AMERICAN HEALTH CONSULTANTS®

ED Management®

The monthly update on Emergency Department Management

Vol. 10, No.11

Inside

November 1998

Is pain management lacking in your ED? Here's what you need to do

Studies show there is a lot of room for improvement for pain management in the ED; managers must develop protocols, stay current on new approaches

Pain is often poorly managed in emergency medical services (EMS) and emergency departments (EDs) for both pediatric and adult patients, says **Emory M. Petrack, MD, MPH,** director of the department of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland, OH. "Of all the various types of help that we can offer people in the ED, effective management of pain is an area where we often fall short of our potential," he notes.

Every ED manager should make improvement of pain management a priority, argues **Gregory Henry, MD, FACEP**, chief of the department of emergency medicine at Oakwood Hospital-Beyer Center in Ypsilanti, MI. "People may expect to sit, waiting in pain, when they come to the ED, but I think we ought to exceed expectations," he says.

Make pain management a priority with staff, urges Petrack. "The ED manager plays an important role in providing leadership to ensure that patients in pain, either from disease or injury or from painful procedures, are helped with their pain as much as possible," he says. "Addressing the need for pain relief leads to both better quality of care and enhanced patient and family satisfaction."

Audit and use protocols. At Ravenswood Hospital's ED in Chicago, IL, a patient satisfaction survey revealed that patients were dissatisfied with pain control. An audit was done to track the use of pain medication in patients with fractures, sprains, and contusions. "We also studied the use of topical LET (lidocaine, epinephrine, and tetracaine) in the use of appropriate pediatric lacerations. We found we did not use much topical anesthetic in kids even though it was available" says **Bruce McNulty, MD,** medical director of the ED.

The results of the audit were shared with ED physicians, including doctor-specific data. "Each doctor on staff saw what his or her rate of use of these pain relievers was," says McNulty. "We have found, as have others, that peer review comparison data is a powerful tool for change. No physician wants to be the low outlier in an audit such as this."

Repeat audits are an effective way to track progress. "After we collected data initially, we again carefully documented use or even the offering of pain relievers,"

McNulty says. "We created a very simple protocol giving nurses the authority to order analgesics for fractures, sprains, and contusions. Previously, pediatric fever was the only time medications were given at triage."

The protocol also included applying LET at triage for appropriate pediatric lacerations. "It takes about 15 minutes or so to work, so if you need to wait two hours for the doctor to do it, that is an unnecessary delay," says McNulty.

Progress is tracked on an ongoing basis. "We track the numbers frequently and give feedback to the individuals involved, so that they are invested in the improvement," says McNulty.

A third audit will be conducted, with the goal of tracking increased use for each step in the process. "We hope this will reflect in improved scores on this part of our customer satisfaction data, as well as overall improved satisfaction with the care we provide," says McNulty.

The idea is for staff to embrace the concept of pain control as an important issue, McNulty explains. "Once the issue of pain control is embraced, our goal is to create protocols for renal stones, migraines, and other painful conditions to standardize and speed care," he says.

Adhering to specific guidelines makes pain management more consistent, says Murphy. "If the algorithm states to use this amount of morphine on a patient with pain, then it's not up to the judgment of an individual," he explains. "If a physician doesn't follow the algorithm, it's not acceptable to say they forgot it. They have to justify that in the record."

Protocols for specific medications can also reduce risks. *(See protocol for Ketamine inserted with this issue.)* "Many painful procedures in the ED require the use of IV or IM sedation and/or analgesia," says Petrack. "Protocols or guidelines should be established for the use of these agents to ensure high quality and safety."

Target patients at high risk. "Patients at high risk for inadequate pain management in the ED include those with abdominal pain, burns, and eye injuries, and children and the elderly," says Henry. Here are some things to consider for these patient populations:

Elderly. Inadequate pain management is particularly dangerous for elderly patients, stresses Henry. "Severe pain causes a release of epinephrine, which raises blood pressure. That can stimulate an elderly patient to the point of vasoconstriction and heart attack," he says. "Treating pain allows other body functions to continue normally."

Abdominal pain. Clinicians are often reluctant to treat patients' abdominal pain before a diagnosis is reached, says **Michael Murphy, MD,** associate professor of emergency medicine and anesthesia at Dalhousie University and executive director of Emergency Health Services for the province of Nova Scotia, Halifax, Canada. "Since the early 1900s, a myth has been perpetuated that pain shouldn't be managed until a diagnosis is made," he says. "That statement was made because if they gave someone morphine and abolished their pain, they didn't operate and the patient died."

New alternatives make that outlook obsolete, notes Murphy. "Back then, management of pain was an all or nothing phenomenon," he says. "Now our pharmacology is much more precise and the risk of anesthesia is so much lower. In the last 10 years, literature has shown that judicious administration of pain medication actually enhances your ability to make a diagnosis."

However, abdominal pain needs to be treated appropriately, says Murphy. "If there is so much pain that the patient can't accurately locate the pain because they are in agony, that works against the diagnosis," he notes. "On other hand, if we take away all their pain, that also works against it, so you need to balance the amount that you give."

Orthopedic pain. "For some reason, there is a reluctance to adequately manage orthopedic pain," says Murphy. "That may be because patients may have multiple injuries, so there is concern about masking one that may be life threatening, Also, it requires opioids, and people are concerned about respiratory depression."

Indigent population and drug abusers. "People that are addicted and homeless also have pain," says Murphy. "It's not unusual for me to administer several hundred milligrams of morphine to an addicted patient."

Pediatric patients. "Children are a special problem and stand by themselves," says Murphy. "For some

reason, we don't consider them as physiologically capable of adults as having pain."

Often, children don't communicate pain well, and have difficulty in using behavioral scores or visual analog scales, notes Murphy. "Also, they learn that the reward for complaining of pain is a needle, so are reluctant to complain," he adds.

Children should be routinely asked about pain, advises Murphy. "If we ask a child if they have pain, they will tell you, but sometimes we don't ask," he says. "Otherwise, children with painful conditions, such as sickle cell crisis, may come to the ED and just suffer in silence."

Physicians may be reluctant to give children certain medications. "We use very potent medications to manage pain in adults, such as opioid analgesics," says Murphy. "Some people may feel these drugs are too powerful for kids."

The margin of error for children is very small, Murphy notes. "But that just means you have to be more careful with dosing," he says. "It's very difficult to give 0.1 of a milligram of morphine. EDs with a lower pediatric volume have less experience managing small children, so they need to pay more attention to details in dosing."

Here are some ways to improve management of pain in the ED:

Measure pain in regular intervals. A regimented approach to pain management includes checking to see how a patient's pain level is changing, recommends Murphy. "You might have a patient's blood pressure and pulse checked every five minutes, and you can do the same with pain management," he says. "Note the pharmaceutical interventions, then study the difference between these patients and others to check outcomes."

Be aware of cultural differences in expressing pain. *(See sidebar on ethnic bias in the ED on page 125.)* "The outward demonstration of suffering, which is often times culturally driven, is no different than a person who wants to eat spicy vs. bland food. It doesn't mean they are abnormal or that we have to coach them to behave in a more stoic manner," says Murphy. Using numerical scores for pain instead of relying on a patient's outward expression can improve accuracy of pain severity, he suggests.

Lessen anxiety. "Anxiety and pain run together. If we can reassure patients, often their pain gets better," says Henry. "If a patient is anxious before a procedure such as spinal tap, I give them pain and anti-anxiety medications through an IV before the procedure."

Simple reassurance can lessen a patient's anxiety. "There are lots of ways of treating anxiety. Even your mannerisms can make pain better or worse," says Henry. "Reassure the patient by saying, 'I will take care of your pain, immediately,' or 'I have more pain medicine than you have pain, and I've never met anybody we couldn't give relief.'"

Diversion strategies are difficult to use in the ED, but they are legitimate, says Murphy. "Patients who are reassured and have confidence in the health care team typically have lower pain scores than those who are anxious," he explains. "If they understand you are there to help them, they don't need to exaggerate the psychological manifestations of pain."

Use multiple modalities of pain control. Combining multiple pain modalities is a better strategy than using a single modality, says Henry. "For example, Tylenol and Ibuprofen act on two separate sites and have no interaction with each other," he explains. "You get better results using them together than if you use either one independently."

Ask every patient about pain. "Ask about pain every single time as part of the initial history, and determine what you are going to do for pain. If a patient has to ask you for pain medication, you have failed," says Henry. "We tend to think that some patients are whiners and complainers, but other patients may be stoic and not volunteer the fact that they're in severe pain."

Some conditions are very painful, but are often not considered painful. "For example, a corneal abrasion can be just devastating, and needs to be properly treated," says Henry.

Ask specific questions about the nature and severity of pain. "Ask where the pain is; [ask about] the radiation, timing, and what makes it better or worse," Murphy recommends. "It would be reasonable to ask how intense their pain is on a 5-point scale, and if it's greater than a 3, treat it."

Give medications IV. "If you are going to use multiple approaches to pain, as with a migraine headache, give all medications IV," Henry recommends. "That way, the patient only has one needle poke and doesn't have any pain from you. Why give a bunch of shots IM if you don't have to?"

Know which methods to consider. "There are all kinds of modalities that help with pain. Use whatever you need to. That may mean medication, ice, elevation, or immobilization," says Henry. "There are all different types of pain, and different modalities are more useful in certain situations than others."

Educate residents. "A major problem with young doctors is [that] most of them have never suffered real pain. A lot of specialties are so limited in training that it takes time on the outside to understand pain management," says Henry. "It's up to the attendings to teach residents about pain management."

Address pain at discharge. "Every checklist should include pain relief," stresses Henry. "Work with the patient to help them decide their pain management, instead of enforcing your beliefs on them."

Provide inservicing to staff. "There are many excellent seminars in pain management offered by the American College of Emergency Physicians, the American Academy of Pediatrics, and others," says Petrack. "The first step toward improving the management of pain is to make a personal commitment to address this area through education and to gain some experience in providing better pain control both for procedures in the ED and for discharge analgesia needs."

Education is extremely important to ensure optimal care, stresses Petrack. "This should include physicians, nurses, and medics if they help with these procedures," he notes. "The American College of Emergency Physicians and the American Academy of Pediatrics have both published guidelines for the provision of procedural sedation and analgesia."

Use child-life specialists. For EDs that provide care to a large pediatric population, child-life specialists can offer a variety of services to help children who are in pain or who need to undergo painful procedures, says Petrack. "Many ED physicians have had the expe-

Continued on page 126

Four myths of administering pain medications

Many misconceptions about pain exist in the ED and throughout the hospital. "There is a great deal of ignorance and myth about pain management that ED managers should be aware of," stresses **Gregory Henry, MD, FACEP,** chief of the department of emergency medicine at Oakwood Hospital-Beyer Center in Ypsilanti, MI. Here are four misconceptions about pain management:

Myth 1: Pain is inevitable in the ED. "Because of that attitude, we let a lot of people suffer who don't need to," Henry argues. "Most patients come to the ED because they are hurting. We have so many drugs today to alter perception or memory of pain, and we can take away pain very effectively."

Pain relief is a key part of all therapies, including those that take place in the ED, Henry emphasizes. "If a patient had bone cancer and had six months left to live, they would be given all the morphine they needed," he says. "So why would we not take away pain on a short-term basis?"

Myth 2: Pain medications mask diagnoses. ED physicians typically face roadblocks in managing pain because of fear of masking the diagnosis, particularly in patients with abdominal pain. However, that is changing. "There is an increasing acceptance of relief for patients with abdominal pain, which was such a no-no until about 10 years ago," says **Bruce McNulty, MD,** medical director of the ED at Ravenswood Hospital in Chicago. "Research shows that we can, in fact, improve diagnostic accuracy by relieving pain."

Still, there is a widespread belief that pain medications may impact the eventual diagnosis, Henry notes. "There is absolutely no evidence that a diagnosis is altered with appropriate use of pain medications," he says. "The newer texts now say there is no reason to delay treating pain."

However, some surgeons may still be reluctant to give pain medications, fearing they will obscure a patient's need for surgery. "If you are seeing a patient with abdominal pain and the surgeon can't be there in ten or 15 minutes, just give a short acting narcotic, which can easily be reversed," suggests Henry.

Myth 3: Pain medications should be given in small increments. "There is an idea that we need to sneak up on pain, by giving little bits of medication over a period of time, but that's not the way to treat pain," says Henry. "The best way is to hit it with high doses and multiple modalities early on."

Many ED clinicians underdose both Tylenol and ibuprofen, says Henry. "A reasonably sized male in good health needs 600 g. of Motrin to do anything," he says. "The tendency is to use too much medication for too long a period of time, but it's much better to use a high dose."

Myth 4: Patients may become addicted to narcotics. "Giving three or four days of a narcotic never made anybody an addict," says Henry. "However, this mistaken belief leads to a kind of stoic ethic which makes patients suffer."

There has traditionally been concern about the use of potent narcotic analgesics, especially in children and the elderly, says **Emory M. Petrack, MD, MPH,** director of the department of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland, OH. "ED physicians who do not have significant experience with these populations may feel uncomfortable with the potential side effects related to respiratory or cardiovascular compromise," he says. "The reality is that with some knowledge and experience, it is not difficult to provide good pain relief in the ED." ■

Avoid racial and cultural bias in pain management

Research has shown evidence of ethnic bias in regard to pain management, says **Knox H. Todd, MD, MPH,** associate professor of emergency medicine at Emory University School of Medicine in Atlanta, GA. "Although the underuse of analgesics applies to all [emergency department] ED patients, I think we've established that ethnic bias exists."

Studies reviewed records from patients with isolated long bone fractures of upper or lower extremities.[1-4] "The majority white culture tended to receive more analgesics than the minority population of African or Hispanic patients," says Todd. "We were able to show identical complaints of pain with identical injuries, and whites were more likely to receive analgesics."

Here are some ways to avoid ethnic bias:

Make assessment for pain mandatory. "The quickest route to more consistent treatment would be to institute guidelines for pain management that are protocol driven and don't require active participation by nurses or physicians," Todd recommends. *(See ED quality assurance process inserted with this issue.)*

Give a non-narcotic analgesic at triage. If all patients complaining of pain are given analgesics at triage, ethnic bias will not be an issue, says Todd. "We need to move the point of analgesic delivery much closer to the patient's complaint," he adds. "For example, any patient who presents with an ankle sprain at triage can certainly receive 600 of ibuprofen prior to getting an x-ray. With time, that becomes a reflex action."

There is no problem in giving a non-narcotic analgesics, whatever the patient's eventual diagnosis, notes Todd. "Narcotics added to a base of non narcotic therapy is a reasonable way to go," he says.

Track reasons for unscheduled returns. Monitoring unscheduled returns due to pain and comparing them for ethnic groups is a way to ensure consistent treatment, says Todd. "One of the blind spots we have is not knowing what happens two or three days down the road, after the patient leaves the ED," he notes. "If you look at unscheduled returns, many of those are due to inadequate pain management."

Audit for ethnic bias in your ED. "If you look for it, you will probably find it," says Todd. "To do a quick audit, choose a typical stereotypic pain stimulus like a fracture, something that is fairly objectively diagnosed. Then simply compare pain management among ethnic groups for a period of time."

Fractures are a good candidate for this type of audit, since the severity can be quantified, says Todd. "Avoid hip fractures or sprains, because they're not as easy to define," he recommends. "It's not difficult to do a year's worth of past charts, and it's become even easier with information systems, to query for differences in analgesia with ethnic groups."

Consider which pain scales should be used. A study assessed whether numeric or word pain scales are more effective with patients who don't speak English.[5] "We looked at whether some cultural groups might prefer a word descriptor scale or a numerical scale," says **Martha Neighbor, MD, FACEP,** at San Francisco General Hospital (CA). "We found both scales can be used very effectively."

The study found that there was very little difference in patient preference for one of the scales, and both scales were valid. Patients should be offered their choice of either of these simple pain rating scales to evaluate pain and the effectiveness of pain-relieving interventions, says Neighbor.

Use multi-lingual laminated cards. Word and numerical rating scales should be developed in the prevalent languages of your community, says Neighbor. "When non-English speaking patients present at the triage desk in pain, you can show them laminated cards that ask them to describe the intensity of their pain," she suggests.

Multi-lingual laminated cards can assess severity of pain consistently among different cultural groups, says Neighbor. "If you can't rate the severity objectively, then, obviously, the providers are left to surmise how much pain [the patient is] having, based on how they look, and different cultural groups don't necessarily manifest their pain the same," she notes. "Some are stoic and quiet, while others overly dramatize the degree of pain they are having." ■

References

1. Todd KH. Pain assessment and ethnicity. *Ann Emerg Med* 1996;27:421-423.
2. Todd KH, Lee A, Hoffman JR. The effect of ethnicity on assessment of pain severity in patients with isolated extremity trauma. *JAMA* 1994;271:925-928.
3. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA* 1993;269:1537-1539.
4. Todd KH, Warner C, D'Adamo A, et al. Ethnicity and emergency department analgesia. *Acad Emerg Med* 1997;4:424.
5. Puntillo K, Neighbor ML. Two methods of assessing pain intensity in English and Spanish-speaking patients. *JEN* 1997;23: 597-601.

Continued from page 124

rience of utilizing child-life specialists to do minor, painful procedures without sedatives or analgesics that would otherwise be required," he explains. This significantly enhances both the quality of care provided and customer satisfaction, Petrack says. "I have received more positive letters about the use of child-life specialists for painful procedures than about any other topic," he reports.

Make pain a fifth vital sign. "There is a movement in continental Europe where pain has been added as a fifth vital sign," says Murphy. "A visual analog score is recorded for every patient, with standing orders for nurses to administer analgesics to those patients."

At triage, acutely painful conditions should be scored as emergent problems, says Murphy. "We routinely audit charts for vital signs, with a 100% compliance. Our tolerance is 1% noncompliance," he explains. "This way, recording pain as a vital sign becomes the norm in your day-to-day practice."

Confront misconceptions of colleagues. "Over the past five years, the sophistication of monitoring and pain management has improved substantially in the ED," says Murphy. "Clinical managers of EDs have a responsibility not only to educate themselves, but also the nurses and physicians they work with, and those we rely on as consultants to [help them] understand pain better than they do now."

However, inpatient management of pain is improving, says Murphy. "Surgeons are becoming more and more aware of pain and its consequences. People are realizing that patients in pain are sicker longer," he notes.

If necessary, take steps to update other departments, Henry advises. "Although antiquated thinking has no connection to reality or current ideas of pain management, it does tend to dominate surgery departments," he says. "You should hold grand rounds with the surgeons and make it explicit, explaining what we do and why we do it." ■

Reduce legal risks of chest pain

Missed MIs are the largest single dollar problem in emergency medicine malpractice nationally, and chest pain liability risks are increasing, warns **Eric Knox, MD,** medical director of MMI Risk Management Resources, based in Deerfield, IL. "It's becoming a more expensive category as time goes on because people are presenting at younger ages," he reports. "If you end up with a death following a misdiagnosis, you are liable for more damages if the patient is a 35 year old instead of a 75 year old, because of the way the legal process works."

Here are some ways to reduce risks of chest pain patients:

Adhere to risk management guidelines. A recent 12-year study found that following risk management guidelines led to substantially lower average dollar losses per medical malpractice claim than following no guidelines at all.

More than 200 EDs were asked to collect data on patients complaining of chest pain. Results showed that more than one-half of the chest pain patients older than 30 years who were discharged left with a nondefinitive diagnosis. "Those patients have almost twice the rate of unplanned returns to the ED within 48 hours, when compared with all patients discharged from the ED," says **Pam Lockowitz,** president of MMI, which developed guidelines in response to the study's findings.

Patients discharged without a definitive diagnosis are more likely to return with an unplanned admission or death, stresses Lockowitz. "It's important for providers to take a systematic approach to diagnose or rule out MI and reduce negative outcomes," she says.

Implementing chest pain protocols that address risk management issues is key, says Knox. "Timely and accurate diagnosis reduces the number of negative outcomes," he adds. "Cases typically involve not perfectly diagnostic ECGs, or atypical chest pain that gets misdiagnosed as muscular or stomach pain or something else."

A task force of ED physicians, nurses, administrators and risk managers developed guidelines and the results were studied. "If the guidelines are followed in a given lawsuit, the cost is much lower than if one or more had not been followed," says Knox. "In many cases where there was litigation, the case would not have been brought if certain things had been done. If guidelines were applied consistently to every case, there would be fewer lawsuits."

The guidelines state that any patient older than 30 years with chest pain gets an ECG. "A lot of claims involve patients walking out without ECGs," says Knox. "Patients who don't get ECGs are the ones who end up in court. Be safe and do the ECG."

Guidelines can improve identification of patients who are most at risk, and ensure that appropriate testing is completed. "The goal is to sharpen diagnostic accuracy," says Knox. "Instead of complicated pathways or algorithms, try to hit a median balance. You want to ask people to do important things, but keep it clear and simple."

Consider charting techniques. History is critical in chest pain patients, emphasizes **Daniel J. Sullivan, MD, JD, FACEP,** chairman of the department of emergency medicine at Ingalls Memorial Hospital in Harvey, IL. "On presentation, you cannot tell the difference between the clinical entities that cause chest pain without a complete history," he says.

"For example, a sudden onset of pain that is maximal at outset suggests a thoracic aortic dissection, whereas a more crescendo type pain suggests cardiac ischemia, a pain in the substernal area suggests ischemic pain, and pain in the substernal area that radiates straight through to the back is more characteristic of a thoracic aortic dissection," notes Sullivan.

Risk factor analysis in the history can also be invaluable, says Sullivan. "For example, there is an increased risk of thoracic aortic dissection in patients with a first-degree relative with the same problem, or in patients with a connective tissue disorder," he notes. "There are few things more important in the chest pain patient than a review of cardiac risk factors."

Documentation is essential in order to establish that the practitioner has met the standard of care in the evaluation of chest pain, Sullivan stresses. "If the practitioner documents these issues, the plaintiff must prove that he did not do the appropriate evaluation," he notes. "If the practitioner does not document these issues, the burden is on the practitioner to prove he did do the appropriate evaluation. It's easy to see which road the practitioner should choose."

Orientation plays a critical role in risk management of chest pain patients, says Sullivan. "In a number of thrombolytic-related lawsuits, the emergency practitioner claims that he or she did not know that thrombolytics could be administered in the ED," he reports. "During litigation, the hospital presents an ED protocol that obviously includes ED administration of thrombolytics."

Include ECGs in abdominal pain protocols. MIs can be mistaken for abdominal pain, stresses **Michael Kohn, MD, MPP, FACEP,** attending physician for the department of emergency services and director of quality improvement for the ED at San Francisco General Hospital. "If a 60-year-old patient has a chief complaint of abdominal pain, the chest pain protocol doesn't get triggered," he notes. "But when the patient is finally examined, it turns out to be very high abdominal pain, without a lot of tenderness, and ends up being an MI."

Abdominal pain protocols need to address this possibility, Kohn urges. "When you have an older patient with abdominal pain, you need to get EKGs on that patient very quickly," he says. "In our protocol, any patient over the age of 50 with abdominal pain gets an EKG soon as they hit the door."

Avoid giving medications to patients assumed to have abdominal pain without ruling out chest pain, says Knox. "Don't rely on a GI cocktail. It may make people with ulcers feel better, but will also make people with heart pain feel better."

Educate staff about Troponin I. In the near future, ED chest pain protocols may include Troponin I testing. "There is a movement to use enzymes to improve our clinical judgment," says Kohn. "The initial cardiac Troponin I is going to possibly prevent us from sending out a patients if results are positive, which will help prevent missed MIs."

At San Francisco General's ED, Troponin I is drawn upon the patient's arrival. "Chest pain patients over the age of 35 with abnormal but non-diagnostic ECGS will get an initial cardiac Troponin I and be monitored for six hours, receiving a repeat ECG at three hours and six hours," notes Kohn.

If the initial Troponin I is positive or if the three-hour ECG shows concerning ischemic changes, the patient is admitted. "If not, a repeat Troponin I will be drawn six hours after the initial level," says Kohn. "If this second Troponin I is also negative, the patient will be discharged with precautions and close follow-up."

The strategy is also cost effective. "By sending these patients to the observation unit instead of admitting them to the hospital, we save money on false positives and reduce unnecessary admissions, which are a huge dollar expenditure," Kohn notes.

Still, cardiac enzymes are no substitute for clinical judgment, stresses Kohn. "They can only be used as an adjunct," he says. "For abnormal but nondiagnostic EKGs, clinical judgment is more sensitive, meaning the ED physician is going to send fewer MI patients home than just blind usage of cardiac Troponin I."

Use observation units appropriately. "If patients with normal EKGs are sent to observation units as a kind of hedging maneuver, the rule in rate would then be extremely low," notes Kohn. "What you'll end up doing is keeping people in the ED unnecessarily who should have [been] sent home."

The solution is to follow a protocol that includes a chest pain observation unit, serial EKGs, and Troponin I, advises Kohn. "But you also need to do very aggressive quality control in that unit, to make sure the patients being admitted do have abnormal EKGs, and you are not admitting patients with such low risk for MI that they should have been sent home," he says.

The rule in rate for those patients should be higher than 10%, says Kohn. "If it's lower than that, it means

you are not using clinical judgment and filtering out very low risk patients who should be sent home without any observation," he explains.

An example of that type of patient is a 47-year-old man with a runny nose and cough who complains of six hours of intermittent chest pain, with no significant past medical history, says Kohn. "The exam reveals BP 150/90, otherwise normal vital signs, nasal congestion, and injected oral pharynx. No chest wall tenderness. CXR and ECG are normal," he notes. "This kind of patient has no business in a chest pain observation unit. In fact, we should be prohibited from enrolling any patient with a truly normal ECG into a chest pain observation protocol.'

On the other hand, take the example of a 47-year-old man with six hours of intermittent chest pain, says Kohn. "He thinks he might have a 'cold' but denies runny nose or cough, has no significant past medical history, and the exam reveals a BP of 150/90, but is otherwise unremarkable. CXR is normal, but ECG meets voltage criteria for LVH and there appear to be repolarization abnormalities in the ST segments and T waves," he adds. "Because of his abnormal but nondiagnostic ECG, this patient might be appropriate for a chest pain observation protocol."

Getting a thorough history is key, Kohn stresses. "Obviously, we would get a much more detailed history from these patients, including severity, position, quality, radiation, and timing of the chest pain," he says. "We would also ask about risk factors for venous thromboembolism and cardiac disease."

Look for patients who don't fit patterns. "You may see patients younger than 50 [years] or female nonsmokers with chest pain and say, this just doesn't fit the profile of MI," says Lockowitz. "There is a nonspecific diagnosis that gets placed on a number of these patients, who are discharged, and within 48 hours have an unplanned return/death."

Have a high index of suspicion for atypical chest pain. "If a patient describes a pain in their shoulder and was playing touch football, think heart attack anyway," advises Knox.

The main thing to emphasize is the ECG, Kohn stresses. "If a young patient presents with atypical chest pain, is sent home, and ultimately turns out to have an MI, the ED care is much more defensible if it included a truly normal ECG," he says. "It is possible for someone with an MI to have a normal initial ECG, but it is very rare. Of a hundred chest pain patients who ultimately turn out to have MI, no more than one will have a normal ECG (although 50 will have ECGs that are abnormal but not diagnostic of acute MI)." ■

Editor's Note: *For more information on risk management guidelines and MMI's report, "Transforming Insights into Clinical Practice Improvements: A 12-Year Data Summary Resource," contact MMI Companies, Inc., 540 Lake Cook Road, Deerfield, IL 60015-5290. Telephone: (847) 374-2400. Fax: (847) 940-2372.*

Mentoring your nursing staff helps create future leaders

ED nurse managers must always be on the lookout for future leaders, urges **Colleen Bock-Laudenslager, RN, MS,** a Redlands, CA-based consultant. "It is your professional responsibility to facilitate the employee's leadership skills and advanced professional skills," she says.

Mentoring others improves the likelihood that your accomplishments will continue to thrive, says Bock-Laudenslager. "When an exemplar manager leaves the department, the transition is potentially smoother, more fluid," she notes. "It is your opportunity to leave a legacy by nurturing potential leaders who could move into your leadership position."

Some managers may avoid mentoring, fearing they will be replaced. "The current financial health care climate is not conducive to mentoring, as it can foster job insecurity," says Bock-Laudenslager. "Having people waiting in the wings who could step into one's position may be threatening, but the leader's most unselfish act is to mentor those within their line of authority."

However, when employees reporting to you are consistently chosen for leadership positions, it validates your leadership capability, Bock-Laudenslager says. "You feel a sense of accomplishment when your employees tend to receive recognition and promotion, because it clearly demonstrates the outcome of your mentoring ability," she explains.

Mentoring can promote retention of qualified nurses and minimize burnout, says Bock-Laudenslager. "Most individuals reach a learning plateau where they may benefit from a manager challenging them to pursue other avenues of their career, especially those who have peaked clinically," she adds.

Nurses managers in the ED need to cultivate leaders from within, stresses **Liz Jazwiec, RN,** a Crestwood-IL-based consultant. "The ED is so different from other nursing units that it is hard for new leaders to learn from other department heads," she says. "We need to grow our own leaders, so that they might be successful in the future."

Many ED nurses will find themselves challenged to

take leadership roles in the near future, predicts Jazwiec. "The challenges of healthcare will dictate that many individuals within a department will need to take on leadership roles in one way or another," she says. "You become a much stronger, effective manager if you have several 'leaders' amongst your staff."

In many EDs, the traditional roles of assistant nurse manager or supervisor are no longer in place, so future leaders need to be identified and mentored, Jazwiec explains. "Every good leader should have two or three possible candidates for her position should she get promoted or decide to leave," she recommends.

Here are some effective ways to mentor nurses:

Make mentoring part of your job description. "In every institution, there needs to be a clearly defined written standard where mentoring is part of a manager's job function," says Bock-Laudenslager. "Leaders must be accountable for the mentoring role. Not only is it prudent to do so, but it is a JCAHO requirement that leadership within the organization encourage staff to become better leaders."

Not only does the job standard need to be clearly defined, but managers need to be evaluated against it, argues Boch-Laudenslager. "Some hospitals are now sending evaluations to their staff which include rating their immediate supervisor in terms of their ability to mentor others," she says.

Likewise, the job descriptions of staff nurses should also have a professional component. "Include a job standard that measures leadership development, including professionalism and the ability to problem solve," says Bock-Laudenslager.

Maintain your own clinical and leadership skills. "You can't teach others what you don't know yourself," says Bock-Laudenslager. "Effective management bridges the gap between art and science, theory and practice, [and] the manager's office and the trenches."

Maintain continuing education. "Managers need to be formally trained in mentoring others," says Bock-Laudenslager. "Often, nurses are promoted through the ranks without any consideration of their management training." Nurse managers should attend ongoing leadership courses that address mentoring, she recommends.

Express enthusiasm about leadership. "Through observing managers, nurses will find a leadership position either desirable or undesirable. Seeing your enthusiasm will affect their interest in pursuing leadership/managerial positions," says Bock-Laudenslager. "If every time they ask you about your job, you're rolling your eyes and expressing frustration, they won't be encouraged."

Recognize leadership potential in nurses. "If you observe an employee demonstrating exemplary leadership skills, such as handling a confrontation with a family member or solving a challenging clinical problem, tell them you admire how they approached the situation," says Bock-Laudenslager.

In addition, give written recognition in their annual performance appraisal. "This may encourage them to pursue expanded nursing roles," Bock-Laudenslager suggests.

Reinforce leadership skills in staff educational programs. "Leadership skills are an integral part of clinical expertise. Even if you are educating staff on clinical issues, leadership principles can be integrated into your teaching programs," says Bock-Laudenslager. "In doing so, you are preparing them for more challenging leadership roles."

Encourage nurses at the grassroots level to develop leadership skills, advises Bock-Laudenslager. "Your education department can develop programs for nurses that will augment their leadership potential, such as charge nurse classes, preceptor classes, resume writing, or writing for publication," she suggests.

A small minority of nurses may be future ED leaders, so emphasize other leadership possibilities. "Of the 3-5% of nurses who would be good leaders, there may only be 1% who be really good administrators," notes Jazwiec. "It may not be their forte to direct and manage other people, or they may not be organized enough to manage many things at once, but an educator role may be a perfect fit."

Inform nurses about available leadership positions. "Inform nurses about available positions, both internally or externally, through a department newsletter, bulletin board, or word of mouth," Bock-Laudenslager advises. "Encourage nurses to interview for positions, even if they are not the most qualified applicant. The interview experience in itself is a learning process."

Delegate tasks that require leadership skills. "Develop their potential by asking them to implement department projects," says Bock-Laudenslager. "It can be as simple as asking their opinion on something, such as 'It looks like the physicians are frustrated with this work space, how do you think we could improve it?"'

Asking nurses to serve on hospital committees such as disaster management or a JCAHO task force is another way to enhance their skills. "Employees at the grassroots level often complain that the individuals making the decisions are the ones furthest from the bedside," Bock-Laudenslager notes. "By asking staff nurses to represent the ED on certain committees, not only are you promoting leadership potential, the committee benefits from having the most qualified people facilitating the decision."

Create a professional learning environment. A department library with Internet access, periodicals and videos sends a positive message. "It's the manager's responsibility to create an environment whereby the staff are motivated to stay current on topics that could impact their clinical practice," says Bock-Laudenslager.

Determine what nurses excel in. "You might have someone that can take the lead in finance just because of natural ability or interest," says Jazwiec. "You do not have to put someone in charge or give them the 'whole ball of wax.'"

Ask nurses what they are interested in and find tasks that match their interests, Jazwiec suggests. "There might be someone truly interested in doing the schedule, and there might be a progression from there," she says.

Keep it simple. "Mentoring is most often overlooked because, like so many things in healthcare, we tend to make it too complicated, that is, try to get a official position approved," says Jazwiec. "Not every situation calls for someone learning the manager's job in its entirety, but we often have the all or nothing approach."

Instead of trying to find the time to cover everything, do what you can, says Jazwiec. "Better to teach 10 people 10% of the role of manager, than trying to teach one person 100%," she says. "Then out of the ten, cultivate the ones with leadership promise."

Share personal stories. "Reviewing and sharing

Which nurses have leadership potential?

It's a challenge to ascertain which nurses would be good leaders. "Pay attention to feedback from patients, physicians, or colleagues from other departments." says **Liz Jazwiec, RN,** a Crestwood-IL-based consultant. "It's sometimes trial and error, but there are signs to look for."

Here are a dozen qualities to look for in future nurse leaders:

1. Listening skills. "A key part of communication skills is the ability to listen to staff, hear their concerns, and put them into action," says **Barbara Pierce, RN, MN,** divisional director of emergency services at Children's Hospital in Birmingham, AL. "Listening is a learned skill."

2. Confrontation skills. "Confrontation is not always the 'evil' that most people feel it is. Confrontation happens every day," says Pierce. "Nursing leaders need to have the ability to defuse confrontation into 'win-win' situations by having good intervention skills."

3. Risk taking. "Leaders need to be willing to try new ways of doing things, to put new ideas into practice," says Pierce. "The only constant is change. There are very few right or wrong ways to do things in this market, only what works. We have to be willing to try many different ways to find the one that will work best for a particular situation."

4. Strategic thinkers. "The ability to see the big picture is a wonderful trait, although it is difficult to evaluate that at a staff level," says Jazwiec.

5. Problem solvers. A desire to make things better is a good sign of leadership ability, notes Jazwiec. "Remember that some of these people might appear negative. But sometimes, given the opportunity to make things better, these folks shine," she says.

Look for nurses who can think on their feet to come up with solutions, says Pierce. "Staff who can act like air traffic controllers to keep everything going, juggling 10 things at one time, are ideal ED leaders," she says.

7. Flexibility. "Being flexible is the most important quality a leader can have," says Jazwiec.

8. Ability to motivate others. "Someone that can get results as a team leader demonstrates not only the ability to get things done, but also to get others to accomplish goals," says Jazwiec.

9. Enthusiasm. "Pick individuals who will not only do a good job, but who are successful leading teams that get results. These nurses make great candidates for future leaders," says Jazwiec. "When you ask the employee to lead a team, let them know that you are doing it because you think that they have good leadership ability. They should feel flattered and want to do a good job."

10. Good communicators. "Communication skills and approachability are very important. Look for nurses who are emotionally capable people and have a personality that stands out in terms of warmth and getting along with others," Jazwiec recommends.

Fairness, consistency, and team skills are important when communicating, emphasizes Pierce. "Being empathetic without being a mother to their peers is key," she says. "They have to be able to articulate the unit needs and yet understand the personal needs of the staff to achieve that important balance."

11. Hard workers. "Nurses who have integrity and a strong work ethic become role models within a group. Other nurses want to learn from them," says Jazwiec.

12. Balance. Balance is important, says Pierce. "Those who are willing to go the extra mile professionally and personally are key," she says. "Those that are happy at home and at work make great leaders." ■

personal failures and what you have learned from them helps to show that the road is not always smooth, but you get up and keep trying, says **Barbara Pierce, RN, MN,** divisional director of emergency services at Children's Hospital in Birmingham, AL. "Mentoring is about teaching the power of the positive attitudes and overcoming discouragement. No one wants or needs a negative, burned out mentor."

Take a personal interest. "Mentoring is seeing that someone achieves more than they ever thought possible because someone was always there pushing and encouraging, not taking no for an answer. It takes someone truly believing in the nurse's leadership potential and making it happen, says Pierce.

Present opportunities such as delegating projects and encouraging nurses to give speaking presentations, Jazwiec recommends. "Success leads to more success. Start with small things and work up to big programs or projects when delegating," she says. "Always give lots of feedback."

Provide information. Give articles and videotapes to nurses for review, Pierce recommends. "I try to send articles about topics I know they are looking for answers to or are interested in, or topics I know will help them to grow and understand the big picture better," she says.

Send positive reinforcement. Getting and giving positive feedback is very motivating for both parties, says Pierce. "You perform your best when you feel good about yourself and what you are doing. Positive feedback is a real energy boost," she notes. "Send encouragement throughout difficult projects or times, at the completion of successful and even not so successful projects,"

Mark time out on your calendar and take a few minutes at the end of every work day to send out positive messages, says Pierce. "School supply stores have cute little notes that are given to grade school children but work just as well for adults," she says. "Or you can make your own recognition certificates on computer software programs." ■

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

This offering for up to 18 nursing contact hours is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. American Health Consultants® is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. American Health Consultants® designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association. This activity was planned and produced in accordance with ACCME Essentials. ED Management® is also approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit. Physician members of American Health Consultants® 1998 Continuing Medical Education Council: Stephen A. Brunton, MD; Dan L. Longo, MD; Ken Noller, MD; Gregory Wise, MD and Fred Kauffman, MD, FACEP.

Subscriber Information
Customer Service: (800) 688-2421 or fax (800) 284-3291 (custserv@ahcpub.com)
Subscription rates: U.S.A., one year (12 issues), $349. With 18 Category 1 CME hours, $389. For 21 ANA hours, $389. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $175 per year; 10 or more additional copies, $105 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $31 each. (GST registration number R128870672.)

Editor: Staci Bonner.
Copy Editor: Suzanne Zunic (404) 262-5444, (suzanne.zunic@medec.com).

Hours of operation:
8:30 a.m. - 4:30 p.m.

Editorial Questions

For questions or comments, call **Suzanne Zunic** (404) 262-5444.

Annual Statement of Ownership, Management, and Circulation

POSTAL BULLETIN 21875, 9–1–94, PAGE 17

UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation
(Required by 39 U.S.C. 3685)

1. Publication Title	2. Publication No.	3. Filing Date
Emergency Medicine Alert	1 0 7 5 - 6 9 1 4	9/25/98
4. Issue Frequency	**5. No. of Issues Published Annually**	**6. Annual Subscription Price**
Monthly	12	$199.00

7. Complete Mailing Address of Known Office of Publication *(Street, City, County, State, and ZIP+4) (Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305

Contact Name: Willie Redmond

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Telephone Number: 404/262-5448

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Catherine Harris, same as above

Managing Editor *(Name and Complete Mailing Address)*
David Davenport, same as above

10. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereafter the names and addresses of stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Do Not Leave Blank.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste. 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check here. ☐ None

Full Name	Complete Mailing Address
Medical Economics, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. For completion by nonprofit organizations authorized to mail at special rates. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: *(Check one)* ☐ Has Not Changed During Preceding 12 Months ☐ Has Changed During Preceding 12 Months *(If changed, publisher must submit explanation of change with this statement)*

PS Form **3526**, July 1995 *(See instructions on Reverse)*

PAGE 18, 9–1–94, 21875 *POSTAL BULLETIN*

13. Publication Name	14. Issue Date for Circulation Data Below
Emergency Medicine Alert	September 1998

15. Extent and Nature of Circulation	Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*	740	744
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not Mailed)*	25	25
(2) Paid or Requested Mail Subscriptions *(Include Advertisers' Proof Copies/Exchange Copies)*	572	594
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*	597	619
d. Free Distribution by Mail *(Samples, Complimentary, and Other Free)*	34	34
e. Free Distribution Outside the Mail *(Carriers or Other Means)*	0	0
f. Total Free Distribution *(Sum of 15d and 15e)*	34	34
g. Total Distribution *(Sum of 15c and 15f)*	631	653
h. Copies Not Distributed (1) Office Use, Leftovers, Spoiled	109	87
(2) Return from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2)*	740	740
Percent Paid and/or Requested Circulation *(15c / 15g × 100)*	95	95

16. This Statement of Ownership will be printed in the November issue of this publication. ☐ Check box if not required to publish.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/25/98

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions *(including fines and imprisonment)* and/or civil sanctions *(including multiple damages and civil penalties).*

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster on or before October 1, annually. Keep a copy of the completed form for your records.
2. Include in items 10 and 11, in cases where the stockholder or security holder is a trustee, the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check box. Use blank sheets if more space is required.
3. Be sure to furnish all information called for in item 15, regarding circulation. Fee circulation must be shown in items 15d, e, and f.
4. If the publication had second-class authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or the first printed issue after October, if the publication is not published during October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be printed.
6. Item 17 must be signed.

Failed to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, July 1995

CE objectives

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

1. Discuss ways to improve pain management.
2. Explain how to avoid ethnic bias with pain management.
3. List ways to reduce liability risks of chest pain patients.
4. Describe effective ways to mentor nurses