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ED Management®

The monthly update on Emergency Department Management

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Inside

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October 2002

ED patient's suicide is wake-up call: Are you putting psychiatric patients at risk?

You need to address unique needs of psychiatric patients

When a 50-year-old woman told an ED triage nurse that she hadn't slept or eaten for two weeks, she also reported depression and a previous psychiatric history. After waiting for more than an hour, the woman left without being seen. Immediately afterward, she committed suicide by jumping off a bridge. The incident triggered an investigation by the state department of health and set off warning bells in EDs nationwide.

Do you worry that a psychiatric patient may fall through the cracks in your ED? If so, you should take steps now to avoid tragedies and lawsuits. Here are ways to improve care of psychiatric patients:

• **Ensure that patients are appropriately triaged.**

Your triage system may not be set up to ensure that agitated patients are treated as quickly as possible, which disregards the urgent nature of psychiatric crises, according to **Kathy Emde**, RN, MN, CCRN, CEN, trauma service coordinator at Overlake Hospital Medical Center in Bellevue, WA.

Psychiatric patients must be a top priority in your ED, stresses **Hartmut Gross**, MD, FACEP, associate professor for the department of emergency medicine at Medical College of Georgia in Augusta. "Until they are calmed, they can be disruptive to the entire ED," he notes.

Gross explains that psychiatric patients are brought straight back or kept in the triage evaluation room until a room is available. "They do not go back to the waiting room to wait," he says. **(See ED's policy for Safe Initial Management of**

ED Management adds critical-care nursing CE

Beginning with this issue, *ED Management* will begin offering critical care nursing contact hours accredited through the American Association of Critical-Care Nurses. The newsletter will continue to offer nursing contact hours accredited through the American Nurses Credentialing Center. No aspect of the continuing education process will change. This simply enhances the value of your subscription and gives you more options on how to allocate your nursing contact hours. If you have any questions about this addition, please call our customer service department at (800) 688-2421. ■

Executive Summary

Psychiatric patients require expedited care, quiet areas, and other measures to reduce risks.

- Restraint use can be reduced by having staff attend a training course.
- Remember that a psychiatric patient's triage status may change, so monitor for worsening agitation or anxiety.
- Avoid placing psychiatric patients in a remote area, since they need continuous observation.

Psychiatric Patients, inserted in this issue.)

Emde says the ED's triage system specifically must address psychiatric complaints and assessments to avoid underestimating the severity of a psychiatric crisis. Staff should elicit information during the initial triage interview to be sure an accurate triage classification and appropriate care are given, she explains. For example, if the patient divulges thoughts about self-harm, the triage nurse should probe further, Emde says.

"If the patient answers, 'I am planning to shoot myself next Thursday, but I do not have access to a gun,' this gives a different message about urgency than if the patient says, 'I am going to shoot myself, and I have a gun in my purse now,'" she says.

Due to limited coping skills, patients may be unable to tolerate long waiting periods, Emde notes.

"I think that the time required for a patient to move through the usual ED is problematic for many psychiatric patients," she says.

To expedite care, use a social worker to assist in evaluation and assessment of patients with psychiatric issues, she suggests. She explains that after initial triage, the social worker often takes the patient to a quiet office or quiet room for further assessment.

"This should not hinder the patient from being seen by the ED physician," she says. "The goal is to enhance the assessment during any necessary waiting time."

• Find a quiet place for patients to wait.

Gross says that psychiatric patients should be kept out of noisy, crowded waiting rooms if at all possible, because this atmosphere can worsen anxiety. "Make a room available," he recommends. "Put the back pain patient into the hallway if you have to."

Emde says you may have to be creative to find a quiet area where a troubled patient can wait, such as a family room or a room isolated from the main waiting area.

"Keep in mind that whatever space is used, psychiatric patients need to be accessible to the triage nurse for repeated assessment and observation while waiting," she notes.

A patient may be triaged initially as nonurgent or urgent, but he or she should be re-categorized if changes occur, such as increasing agitation, worsening anxiety, pacing, and other behavioral signs, she explains.

Some psychiatric patients cause unacceptable noise levels themselves, by yelling or banging on the walls, Gross adds. However, he cautions managers to resist the urge to place the lockup room in the most remote corner of the ED. "These patients are precisely the ones you need to watch the closest," he says.

• Use alternatives to restraint.

According to Emde, ED staff may resort to restraints too often and need to find other ways to deal with agitated patients. At Overlake's ED, a goal was set to avoid restraint use except when absolutely necessary.

Training teaches de-escalation techniques

An eight-hour training program was developed for all ED nurses and technicians on managing agitated patients, including de-escalation techniques and alternatives to restraint. Instructors included Emde and the ED director, and all staff members were required to attend the course.

"We urged the staff to try less-restrictive approaches in all but the most out-of-control patients," she says. As a result of the training, the number of ED patients restrained decreased from an average of 20 per month to seven, Emde reports.

• Document restraint use appropriately.

When restraints are used, staff members need to document the frequency of observation required, care required by the restrained patient, and reassessment of the need for physical restraints, she emphasizes. **(See the ED's Restraint/Seclusion Flowsheet, enclosed in this issue. For more information about documentation and restraint use, see "New restraint standards**

COMING IN FUTURE MONTHS

- Update on ED sentinel events
- Effective ways to increase reimbursement
- How to avoid conflicts with nurses and physicians
- Strategies to reduce liability risks

Use This Checklist to Revamp Your Policy

Your guidelines for psychiatric patients should address the following questions, says **Hartmut Gross**, MD, FACEP, associate professor for the department of emergency medicine at Medical College of Georgia in Augusta:

- ❒ Do your current triage criteria ensure that psychiatric patients receive appropriate care?
- ❒ What mechanisms are in place to deter elopement?
- ❒ Is there a lockup room? Do you need one?
- ❒ How do you prevent patients from injuring themselves while in the ED?
- ❒ Do staff know how to intervene and defuse an angry or violent patient?
- ❒ Do you have enough staff to have one potentially function as a sitter while you do work-up on a psychiatric patient?
- ❒ What happens if you see the patient leaving? How do you stop him or her?
- ❒ What protocols are in place regarding use of restraints? Are you compliant with them?
- ❒ Do your staff know how to do a psychiatric evaluation? Is there a template or checkoff list they can use if they don't do this often?
- ❒ Do you know where to send patients? What resources are available in the hospital and in the community?

will change your practice," *ED Management*, August 2000, p. 93.)

"This organized and monitored approach helps staff to make informed, appropriate decisions about patient care and ensures that our psychiatric patients receive appropriate and humane care," says Emde.

• Prevent patients from harming staff or themselves.

Gross warns that staff must be aware of items they are carrying as they enter a psychiatric patient's room. "We had a staff member receive a minor wound when a patient grabbed their pen and struck them in the face with it," he says. "It easily could have been worse."

The ED uses two seclusion rooms exclusively for psychiatric patients, with beds bolted to the floor and no other equipment in the room, Emde says.

Previously, equipment was left in the room, such as metal IV poles or oxygen cylinders on stretchers, which the patients then used as weapons, she says. "We had experience with patients picking up stretchers and bashing holes in walls and doors," Emde says.

The rooms are under continuous surveillance to ensure patient safety, she says. Equipment needed for patient assessment, such as otoscopes, blood pressure cuffs, and stethoscopes, is stored outside the room in a cart accessible to the physician and nursing staff but away from the patient, she says.

Gross emphasizes the need to make sure a locked room is monitored. "The last thing you want is to be trapped in a room with a dangerous patient," he says.

• Prevent patients from eloping.

Elopement of the patient is not only embarrassing, but it's also a medical/legal disaster waiting to happen, Gross says. For that reason, psychiatric patients are asked to disrobe and put on a patient gown, then their belongings are removed from the room, he says.

The ED's lockup room has a bathroom shared with the next room, Gross says. "While it is supposed to be locked, you can guess that the inevitable happened," he says. "A patient fled through that egress, flashed the poor patient and family and children in that room, and bolted out of the facility."

The idea is to be proactive and avoid elopement from occurring in the first place, he emphasizes. However, if psychiatric patients elope before you've seen them or while you're still in the work-up stage, alert law enforcement officials, he adds.

Making every reasonable effort to get the patients back will reduce your liability risk, Gross says.

"It is the right thing and the only thing you can do at that point," he adds.

"If you just wave and let them go and there is any kind of bad outcome, you legitimately don't have any defense," Gross adds. ■

Sources

For more information on psychiatric patients, contact:

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CASE STUDY

Florida ED revamps its decontamination plan

After 9/11, decontamination procedures became a top priority for ED managers nationwide.

Although most EDs had included these in disaster plans, the focus was a small-scale event, according to **Karen G. Ketchie**, RN, EMT-P, disaster preparedness manager at Shands Jacksonville (FL) Medical Center. "We have to change our perception of treatment of the contaminated patient from a few to the hundreds, or even more," she says.

Here are several recent changes made to the facility's decontamination procedures: **(See Mass Decontamination Unit Procedures, inserted in this issue.)**

1. Standby rescuers were added to assist team members.

Ketchie says a signal was previously used for team members to convey distress. "However, we didn't have a system to go get them if needed," she adds.

Team members may become dizzy from the heat or chemicals and need help getting out of the mass decontamination unit (MDU), she explains.

"The standby rescuer is already suited up to go get them, as opposed to a team member leaving a patient he is taking care of," Ketchie adds.

The idea is to be able to "rescue the rescuers," says **David J. Vukich**, MD, professor and chairman of the department of emergency medicine at the University of Florida in Jacksonville.

"Should staff be overcome with heat exhaustion or the chemical or agent, we must be prepared to pull them out," he adds.

2. Team members are given "pre- and post-" medical screenings.

The goal is to avoid exposing staff with borderline fitness or pre-existing diseases to heat stress or potential toxins, Vukich explains.

Staff are screened before and after they enter the decontamination area, he says.

If pre-entry medical screenings reveal abnormal vital signs such as hypertension that could be exacerbated by the heat and stress, Ketchie says, those staff members will not enter the MDU.

"Their knowledge will be utilized in a way without them having to suit up," she adds. The screening also includes a mental health assessment, she notes.

"If they are near hyperventilating prior to entering due to stress, they do not go in," Ketchie says.

3. A staging area was selected for team members before entering the MDU.

In this location, team members buddy up, are briefed, undergo suit inspection, and review distress and safety signals prior to entering the hot zone, Ketchie says.

4. The threat of contamination to the facility was addressed.

Vukich advises that sites must be designed for a large number of casualties and to keep contamination away from the hospital itself. "Contaminating the facility and losing it as an asset is a very real threat," he underscores.

To address this, Vukich says decontamination is done at a considerable distance from the building, to contain the runoff water and prevent patients or staff from wandering in.

5. The employee parking garage is utilized.

Most hospitals have a covered walkway, overhang, or covered parking garage, Ketchie says. "Any of these areas can be quickly converted into 'chutes' with the addition of tarps," she says.

She explains that the ground floor of the employee parking garage serves as a mass decontamination area. Once dropped and anchored, tarps suspended from the ceiling create three chutes or corridors for males, females, and nonambulatory patients.

"As I consult with other hospitals, I see items such as privacy screens and sheets being utilized for privacy," Ketchie says. "Although this is a start, a more clearly identified and permanent system is needed."

Ketchie reports that one hospital fought the wind during a chemical incident drill, and their privacy screens kept falling over.

6. Staff are trained in decontamination.

Ketchie teaches a quarterly class that follows the

Executive Summary

Your decontamination plans should address both small-scale events and treatment of hundreds or more patients.

- To protect team members, use rescue signals and medical screenings before staff enter the decontamination unit.
- Use covered walkways, overhangs, or covered parking garages to decontaminate large numbers of patients.
- Choose a site at an appropriate distance from the hospital to prevent contaminated patients or staff from entering.

Here are sample decontamination drills

Here are two recent disaster drill scenarios used by Shands Jacksonville (FL) Medical Center to practice decontamination procedures:

1. **A small institutional drill with 15 casualties using limited decontamination facilities built into the ED/trauma center.**

The scenario: 15 individuals contaminated with organophosphates from an explosion at a storage facility. "This caused us to use the smaller decontamination facility integral to the ED/trauma center instead of the parking lot decontamination facility," says **David J. Vukich**, MD, professor and chairman of the department of emergency medicine at the University of Florida in Jacksonville.

The trauma center was used as the receiving unit, with patients decontaminated in the single decontamination shower built for this purpose. The floors were covered with tarps, areas were taped off, and staff dressed in Level C suits, which are used for known contaminants, are protective for liquid and vapor agents, and require an air-purifying respirator. Patients with simple contamination were combined with contaminated patients with injuries, and staff went through the process of decontamination, triage, and treatment.

According to **Karen G. Ketchie**, RN, EMT-P, the facility's disaster preparedness manager, the drill revealed that the one-room, one-shower area is not suitable for a large volume of patients. "Patients must use a single-file approach, and this is very time-consuming, while the patients in the rear may be deteriorating," she says.

As a result, the small decontamination room outside the trauma center was replaced with a larger mass decontamination unit (MDU).

Vukich says he learned that crowd control and staff flow are difficult to manage. "Whatever you think it will take to keep people in the right places — security, taped floors, barricades — is not enough," he says. "Even well-trained staff can contaminate themselves in a hurry. It was embarrassing."

While ED staff may be familiar with the need to avoid contaminating the facility and themselves, other departments may not be as well-educated, Vukich adds. "The rest of the hospital is probably clueless and sees little reason to play the game," he says.

2. **A larger citywide drill using the MDU in the hospital's parking garage.**

The scenario: A terrorist attack at the airport with explosives and nerve agents with hundreds of casualties. Every hospital in the area received patients. At Shands Jacksonville, staff set up the large decontamination center and prepared for dozens of contaminated patients.

Because the hospital is closest to the airport and is the primary receiving hospital, about 50 patients were received, significantly more than the other facilities, Vukich says. "We followed the same general process as with the smaller drill. But with the larger volumes, traffic, media, and family control were issues as well," he adds.

Ketchie stresses the importance of learning as much information about a mass-casualty incident scene as possible. For example, if only 10 patients are expected, she says there would be a minimal impact on the operations of areas outside the immediate patient care areas. However, if 25 patients may be received, some advanced warning time can allow for other areas to be prepared, including alternate care sites.

As a result of concerns that arose during the critique of the citywide drill, Ketchie says it was agreed to have a hospital liaison at the scene whose job was exclusively to communicate directly to the hospitals and answer their questions.

A communication problem was identified since some personnel received notification of the disaster, while others did not, Ketchie says. This was resolved when the Hospital Emergency Incident Command System (HEICS) was implemented. **(For more information about the HEICS system, see "Use this proven system for disaster communications," *ED Management*, December 2001, p. 136.)**

Through the HEICS structure and command chart, the appropriate personnel are notified, says Ketchie. "We also have the HEICS organizational chart set up as a group text page, sending everyone the same message at the same time," she says. "This is a great tool for updates as well." ■

Department of Defense Domestic Preparedness Program. **(See resource box, p. 114, for more information on these courses.)**

"We have used this program here for four years, and it is excellent," she says.

The class is mandatory for all ED staff, and consists of four hours of lecture and three hours in the MDU covering suit application, unit setup, and patient flow. **(See story on lessons learned from the facility's decontamination drills, above.)**

In addition, ED staff attend inservices featuring presentations on decontamination procedures, developed by Ketchie. (These can be downloaded at no charge at the Northeast Florida Disaster Medical Assistance

Sources and Resources

For more information on decontamination procedures, contact:

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- **David J. Vukich**, MD, Professor and Chairman, Department of Emergency Medicine, University of Florida, 655 W. Eighth St., Jacksonville, FL 32209. Telephone: (904) 244-4107. E-mail: vukich@ufl.edu.

The Office for Domestic Preparedness (ODP) offers training to state and local jurisdictions to prepare for and respond to events of terrorism involving weapons of mass destruction, including biological, nuclear/radiological, incendiary, chemical, and explosive devices. For more information regarding ODP training programs, or to obtain a copy of the Weapons of Mass Destruction Training Programs course catalog, call the State and Local Domestic Preparedness Support Helpline at (800) 368-6498. To download a copy of the Course Catalog, visit the web at www.ojp.usdoj.gov/odp/. For more information, contact:

- **Gabrielle Meszaros-Parada**, Technical Assistance Coordinator. Telephone: (202) 307-6061. Fax: (202) 616-2922. E-mail: Meszaros@ojp.usdoj.gov.

Team web site: www.dmatfl4.org. Click on "Mass Decontamination Unit," and "Personal Protective Equipment.)

7. Security concerns were addressed.

Security is critical, because a real event could send hundreds, if not thousands, of potential patients storming your ED, Vukich says.

"We have no real way to test this, and the thought is very daunting," he adds.

Security is posted at the hospital entrances and outside the MDU to direct traffic, Vukich says.

"Frankly, we do not have enough security. Our drills clearly show we would probably be overrun if more than 50 or 60 patients arrived in short order," he says. "I consider this to be the greatest problem for our system."

[Editor's note: Do you have an innovative strategy to address security needs during a disaster? If you have a solution to share with other EDM readers, please contact Staci Kusterbeck, Editor, ED Management, *280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: Staci Kusterbeck@aol.com.]* ■

Use score card to boost quality

Have you ever wanted to see at a glance how your ED is improving in various areas — or identify the worst problem areas? At Southern Ohio Medical Center in Portsmouth, a "Balanced Score Card" is used to gauge the operational health of the ED.

"This gives you a tool to track and trend change, measure both short- and long-term objectives, and communicate with physicians, nursing staff, and hospital administration," says **Mary Kate Dilts**, RN, MSN, director of nursing for emergency and outpatient services. **(See list of what the score card measures, p. 116.)** Here are benefits of using a score card tool to track ED operations:

• It allows you to benchmark.

The score card enables Dilts to measure her ED against national benchmarks for the following areas:

— **Number of patient complaints.** The ED uses data from the Dallas-based American College of Emergency Physicians to compare the number of complaints per 1,000 patient visits.

— **Patient satisfaction.** South Bend, IN-based Press, Ganey Associates Inc. is used to collect patient and employee satisfaction data.

— **Delays.** Data are used from the Clockwork ED Series on Eliminating Bottlenecks and Delays, developed by the Washington, DC-based Clinical Initiatives Center, a membership-based health care organization that performs research for more than 1,500 hospitals. **(For more information on the Clockwork ED series, see "Study offers solutions for bottlenecks: Treat and move patients in record time," *ED Management*, March 2002, p. 25.)**

— **Door-to-drug time for thrombolytics.** The ED

(Continued on page 116)

Executive Summary

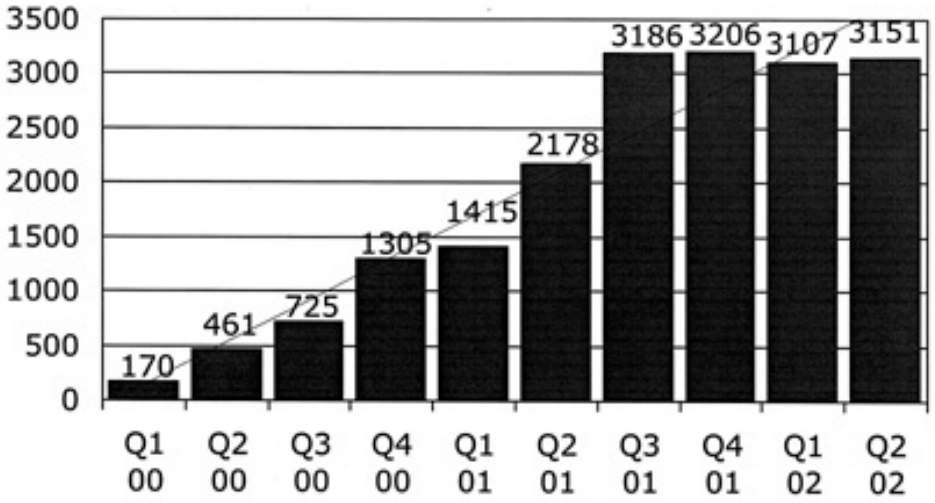
Keeping a score card can identify problem areas and track improvements.

- When specific goals are reached, staff are given rewards such as thank-you letters, tokens, or pizza parties.
- Staff are kept informed about the results of the score card through bulletin board postings, staff meetings, and the hospital Intranet.
- Data are collected with manual entry by nursing staff, chart review by performance improvement, and a computerized program.

♦ *Safety* ♦ *Quality* ♦ ***Service*** ♦ *Relationships* ♦ *Performance* ♦

Bedside Registration

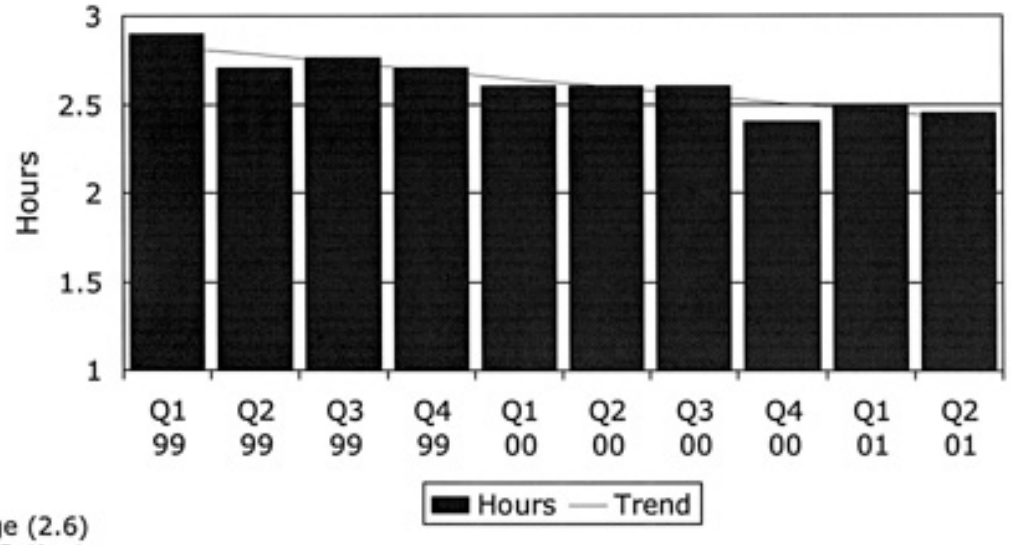
By Rosie



♦ *Safety* ♦ *Quality* ♦ ***Service*** ♦ *Relationships* ♦ *Performance* ♦

Average Throughput Time

Main Campus



Average (2.6)
All ED Patients
(Outpatient Care Institute 1997 for ED's treating 60-80K patients per year)

Source for both charts: Southern Ohio Medical Center, Portsmouth.

Here is What Balanced Score Card Measures

Here is what is measured by the emergency department at Portsmouth-based Southern Ohio Medical Center with the use of a Balanced Score Card:

- unscheduled returns to ED within 72 hours;
- unscheduled returns to ED admitted;
- patients in the ED more than six hours;
- ED X-ray report discrepancies requiring change in patient management;
- patients who leave the ED before completion of treatment;
- presentation to thrombolysis;
- average door-to-doctor time;
- percentage of patients registered at the bedside;
- average throughput time;
- patient satisfaction (overall, nurses, and physicians);
- patient complaints;
- staffing budgeted compared with actual FTEs;
- hours staff are absent;
- staffing turnover rates;
- number of ED physicians living in the community;
- number of ED physicians attending medical staff meetings;
- patient volume;
- financial performance: gross margin.

Here is how the data for the score card are collected:

- The performance improvement team collects data from chart reviews.
- Nursing staff count unscheduled returns to the ED within 72 hours.
- Times are tracked for each patient visit using a computerized "ED Log" (manufactured by Stockell Healthcare Systems in Chesterfield, MO).
- Turnaround time numbers are entered manually on patient charts by nursing staff, and logged by the unit clerk.

compares its data with the National Registry of Patients with Myocardial Infarction, sponsored by South San Francisco, CA-based Genentech, which has collected data on more than 1.8 million acute myocardial infarction patients.

Dilts says the ED's door-to-drug time was 80 minutes in 1996 and currently is 15 minutes. This achievement, she says, was made by cross-training ED technicians to draw labs and perform electrocardiograms, and collaborating with the pharmacy for the stat preparation of thrombolytics. "Our data now exceed the benchmarks for both . . . Ohio and the United States," Dilts says.

Sources

For more information about the Balanced Score Card, contact:

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• Delays are reduced.

Although the ED's census has climbed from 32,000 in 1998 to 52,000 currently, delays are reduced or stable, which Dilts credits to use of the score card. "I'm convinced if we hadn't been paying attention to it, we would be in a very difficult situation today," she says.

The ED has dramatically reduced average door-to-doctor times from 100 minutes in 1996 to only 40 minutes with the use of bedside registration, she adds. The switch started off with only 35 uses of a wireless computer, but within a year increased to 1,400 uses, and it is now at more than 3,000 uses per quarter, Dilts says. Average throughput time decreased by 30 minutes since the score card was implemented, she adds. **(See graphs depicting the ED's use of bedside registration and average throughput time, p. 115.)**

The score card helped with this endeavor, she says. "We were putting data out in front of people every month, and reminding staff that this is a decision we made based on the needs of the patient," she says.

• Celebrating achievements boosts morale.

Tracking the results from the score card is a morale boost for nursing staff, Dilts says. "It becomes fun, throwing out a different goal every month," she says.

When the stated goals are achieved, the staff are rewarded, says Dilts. For example, when the number of patients registered at the bedside reached several hundred, staff had a ribs and chicken dinner. Staff occasionally receive tokens with a $5 value or 5 points, with 90 points equaling a day off with pay.

Recently, every staff member received a letter with a 99 cents coupon for a fast-food restaurant as a reminder of the ED's goal to achieve the 99th percentile for patient satisfaction.

• Staff are kept apprised of problem areas.

The score card is available on the hospital intranet and is posted on the ED bulletin board every month, Dilts says.

Armed with this knowledge, staff enthusiastically target goals they can directly impact, according to **Betsy Marsh**, RN, assistant nurse manager of the ED.

Feedback provided by the score card allow staff to see how their actions directly impact the results, Marsh says. "When the scores improve, the staff are motivated to keep working harder to achieve more." Likewise, when the numbers slide a little, staff become more creative in finding ways to get the scores back up, Marsh says. For instance, when patient satisfaction data were compared between day and night shifts, the night shift scores were significantly lower.

"The staff created 'hot blanket night,' and 'cold drink night,' with staff making patient rounds," Dilts says. "Their scores jumped!" Currently, the ED is planning staff retreats with the day and night shift nursing staff, which will include a discussion of the score card, she says. The retreat will be held on the hospital campus, but out of the ED, and will focus on trauma care and team building, she says. "The idea is to let everyone know exactly what we are measuring, so I can get 125 people rowing in the same direction," Dilts says. ■

What to expect from new OPPS

Attention ED managers: There finally may be some good news on the reimbursement front. Consider the proposed rule from the Baltimore-based Centers for Medicare & Medicaid Services (CMS) for the outpatient prospective payment system (OPPS).

Overall, hospitals would receive in excess of $500 million more in 2003 than this year because of a overall 3.5% pay increase for outpatient services, says **Marty Karpiel**, MPA, ambulatory care consultant for the Karpiel Consulting Group in Long Beach, CA, which specializes in operational and financial process improvement for EDs. Payments to rural hospitals would increase an estimated 7.6%. However, EDs would see a much greater percentage increase, due to the new proposed method for recalculating the relative weights using "multiple-procedure" claims data from 2001, he says.

Here are the key changes for the proposed OPPS rules:

1. The 2003 payment rates were developed using actual data from claims submitted by hospitals under OPPS. This is a significant change, Karpiel says, since rates for the prior two years were based on cost information from 1996.

2. CMS would set relative rates based on data from multiple-procedure claims instead of claims with a single procedure. As a result of this change, Karpiel says, the percentage of claims used to set relative weights would nearly double, from 42% for 2002 to 82% for 2003. He calculates that ED visit level payments would increase more than 20% total, assuming an average acuity. "We've been urging hospitals to accurately report visit levels and charges to make certain the database is populated by accurate distributions of the various levels," he says.

3. Separate codes would be established for outpatient evaluation and management services. However, these would not be used for enforcement until 2004, Karpiel notes.

4. New "G" codes would replace the 9928x series. "Happily, this would eliminate the potential for Medicare payers to deny or downcode physician levels because they don't match hospital claims," Karpiel says. "However, it remains to be seen whether non-Medicare payers will use the new level coding system. Some type of crosswalk will likely be necessary."

5. Payment would be given for observation cases for congestive heart failure, chest pains, and asthma for patients admitted directly from a physician's office. Karpiel notes that the proposed rule would ensure payment of intravenous therapy for observation patients, whereas the current rules deny this separate payment when observation is claimed.

6. Certain pass-through services would be reassigned to associated ambulatory payment classifications (APCs). The proposed rule would cut 95 categories of devices and 240 drugs from the pass-through payment system. Instead, these items would be included in associated APCs, with separate APCs created for the higher-cost drugs. For example, there would be a separate payment for drugs used solely to treat a rare condition or disease, blood and blood products, and vaccines such as the flu and hepatitis B vaccine. "While the news is good for emergency medicine overall, it's particularly good for hospitals who are accurately assigning ED visit levels," Karpiel stresses. Most hospitals still undervalue emergency visit levels by an average of 30%, he says.

He refers to additional revenue from coding for

Source

For more information about the proposed rule, contact:

- **Marty Karpiel**, MPA, Ambulatory Care Consultant, Karpiel Consulting Group, 6475 Pacific Coast Highway, Suite 402, Long Beach, CA. Telephone: (562) 597-1108. Fax: (562) 597-7448. E-mail: marty karpiel@karpiel.net.

reportable procedures, such as intravenous therapy, injections, laceration repair, splinting/strapping, fracture care, and critical care. "The ED can now show a profit where, in years past, it was considered only a loss leader for the hospital," Karpiel predicts. ■

Smallpox vaccine urged for at least 250,000

If you haven't seriously considered how you would handle administration of smallpox vaccine to your staff, now's a good time to start. The Washington, DC-based Department of Health and Human Services (HHS) has recommended that smallpox vaccinations be given to 250,000 to 500,000 individuals, including hospital and emergency workers. This new plan conflicts with a June 2002 recommendation from the Atlanta-based Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices for only 10,000 to 20,000 vaccinations because of concerns about the vaccine's side effects.

At press time, the HHS plan had been sent to the White House for approval, with a final decision on the number of vaccinations expected shortly. State health officials will determine who will be offered the vaccine.

Resource

For updated information on smallpox vaccination plans, go to the Centers for Disease Control and Prevention's National Immunization Program's home page on smallpox at www.cdc.gov/nip/smallpox/default.htm.

Eric Lavonas, MD, FACEP, emergency physician and toxicologist at Carolinas Medical Center in Charlotte, NC, says that the complications of a mass vaccination campaign are predictable. Lavonas points to statistics that indicate the vaccine causes serious illness in one out of every 1,000 adults who receives the vaccine for the first time, and one out of every 10,000 adults who is revaccinated.

About half of all health care workers were born after routine smallpox vaccination stopped in 1971, he adds. "We can predict that vaccination of 500,000 health care workers would cause about 2,800 of them to become seriously ill," he says. Still, Lavonas predicts that most ED staff will choose a voluntarily chosen risk such as vaccination over the unknown risk of exposure to smallpox from a terrorist attack. ■

EMTALA Q & A

Question: Suppose there is an off-site accident, and the patient needs to be life-flighted to a tertiary care center, but the helicopter cannot land at the site. If that patient is transported by emergency medical services to the helicopter site on our campus, does the patient need to be registered in our emergency department and seen by our ED physicians? Or can the patient be taken directly to the helicopter and flown to a tertiary care center?

Answer: The general rule is that if the helipad is being used for the sole purpose of transferring a patient between a ground ambulance and a helicopter, then EMTALA screening and stabilization requirements do *not* apply, says **John D. Lipson**, MD, MBA, principal of Columbus, IN-based Medical Staff Support Services, which assists medical staff leaders and administrators with EMTALA compliance.

However, if the ambulance or helicopter crew asked for hospital assistance with patient evaluation, stabilization, or management, then EMTALA *does* apply, Lipson adds. This would include creating a medical record, providing a medical screening examination by a physician, and providing stabilization treatment, he says.

The other exception to the "bypass" rule is when the ambulance is hospital-owned and not acting as part of a communitywide emergency medical services protocol, Lipson adds. "EMTALA requirements would apply in this case," he says.

Lipson recommends that if the helipad is being used for this transfer purpose, a hospital administrative person (such as the nursing supervisor or other clinical manager), meet the unit on the pad to ascertain if hospital assistance is needed. The incident should be documented in the administrative log in case any questions arise in the future, he says. ■

Audio conference clarifies final EMTALA regulations

At press time, the final version of the recently proposed changes to the Emergency Treatment and Labor Act (EMTALA) was expected to become effective soon. Issues in the final regulations could include changes to physician on-call requirements, "comes to

the emergency department" definitions, later-developed emergencies, nonhospital entities, and prior authorization. With all the confusion surrounding the proposals during the past year, make sure you know what it takes to comply with the final regulations.

To keep you on track, American Health Consultants offers the **EMTALA: Complying with the Final Regulations** audio conference, scheduled for Tuesday, Nov. 12, 2002, 2:30 to 3:30 p.m. ET. The conference 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 Co. in Hingham, MA. Brent is a Chicago-based attorney with extensive experience as a speaker on EMTALA and related health care issues. In June, both speakers presented **EMTALA Update 2002**, one of AHC's most successful audio conferences.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $299, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. The conference package also includes, handouts, additional reading, a 48-hour replay of the live conference, and a CD recording of the program.

For more information, or to register, call customer service at (800) 688-2421 or (404) 262-5476, or e-mail customerservice@ahcpub.com. When ordering, please reference effort code: **63221**. ■

CE/CME *questions*

For more information on the CE/CME program, contact the customer service department at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

1. Which of the following is recommended to improve care of psychiatric patients, according to Hartmut Gross, MD, FACEP, associate professor for the department of emergency medicine at Medical College of Georgia?
   A. Contact police after patients elope only if violence is threatened.
   B. Keep psychiatric patients out of the main ED waiting room.
   C. Put a lockup room in a remote section of the ED.
   D. Avoid placing psychiatric patients in empty rooms.

2. Which is recommended to manage decontamination procedures, according to Karen G. Ketchie, RN, EMT-P, disaster preparedness manager at Shands Jacksonville Medical Center?
   A. giving all team members a medical and mental health screening before entering the unit
   B. using privacy screens or sheets for privacy
   C. selecting a decontamination site right next to the hospital
   D. screening of team members only if an individual has a known pre-existing condition

3. What lesson was learned by the department of emergency medicine at the University of Florida in Jacksonville in a disaster drill?
   A. The one-room, one-shower area is not suitable for a large volume of patients.

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THOMSON
AMERICAN HEALTH CONSULTANTS

B. The trauma center is not appropriate as a receiving unit.
C. Level C suits do not work well for known contaminants.
D. Air-purifying respirators are not necessary.

4. Which is an effective way to use a score card in the ED, according to Mary Kate Dilts, RN, MSN, director of nursing for emergency and outpatient services at Southern Ohio Medical Center?
   A. giving nursing staff the responsibility of collecting all data
   B. relying on a single source for benchmarking
   C. focusing on one problem area at a time
   D. celebrating specific goals as they are achieved

5. Which of the following is part of the proposed rule for the outpatient prospective payment system?
   A. EDs will see a decrease in overall payments.
   B. ED visit level payments will be significantly lower.
   C. Direct admits to ED observation from physicians' offices will be paid.
   D. Intravenous therapy will not be paid for observation patients.

6. For which scenario would Emergency Medical Treatment and Labor Act requirements not apply during a patient's transfer by helicopter transport, according to John D. Lipson, MD, MBA, principal of Medical Staff Support Services?
   A. if the helipad is being used specifically to transfer a patient between a ground ambulance and a helicopter
   B. if the ambulance or helicopter crew asked for hospital assistance with patient evaluation
   C. if the ambulance is hospital-owned and not act ing as part of a communitywide EMS protocol
   D. if the patient is being sent for diagnostic tests

CE/CME objectives

1. Name one way to improve care of psychiatric patients. *(See "ED patient's suicide is wake-up call: Are you putting psychiatric patients at risk?")*
2. Identify one recommendation for decontamination procedures. (*See "Florida ED revamps its decontamination plan."*)
3. Identify one lesson learned by a facility during a disaster drill. (See *"Here are sample decontamination drills."*)
4. Name one effective way to utilize a score card in the ED. (See *"Use score card to boost quality."*)
5. List one item in the proposed rule for the outpatient prospective payment system. *(See "What to expect from new OPPS."*)
6. Cite one EMTALA requirement for patient transport by ambulance. *(See "EMTALA Q&A.")* ■

24 Hour Restraint/Seclusion Flowsheet

INITIAL ASSESSMENT AND FAMILY EDUCATION TO BE COMPLETED BY RN

Attempt(s) at Alternative intervention(s) *(check all that apply)*

Medication review	Bowel/bladder assessment/toileting	Ambulate/reposition	Food/ Fluids
Pain assessment	Frequent reorientation/ reminders	Family/S.O. at bedside	Help pt express feelings
Diversional activities	Near nursing station/? environment	Bed/ Leg alarm	Other:

Alternative Interventions unsuccessful or inappropriate ***Focus note required on back of form***

Medical Criteria for restraint	**Behavioral Criteria**
Patients with Invasive Catheters, Lines, Tubes	Significant risk of self-injury
Requires immobilization to aid therapy/healing	Significant risk of injury to others
Mechanical Ventilation	Significant risk of injury to environment
Fall Precaution (significant risk of severe injury if fall occurred)	

Restraint use Education: explained to patient/family/S.O. family/S.O. unavailable restraint education sheet given

Pt. / Family (circle one) **Response to Education:** verbalizes understanding refuses information needs reinforcement

For Leather Restraints and Seclusion only: ♦ *if leather restraints or seclusion are used, documentation on flow sheet is required q 15 min.*

Searched by: Dangerous objects removed by: Valuables removed by:

RN:_____ **Date:**_____

DATE :

Time♦ q 2 hrs	Type	Level	Food Fluids	Elimination	Position Change	Initials	* LOC	* Response	* CMS	Pain/ Comfort *	Restraint* Criteria Met	Reason for continued* restraint use if applicable	RN's Initials

***Shaded Areas RN assessment only** ** New form to be initiated at 0000 hrs q calendar day.*

Type of Restraint	*Level*	*LOC*	*Response*	*Food & Fluids*	*Positioning*
CW=cloth wrist L= Leathers CV=cloth vest S= Seclusion CA=cloth ankle SR= Siderails HM=hand mitt C= Chemical R = recliner O= other_____ OFF=restraint off	2=2 point 4=4 point 3=3 point 5=5 point ***Restraint Criteria Met Assessed by RN*** v=patient continues to meet criteria	O=oriented C=confused E =easy to arouse D=difficult to arouse	A =agitated C =calm I =irritable CO=combative R =restless S =sleeping	OR=offered, refused T =taken ***Elimination*** OR=offered, refused V =voided BM=bowel movement INC=incontinent	R = repositioned ROM=ROM to affected extremity ***Pain/Comfort*** Level 0-10 ***CMS*** v = intact

Init	Signature/Title	Init	Signature/Title

OVERLAKE Hospital Medical Center

24 Hr. RESTRAINT/SECLUSION FLOWSHEET

[3159]6226-7230-52 (6/01)

When the Restraint and Seclusion flowsheet is implemented an initial Focus note is **required.**
Information in this note should include:

1. **What alternative interventions were tried?**
2. **Why they were unsuccessful or inappropriate?**
3. **A description of the behavior or medical necessity that led to the use (or continued use) of the restraint or seclusion.**

**Additional focus notes, with the above information, is required q 8 hrs.*

Date	Time	Focus Notes	Initials

DEBRIEFING (for behavioral use only)

Date of behavioral episode: _____ Date of Debriefing: _____
Time of behavioral episode: _____ Time of Debriefing: _____

Who attended the debriefing:

1. Identify what led to the incident:

2. Identify what could have been handled differently:

3. Were the patient's physical well-being, psychological comfort, and right to privacy addressed? Yes No
Comments:

4. Was counsel provided to the patient involved for any trauma that may have occurred from the incident? Yes No
Comments:

5. Was the patient's treatment plan modified? Yes No
Comments:

Signature:

[3159]b

Source: Overlook Hospital Medical Center, Bellevue, WA.

MCG Emergency & Express Care Services

Subject: Safe Initial Management of Psychiatric Patients

Policy Number: A15
Effective Date: 08/01/2002
Revision Date: 08/01/2002

OBJECTIVE

To establish safe guidelines for the management of patients with acute psychiatric illness being evaluated in the Emergency Department.

SCOPE

This guideline applies to MCG Health Inc. Emergency Services Department both Main and Pediatric. This guideline will apply to management of patients with psychiatric concerns in the Emergency Department by Emergency Department Staff and Public Safety/Security staff members.

JUSTIFICATION

Patients with a variety of psychiatric complaints present to the ED by various means. There exists a subset of these patients who are at risk of harming themselves or others and others who are at risk of eloping from the department. These guidelines will facilitate consistent management of these patients to assure the safety of the patient, as well as other ED patients, visitors, and ED staff.

GUIDELINES

All patients with psychiatric complaints should be brought back to an exam room expeditiously.

1. Patients who are referring themselves who are not suicidal or homicidal:
   • May be placed into any examination room.
   • Should be instructed to disrobe and don a patient gown in keeping with general ED practice for all patients.
   • Clothing and belongings should be kept in the room.

2. Patients who refer themselves and express suicidal or homicidal ideation:
   • Should be placed directly into an exam room.
   • Public safety should be called to perform a “Terry frisk” (patting down the patient and scanning with a hand-held metal detector)**. For discretion, this should be performed in the exam room, whenever possible.
   • The security and ED staff will assure that the patient fully disrobes and puts on a patient gown.
   • All patient belongings will be searched by security for weapons.
   • All medications will be secured from the patient and removed from the room.
   • All belongings will be bagged, labeled with the patient’s name, and removed from the patient room for safe keeping where the patient is not allowed easy access to these items. This will be performed by ED staff and security personnel. All belongings will be transferred with the patient to whatever final destination he or she is transferred (e.g., admission, transfer to another facility, discharge home). This will be performed using current policies for patient belongings **(see Policy A.04)**.
   • Either family members or nursing staff should closely monitor this patient. If there is any concern expressed by the patient, family, or other staff members that the patient may elope, a sitter (family member, staff member, or police office)” should be posted in or outside the room.

3. Patients deemed by triage, or later examining staff, to be at any risk for hurting themselves or others, should be treated similarly as in Guideline 2.

4. Any patient brought in involuntarily (by family, EMT, or police):
   • Will be placed into room A1. If this room is not available, the patient will be placed into another room with a dedicated sitter assigned to the room.
   • "Terry frisking" will be performed routinely.
   • This patient will be completely disrobed and placed into a gown under supervision.
   • All patient belongings will be searched by security for weapons.
   • All medications will be secured from the patient and removed from the room.
   • All belongings will be bagged, labeled with the patient's name, and removed from the patient room for safe keeping where the patient is not allowed easy access to these items. This will be performed by ED staff and security personnel. All belongings will be transferred with the patient to whatever final destination he or she is transferred (eg admission, transfer to another facility, discharge home). This will be performed using current policies for patient belongings **(see below and see Policy A.04)**.
   • The room will be locked from the outside, and the patient will be monitored closely, in accordance with hospital seclusion policy.
   • Violent patients may require additional physical or chemical restraint at the order of the examining physician. This will be carried out in keeping with the hospital "restraint" policies.

5. Any medically unstable psychiatric patient:
   • Will be treated in a critical care room.
   • "Terry frisking" will be performed routinely as soon as medical stabilization allows.
   • This patient will be completely disrobed and placed into a gown under supervision.
   • All medications will be secured from the patient and removed from the room.
   • All belongings will be bagged, labeled with the patient's name, and removed from the patient room for safe keeping where the patient is not allowed easy access to these items. This will be performed by ED staff and security personnel. All belongings will be transferred with the patient to whatever final destination he or she is transferred (eg admission, transfer to another facility, discharge home). This will be performed using current policies for patient belongings **(see below and see Policy A.04)**.
   • Violent patients and/or patients threatening to leave before being fully evaluated may require verbal confrontation to calm down and/or stay. Failing this, the use of physical restraints or sedation at the order of the examining physician may be required. This will be carried out in keeping with the hospital "restraint" policies.

Patient belongings (See also Policy A.04)

• Patient belongings will be returned to those patients who are determined to be stable for discharge home.
• Patients who are admitted or transferred: Patient belongings will be transferred with the patient and handled securely by transferring personnel.
• Any weapons will be secured by public safety according to hospital policy.

** Patients will be informed that "Terry frisking" and disrobing are hospital policy providing safety for the patient, other patients, visitors, and staff members.

RESPONSIBILITY

The Department of Emergency Services is responsible for the upkeep of this policy.

These guidelines have been reviewed and agreed upon by the Department of Psychiatry and MCG Public Safety.

Approved:

_____	_____
Michael Flake, RN	Michael Shafe, MD
Director, Clinical Operations	Director, Emergency Department
MCG Health Inc.	Medical College of Georgia
Date: _____	_____

Source: Medical College of Georgia, Augusta.

SHANDS
Jacksonville

Policy Number: A-03-047
Review Responsibility: Disaster Coordinator
Revised Date: December 2001
Reviewed Date: April 2002
Approval Date: November 2001
Approved by: Karen Ketchie, RN, Disaster Coordinator

MASS DECONTAMINATION UNIT PROCEDURES

PURPOSE:

To provide a plan for Shands Jacksonville Medical Center in the event of an incident that requires decontamination procedures for mass casualties. The Mass Decontamination Unit (MDU) will be utilized for patient volumes that exceed our capabilities to properly decontaminate patients in the shower located adjacent to the Trauma Center.

POLICY:

All personnel who are identified as being part of the decontamination team, and those who interact with the team, are required to be familiar with this policy and review annually.

PROCEDURE:

The procedure is as outlined:

All personnel who enter the MDU hot zone must:

- Have prior Shands Jacksonville Decontamination Unit and Personal Protective Equipment (PPE) training.
- Have a pre-entry medical screening that includes a set of vital signs including weight, temperature, blood pressure, and pulse. This evaluation will occur again upon exiting the MDU.
- Understand the importance of oral fluid hydration prior to donning the PPE and upon the rest phase after the doffing of PPE.
- Know the “distress” signal for all personnel in the MDU. The distress signal is both arms raised high over the head.
- Have their name taped in large bold letters on the back of their suit.
- Have their suit inspected prior to doffing; if there is a breach in its integrity, they will submit to decontamination procedures.
- Follow the commands of the Safety Officer and Medical Control Officer.
- Have an identified “buddy” within the same visual zone.

A staging area will be established adjacent to the entry of the MDU. It is here that:

- Initial briefing for the MDU team is provided.
- Buddy teams (two persons) identified.
- PPE is selected, evaluated, tested, and donned.
- Team member role identification is established.
- A water cooler is provided.

Before patient arrival:

- Remove rolling carts containing PPE from the storage area and take to the Staging Area (cold team assistants).
- Bring two water coolers (filled with cold water) and drinking cups to the MDU area. One is to be placed in the Staging Area and one in the Team Recovery area.
- Transportation personnel will bring six stretchers and six wheelchairs to be placed at the perimeter of the MDU entrance: half near the entrance of the MDU and half at the exit (COLD ZONE) of the MDU.

I. UNIT OVERVIEW AND TERMINOLOGY

The Decontamination Unit is set up to accommodate three distinct zones and includes an adjacent "Green" area to which patients needing only minor care can be treated. The zones are as follows:

HOT ZONE: This is the area from the entrance into the garage to the exit of the showers. In this area, contaminated clothing is removed and the patient enters the shower. This is a restricted area for specified decontamination team members only. Only staff members trained in the use of PPE are permitted in the Hot Zone. At the discretion of the Medical Control Officer, patient treatment supplies may be brought into the hot zone.

COLD ZONE: Upon exiting the shower, the patients are now considered "cold." The patients are dried, re-clothed, and secondary triage begins. At the discretion of the Medical Control Officer, patient treatment supplies may be brought into the cold zone.

STAGING AREA: Area identified where MDU members meet to discuss plan, don equipment, identify buddies, and await their rotation into the MDU. See above "A Staging Area" for further detail.

II. UNIT SETUP (See Mass Decontamination Unit setup photos)

The MDU is located on the ground floor in the Employee North garage. Setup of the Decon Unit will primarily be the responsibility of the Facilities Department. There will be three corridors created: Corridor one, located closest to the Flight Crew Quarters, is for female patients. Corridor two, the middle corridor, is for nonambulatory patients or for overflow of the other two corridors. Corridor three is for male patients.

A. Hanging tarps and ground covering: The divisions between the three corridors are created by tarps that are permanently suspended from the ceiling in the ground floor entrance of the garage. To create the corridors, release the tarps and they will drop down. The flooring of the corridors also is covered with tarps. Place the shower bases (yellow) onto the pre-painted site near the elevators.

B. Erect shower frame. The tips of the PVC pieces are color-coded for easy identification and assembly.

C. Attach water hoses to manifold and shower frame.

D. Place shower curtain onto shower frame.

E. Provide bucket of solution (as approved by toxicologist on call, ext. 4480). Provide scrub brush.

F. Biohazardous materials barrel and personal effects bags are placed inside each corridor.

III. UNIT PERSONNEL

In addition to the below mentioned personnel there will be:

1. **Team Member Monitor:** This person will be in the HOT ZONE to monitor personnel for signs of stress and required assistance by team members. This person is not to decontaminate patients but to observe and monitor.

2. **Safety Officer:** The Safety Officer is to monitor the team and patient movement to prevent a breech in safety of personnel as well as the environment. He/she will observe and enforce zone boundaries in the Decontamination Unit. He/she will observe proper setup of unit and enforce all safety protocols. The Safety Officer has the final authority related to the management of personnel and the environment.

3. **Medical Control Officer:** The Medical Control Officer decides who is fit to enter the MDU, being sure to take into consideration the team members' pre-entry medical screening and mental health status. This officer decides medical management of all patients as well as agreement of patient disposition from the MDU (green/walking wounded area, or entrance into the medical facility). The Medical Control Officer has final authority on medical management of patients within the MDU.

Patient arriving at the Decontamination Unit will be met by the following hospital personnel:

A. **Primary Triage Officer:** located at entrance into the Unit. Evaluates for life-threatening conditions and decides priority of patient decontamination.

B. **Patient Flow Personnel:** Explains procedures to victims and directs them into the proper corridors.

C. **Corridor Attendants:** Corridor one and three each will have one attendant, as these victims are able to ambulate and wash themselves with little assistance. Corridor two will have a minimal of two attendants, as these patients present via stretcher or are assistance-dependent. This corridor also can be used as overflow of the other two if there is not a large volume of nonambulatory patients.

D. **Secondary Triage Officer and Staff:** Evaluate patients as they exit the showers and direct them to the appropriate treatment areas.

E. **Assistants:** Provide patients towels and gowns. Assist with walking and directing the patients to the proper areas as assigned by the triage staff.

F. **Registration Staff:** Provide identification bands to all patients before leaving the Decon Unit. Gather pertinent information such as demographics and their initially assigned destination of care. Location: Near elevators after patient exits shower and in the Minor Treatment Area.

G. **Transporters:** Will be utilized to transport those patients that need assistance. They will bring wheelchairs to the sidewalk that exits the Decon Unit.

H. **Minor Treatment (green) Area Staff:** This area is located adjacent to the Decon Unit near the Handicapped Parking Area on the ground floor. The patients seen here presented for decontamination purposes only, or have minor care issues such as abrasions. These patients will be evaluated, treated, and discharged from Shands Jacksonville directly from this area. A registration person(s) will be assigned to staff this area.

I. **Mental Health Personnel:** Personnel from the Stress Response Team will be stationed in the Minor Treatment Area as well as other gathering places of victim and staff.

J. **Security Personnel:** (Or designee) will ensure a perimeter around the Decontamination Unit. Additional personnel will be utilized to secure the doors closest to the Emergency Departments and Trauma Center, staff entrance, and tower entrance. See Security procedures for further information.

IV. PATIENT FLOW

It is standard operating procedure for Jacksonville Fire-Rescue to decontaminate patients prior to transport. It is the policy of Shands Jacksonville to secondarily decontaminate all patients prior to entrance into the building(s).

Patients arriving to the Decontamination Unit will proceed as follows:

A. **Ambulatory Patients:**
Present to the Primary Triage Officer and after evaluation, the Patient Flow personnel will direct them to the proper corridor. In the corridor they will be instructed to remove all clothing and all personal affects. These items will be placed separately in a patient clothing bag and a smaller bio zip-lock bag for personal affects. There will be a separate barrel for clothing and personal affects. A corridor attendant will handle this process as well as place patient ID bands on them. The patient will be instructed and/or assisted with the gross decontamination process of scrubbing their body with the solution in the bucket (as determined by toxicologist, for they may simply need to step into the shower and wash with soap and water). After this process and that of a final rinse, the patient then will be handed a towel and provided a patient gown/sheet for privacy.

B. **Nonambulatory Patients:**
May present via privately owned vehicles as well as rescue units. They will be placed on stretchers at the entrance of the HOT ZONE and proceed as above. They will be wheeled into Corridor Two, where their clothing and effects will be removed. The personnel then will begin gross decontamination, anteriorly and posteriorly. The patient then will be wheeled into the shower for a final rinse of water, anteriorly and posteriorly. The contaminated stretcher will remain in the contaminated area, and the patient will be transferred to a clean stretcher after the final rinse phase. There the patient will be evaluated by the Secondary Triage Officer and transported to the appropriate care area.

ED Management Fax-Back Survey

American Health Consultants is working to create more focused and timely health care information and staff education resources. To help us in that effort, we'd like to know what you're thinking. Please take a moment to complete this short survey. Your thoughts, input, and suggestions will allow us to more accurately respond to your health care information needs. **Please fax your completed form to (800) 284-3291, Attn: Jean Leverett.** The deadline for submission is **Oct. 31, 2002**.

1. What health care regulatory issues concern you most?

_____

_____

_____

_____

_____

2. What compliance issues does your facility deal with most often?

_____

_____

_____

_____

_____

3. On which topics is it most difficult to educate your staff? On which topics is it most difficult to find information?

_____

_____

_____

_____

_____

Contact Information

- Name & Title _____
- Facility & Address: _____
- Telephone & Fax: _____
- E-mail _____