, and chairman of the disaster committee and bioterrorism task force. "During most disasters, for instance, you don't rely on the microbiology lab to identify pathogens. Also, infectious disease and infection control staff take on a major, heightened role."

In disasters such as an earthquake, Weiss notes, you generally don't have to worry about the quarantine of patients or the spread of infectious agents. Similarly, you may not have to put on protective clothing or worry about cross-contamination of existing patients who may be immunosuppressed.

A bioterrorism plan had been in place prior to 2001, Weiss says, "but it was really just a skeleton plan — not very comprehensive. It was part of a larger disaster preparedness plan, but a plan to deal with mass casualties from bioterrorism is very different."

When you have a major disaster such as the collapse of the World Trade Center, Weiss notes, local health care providers are likely to come to the hospital and offer to chip in and help wherever they can.

"But what happens when the word goes out that patients are walking around with smallpox?" he asks. "Are providers going to want to stream down to the hospital and potentially infect themselves and their families? You need a response plan to address the safety of health care providers, so they will feel comfortable and want to show up for work."

To create such a plan, the Bioterrorism Planning Task Force was formed, incorporating personnel from 30 or more different departments at both facilities. Those departments include infectious diseases, infection control, emergency medicine, pediatrics, critical care, intensive care units, nursing and hospital administration, dermatology, psychology, social services, and environmental health and safety.

"We began putting the plan together when we identified the fact that the current plan was not adequate," notes Weiss. "We accelerated our activities after Sept. 11. After Sept. 11, *everybody* wanted to be part of it."

*[Editor's note: The bioterrorism plan is available on the Stanford web site at www.stanfordhospital.com.]* ■