ED NURSING™
A MONTHLY CLINICAL UPDATE ON EMERGENCY NURSING

In January:
Impact of New Administration

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Study: Older patients are at risk for receiving harmful drugs in the ED

Decreased renal and hepatic blood flow. Decreased glomerular filtration rate. Decreased total body water. Increased percentage of body fat. For these physiological reasons, a medication that causes no problems in a younger patient can harm an older one, says **Amanda Person**, RN, MSN, ED nurse at Methodist Healthcare North in Memphis, TN.

"It is of utmost importance for the nurse to remember that drugs given to the elderly will likely have higher serum levels, prolonged clearance time, and therefore a greater chance of drug toxicity," says Person.

Potentially inappropriate medications were given in the ED during 12% of the nearly 21 million injury-related visits made by older adults, according to a new study based on data from the National Hospital Ambulatory Care Survey from 2000 to 2004.[1]

Researchers used the Beers List of Potentially Inappropriate Medications to identify potentially problematic prescription drug use in the ED among older adults. The researchers found two problems with older ED patients and medications: "Patients were arriving in the ED because of complications with previous medical care, and also were given the drugs in the ED," says the study's author, **Mary Carter**, PhD, an associate professor with the Center on Aging at the West Virginia University School of Medicine.

ED nurses could harm elderly patients by giving inappropriate medications, warns **Karen Hayes**, PhD, ARNP, assistant professor at the School of Nursing at Wichita (KS) State University. "Adverse drug reactions occur too often in the ED population," she says.

EXECUTIVE SUMMARY

Older patients were given potentially inappropriate drugs during 12% of injury-related visits to EDs, says new research. Drugs probably will have higher serum levels and prolonged clearance time in older patients. To reduce risks, remember that:
- Doses typically need to be lower.
- Drugs generally will have a slower onset.
- Your patient probably will "clear" drugs more slowly.

Take these steps to reduce risks:

1. Know which patients are at high risk for adverse drug reactions caused by medications given in the ED.

These include patients taking multiple prescriptions, patients with dementia, patients with multiple chronic medical conditions, patients with renal insufficiency, those over age 85, and patients with prescriptions from multiple prescribers, says Hayes.

2. Avoid giving drugs that may be problematic.

ED nurses generally try not to give: promethazine to older adults, sleeping medications unless they normally take them, or too high a dose of narcotics or sedating medications, says **Catherine Hawley**, RN, ED nurse at University of North Carolina — Chapel Hill. "I have seen adverse reactions to digoxin, lithium reactions, and oversedation," she says. "We probably need more education about these issues."

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Narcotic analgesics were the most frequently identified class of potentially inappropriate drugs in the above study and represented 31% of all cases, with meperidine accounting for about 20% of inappropriate pain medications.

Other inappropriate drugs given in the ED included muscle relaxants such as metaxalone, cyclobenzaprine, methocarbarnol, and long-acting benzodiazepines, such as diazepam.

Medications such as beta-blockers might compromise your clinical assessment of the patient's injury severity, says Carter. "Also, the use of any new drugs in the ED that are not well tolerated by older adults need to be avoided, such as long-acting benzodiazepines," she says.

Hayes says specific medications of concern include hydroxyzine, diphenhydramine, amitriptyline, flurazepam, diazepam, carisoprodol, and doxepin.

Joan Somes, PhD, MSN, RN, CEN, FAEN, an ED educator at St. Joseph's Hospital in St. Paul, MN, often sees patients present to the ED with injuries related to medications used for pain, sleep, depression, or blood pressure, which can cause drowsiness, clumsiness, and postural hypotension. "One really needs to be aware that all medications administered to the geriatric patient put them at risk," she says. "Doses typically need to be lower. Expect them to have a slower onset, and the patient will 'clear' them more slowly. Thus, they can become toxic much more quickly." **(For more information on medications and elderly ED patients, see stories on side effects to watch for, below, adverse reactions to niacin, p. 15, and potentially harmful medications given by emergency medical services, p. 15.)**

Reference

1. Carter MW, Gupta S. Characteristics and outcomes of injury-related ED visits among older adults. *Am J Emerg Med* 2008; 26:296-303. ■

Here are specific side effects to watch for

"Textbook" side effects will be more pronounced in the older adult, says **Joan Somes**, PhD, MSN, RN, CEN, FAEN, ED educator at St. Joseph's Hospital in St. Paul, MN. Here, she gives several to watch for:

• Anticholinergics commonly cause urinary retention in the elderly and also can affect mood or level of consciousness.

• Slow heart rates often are a clue to the patient taking a beta-blocker, calcium channel blocker, or digitalis. "If the older adult's liver or kidney cannot clear the drug, we

RESOURCE

A free online resource, Nursing Standard of Practice Protocol: Reducing Adverse Drug Events, is available at www.consultgerirn.org, the geriatric clinical nursing web site of The Hartford Institute for Geriatric Nursing, New York University College of Nursing, New York City. In the search box for "evidence-based geriatric topics:" scroll down to "Medication."

see side effects much sooner," says Somes. "One gentleman started on a small dose of a beta-blocker on Friday. By Monday morning, his heart rate was 24."

• Patients with atrial fibrillation often are taking a rate-controlling drug, a blood thinner, or both.

• People with "barrel chests" and wheezy lungs sounds usually are taking a steroid and multiple inhalers.

• Patients who come in with bleeding problems — bruises all over their bodies, or wounds that don't stop bleeding — often are taking a blood thinner or taking too much aspirin or ibuprofen.

"Therapeutic drug levels for anticoagulants are often difficult to achieve and maintain in the elderly population," says **Amanda Person**, RN, MSN, ED nurse at Methodist Healthcare North in Memphis, TN. "Prolonged bleeding times can complicate injuries such as falls and may even cause spontaneous problems such as epistaxis or hematomas. Warfarin also interacts with many other drugs, which may impact efficacy."

• Acetaminophen is found in so many different medications that the older adult may end up with a toxic amount in a day. "Chronic doses of 4 g per day can lead to liver and renal failure," says Somes. "This leads to problems detoxifying many other medications and more toxic effects."

Somes says the indication of an acetaminophen overdose is fairly vague. "We see lab studies that are off, or toxic levels of other drugs as the liver is unable to process and clear them," she says. "The patient may complain of abdominal pain. Since this is a slow onset overdose, symptoms don't jump out at us."

• If the patients tell you they have diabetes or a "sugar problem," they typically are taking insulin or another diabetic medication. "With the many new varieties of diabetic medications, it is very important to know what kind they are taking," says Somes. For example, if they are taking glucophage or metformin, the staff have to take special precautions if they are going to use intravenous contrast for a CT scan. "We can easily put this patient into renal failure," she says. ■

Watch for this common reaction to niacin

"This is one of my favorite problems to 'diagnose,'" says **Joan Somes**, PhD, MSN, RN, CEN, FAEN, ED educator at St. Joseph's Hospital in St. Paul, MN.

After taking over-the-counter niacin for cholesterol, patients present to the ED with significant flushing. "Their skin feels tingling, and they are sure they are in the process of dying," she says. "Some will actually vasodilate enough they can drop their blood pressure. But typically, the reaction to this drug is uncomfortable, but benign."

Ask about supplements, vitamins, and over-the-counter drugs, says Somes. "I would say I see this in our ED on the average of once every couple of months," she says. "In fact, one of our docs recently had it happen to him, and he came to the ED, just in case." ■

CLINICAL TIPS

Ask what medications EMS has given in field

"Many times in the pre-hospital arena, we see medications given as if the person were young and with good kidneys and liver," says **Joan Somes**, PhD, MSN, RN, CEN, FAEN, ED educator at St. Joseph's Hospital in St. Paul, MN. "One of the issues I have dealt with frequently of late, is fentanyl given for pain."

Medics may know that fentanyl clears more quickly in younger patients — "typically, we see the effects of this medication about twice as long in the older adult," she says — but they often don't realize it takes longer to "kick in." Therefore, they repeat the dose before the patient has a response to the first dose. "This leads to respiration depression that lasts two hours, instead of the 45 minutes they are expecting," says Somes.

In addition, many times emergency medical services still are giving 100 mcg of this medication, instead of starting with a lower dose of 25 mcg. "Many older patients are hypoxic due to decreased drive," she explains. "This will adversely affect the patient."

Doses of nonsteroidal anti-inflammatory drugs, such

as ketorolac, ibuprofen, naproxen, and tramadol, need to start lower, or not only will the patient have problems with bleeding, but they also might develop liver and renal problems. "Mix this with a dose of aspirin, and you have a real bleeding problem," warns Somes. ■

Risk is great if you don't reassess psych patients

Patients may wait 2 or 3 days in the ED

(Editor's note: This story is part two of a two-part series on care of psychiatric patients in the ED. This month reports on the best ED nursing practices for reassessment during long waits. Last month, we gave tips for identifying underlying medical conditions.)

As psychiatric patients wait in EDs for hours, their condition can suddenly worsen — as it did for one woman who died on the waiting room floor of a New York City ED recently. ED nurses nationwide say this is a growing problem with safety concerns for patients and staff.

Although the ED at MetroHealth Medical Center in Cleveland has four psychiatric rooms that allow nurses to institute seclusion if necessary, there are sometimes six or eight psychiatric patients in the ED. "The calm ones end up in the hall many times. Naturally, this poses risks for the psych patients, the other ED patients, and for staff," says **Barbara Wolfe**, RN, charge nurse/quality improvement facilitator for the ED.

Other patients are in the ED exam room and already have been determined to need inpatient psychiatric care, but there are no beds available, sometimes for two or three days, says Wolfe. "Another scary thought is that we are seeing younger and younger cases with psychiatric issues. There are even less resources for children," she says.

At the Cleveland Clinic, "our ultimate goal is to expedite patient treatment in the exam area and to minimize the number of patients in the waiting area," says **Barbara Morgan**, RN, director of emergency services. "Having said that, due to capacity restraints, it is often necessary for patients to wait. In this case, it is extremely important to reassess patients during the waiting period." **(See story on keeping patients out of the waiting room, p. 18.)** To keep patients safe:

• Create a specific protocol for psychiatric patients who are waiting for inpatient beds.

ED nurses at Bixler Emergency Center in Tallahassee created a special order set for these patients. "We use this when patients have been medically cleared but are awaiting psych bed placement," says **Freda Lyon**, RN, BSN, MHA, service line administrator. **(See the "Emergency Center's Orderset for Patients Awaiting Disposition," p. 17.)**

"I am working on setting up a 'care plan' or 'routine care protocol' to address this, because more patients are being held longer due to inability to find placement," says Wolfe.

Wolfe says she hopes that her ED's protocol will include frequency of assessments, medication administration, meals, showers, diversionary activities, frequency of documentation, and reportable behaviors. "I have been working with the unit manager and clinical nurse specialist of our inpatient psych unit and using their 'routine care' protocol for their unit as a reference," she says.

• Give electronic reminders for nurses to reassess.

"Our Emergency Center has an electronic tracking board with reminders for the nurse to reassess and document every two hours on all patients," says Lyon. If the ED nurse wants the patient to receive a psychiatric assessment, this goes on the tracking board.

• Have a psychiatric nurse evaluate the patient while in the ED.

On the day and evening shifts, a "crisis nurse" trained in psychiatric nursing evaluates the patient and, with the ED physician, decides on course of treatment, medications, admission, and transfer to another facility if necessary. **Nancy Bennett**, RN, MSN, ED educator at The Hospital of Central Connecticut in New Britain, says, "Our crisis nurses work very hard to get these patients into a facility where they can be helped, but there just aren't enough facilities to care for mental illness. [Lack of] insurance is a major issue."

The ED nurse's primary concern is for patient safety, nourishment, toileting, and attempting to keep the patient calm using medication and communication as needed,

Continued on page 18

EXECUTIVE SUMMARY

Since the condition of psychiatric patients can worsen suddenly, long waits in the ED can be dangerous. To reduce risks:

- Create a protocol for psychiatric patients waiting in the ED for inpatient beds.
- Flag patients as needing a psychiatric assessment on tracking boards.
- Have a clinical technician in the waiting room to report concerns to the triage nurse.

Patient Label

MD Initals	Emergency Center Orderset for Patients Awaiting Disposition To be initiated when EC patients have been **medically cleared** and are awaiting disposition	Time	RN Initials
	Secure patient's belongings in labeled "Patient belongings bag"; Security officer to watch until disposition, upon disposition these are to accompany patient to designated facility		
	Diet:		
	Allergies:		
	Vital Signs Every ____ hrs with Neuro checks (may use neuro. flow sheet to document) T: _____ P:_____ BP:_____ RR_____ SaO2 _____ T: _____ P:_____ BP:_____ RR_____ SaO2_____	____ ____	
	For extended stay offer pt. hygiene articles/activities of daily living (oral care, shower)		
	☐**CardiacMonitor** ☐**Pulsoximeter** (Every _____ hours)		
	PRN Medications:		
	Tylenol (15mg/kg) PO every 4hrs HA\Fever>100.4 F\Pain _____mg given For Fever notify Physician Dr. _____ notified at _____.		
	Motrin (10mg/kg) PO every 6 hrs HA\Fever>100.4 F\Pain _____mg given		
	Maalox\Mylanta 30cc PO every 6 hrs Heartburn\GI upset		
	Haldol_____mg IV\IM\PO every ___ hrs for agitation		
	Ativan _____mg IV\IM\PO every ____hrs for anxiety/sedation/agitation		
	Benadryl _____mg IV\IM\PO every ____hrs with Haldol		
	Compazine 10 mg IV\IM\PO every ____ hrs for nausea		
	Other Medications: _____ _____		
	Diabetic Management:		
	Accuchecks: ☐ AC ☐ HS ☐ Every _____ hrs ☐ Other_____ (May document on diabetic flow sheet PRN)		
	Bed Side Blood Glucose _____		
	Lispro (Humalog) insulin subcutaneously using the following sliding scale: BBG less than 70 ----- hypoglycemic procedure BBG 70-120---------- give 0 units subcutaneously BBG 121-150 ---------give 2 units subcutaneously BBG 151-180 ---------give 4 units subcutaneously BBG 181-250----- ----give 8 units subcutaneously and recheck in 2 hours BBG 251-350----------give 10 units subcutaneously and recheck in 2 hours BBG greater than 350---give 12 units subcutaneously and recheck in 2 hours, notify physician If patient is eating and BBG is **greater than 180 on two consecutive BBG checks,** increase insulin dose by 2 units at each level. Continue scale at increased level, if still greater than 180 after 8 hours, notify MD regarding uncontrolled hyperglycemia. Consider admission.		
	Social Service consult		
	Neurology consult: Dr. _____ called at (time) _____		
	Psychiatric consult: Dr. _____ called at (time) _____		

RN Signature	RN Initials	RN Signature	RN Initials	MD Signature	MD Initials

T:\Pathways\Patients awaiting Dispo. 4/05, revised 5/05,10/05

Source: Bixler Emergency Center, Tallahassee, FL.

says Bennett. "If you keep the patient updated as to what's going on, and what they are waiting for, it helps to lower their agitation," she says. "If a nurse has time to sit and listen to a patient, he or she will, but that's not as often as we'd like. Our main concern is safety for all until a disposition or transfer can be made."

• Have a clinical technician round on patients in the waiting room.

"This enables the patient to have access to staff should they have a question or issue. Similarly, the tech can observe patients and report any concerns to the triage nurse," says Morgan. "Behavioral changes such as restlessness, anxiety, agitation, or despondency require attention and reassessment by the nurse." **(See story on what not to assume about patients taking psychiatric medications, right.)** ■

Don't leave a psych patient in waiting room

Patients can harm themselves or others

Psychiatric patients can leave your ED without warning or cause harm to themselves or someone else, says **Nancy Bennett**, RN, MSN, ED educator at The Hospital of Central Connecticut in New Britain.

"When we hear 'depression,' 'suicidal ideation,' or 'hearing voices,' we get the patient out of the waiting room and anywhere we can find that's going to be safe," she says. "Even if we don't have a bed for them, we'll put them in a chair in an area where they're watched."

The ED has a psychiatric area where patients are reassessed every four hours, including vital signs. Nursing technicians assist with vital signs, feeding, and toileting patients, remove all of their belongings, and have them change into hospital clothing that has snaps instead of strings to tie. "If a patient is of particular concern to harm themselves or attempt to leave, we have sitters who literally sit in front of them and make sure they stay in their bed and don't attempt to harm themselves," says Bennett. "We call it 'constant observation.'"

A security guard is stationed outside the ED in the event a patient exhibits out-of-control behavior. "We have cameras so security can see the area, and silent alarms in case of a patient acting out and attempting to leave or harm a staff member," Bennett reports.

If a patient comes to triage with a behavioral or emotional problem at Bixler Emergency Center in Tallahassee, FL, a psychiatric emergency response program (PERP) is triggered, with patients checked by a security officer every 15 minutes and an assessment done by a behavioral health nurse. "They assist us in determining if the patient is a danger to themselves or others," says **Freda Lyon**, RN, BSN, MHA, service line administrator. "Unfortunately, this does not assist in alleviating the Emergency Center overcrowding. We have six PERP beds, and six is usually never enough." ■

Clinical Tips

Don't assume patients aren't taking psych meds

If a psychiatric patient came to your ED acting aggressively with pressured speech, you might conclude that the behavior was caused by failure to take antipsychotic medications. But this is a dangerous assumption. When ED nurses at Beth Israel Deaconess Medical Center in Boston treated a woman with those symptoms, they discovered something surprising.

"At triage, she was uncooperative with a basic exam, so she was brought back to a room," says **Dan Nadworny**, RN, BSN, CEN, clinical advisor for the ED. The ED nurse insisted on a thorough examination and a core temperature before continuing.

Nurses discovered that the woman, who was wheelchair-bound due to her diabetic neuropathy, had a heart rate of 120 and a temperature of 102° by temporal artery. When an ED nurse checked a rectal temperature and gave an acetaminophen suppository, the patient was found to have a large decubitus on her coccyx.

"Within two hours, the patient was more coherent and was admitted to the medical service for management," says Nadworny. ■

3 things to do immediately if measles is a possibility

Make policies 'very specific and very strict'

When a Swiss tourist came to a Tucson, AZ, ED with pneumonia, none of the ED nurses suspected that measles was the underlying cause. As a result, the patient wasn't isolated, and patients and health care workers in the ED were needlessly exposed.

EXECUTIVE SUMMARY

Because nurses in an Arizona ED didn't suspect measles was the cause of a patient's pneumonia, patents and staff were exposed. To reduce risks:
- Have a high index of suspicion for measles in patients who present with fever and rash, especially if they have a history of foreign travel.
- Ensure that you are immune to measles.
- If you suspect measles, immediately isolate the patient in a negative pressure room.

Also, because there was inadequate documentation of the measles-immune status of health care workers, the hospital needed to conduct a massive immunization.

"Although rare, cases of measles do still occur in the U.S., emergency room nurses should maintain a high index of suspicion for measles in patients who present with fever and rash, especially if they have a history of foreign travel," says **Kathleen Gallagher**, DSc, MPH, team leader for the Center for Disease Control and Prevention's Measles, Mumps, Rubella, and Polio Team. To reduce the risk of disease transmission, Gallagher recommends:

• All ED nurses should ensure that they are immune to measles.

• If you suspect measles, immediately isolate the patient in a negative pressure room.

• Ensure that appropriate infection control precautions are taken with the patient.

• Alert the hospital's infection control practitioner, who should notify local public health authorities.

The University of California-Davis Medical Center has "very specific and very strict policies" for measles and German measles cases, says **Ann Bennett**, RN, MSN, nurse educator for the ED. "In essence, all employees who have direct patient contact or whose work requires them to be in patient care areas must be immune to rubella and rubeola," she says. "Immunity is obligatory and a condition of employment."

If a case of measles is suspected, Bennett says these immediate steps would be taken:

1. A mask is placed on the patient.
2. The patient is isolated in a negative pressure room, or a private room with the door closed.
3. Rooms are wiped down with disinfectant and not used for at least two hours after a suspected measles patient has left the room.

The ED recently was alerted by the California Department of Public Health that recent cases of measles have occurred, so nurses have a high index of suspicion for this diagnosis if a patient presents with fever and rash and has a history of international travel within the previous three weeks or had had contact with international visitors.

"Luckily, we have not had any cases," says Bennett. "However, if we did, we would treat it as we would treat any infectious, contagious disease. Since all our patient care staff are immunized, any staff could care for the patient." ■

Signs of DVT can be surprisingly subtle

If a middle-aged woman walked into your ED and told you she felt as if something terrible was going to happen to her, but denied any other symptoms, what would you suspect?

"I took her to one of our critical rooms and while taking her there, she was giving me her daughter's phone number and asking me to call her immediately, because she wanted her there now," recalls **Lois Nicholas**, RN, an ED nurse at Baylor Medical Center of Irving (TX). "The woman died within an hour of a pulmonary embolism. She had no symptoms except anxiety."

Pulmonary embolism is a potentially life-threatening complication of a deep venous thrombosis (DVT), when a portion of the clot in the peripheral deep vein vessel breaks off and travels into the lungs, says Nicholas. "Ask the patient if they have any shortness of breath or chest pain," she says. "Some patients will verbalize a sense of impending doom or may exhibit a high level of anxiety that is relieved by administration of oxygen."

However, you also need to have a high index of suspicion for the patient who might have a DVT even if they have no clear symptoms. For example, Nicholas

EXECUTIVE SUMMARY

Suspect deep venous thrombosis if patients have shortness of breath, chest pain, or a high level of anxiety. However, patients also may have very vague symptoms, such as anxiety that they cannot explain. To improve your assessment:
- If the patient complains of lower leg or calf pain, perform a further assessment of the extremity.
- Ask the patients to pull their toes toward their head.
- Ask about recent travel, increase in exercise level, cast removal, and surgery.

says patients might tell you they have "some shortness of breath, vague chest pain, or even a complaint only of anxiety that they cannot explain."

A 32-year-old woman told triage nurses at EMH Regional Medical Center in Elyria, OH, that she was short of breath and that her right calf was swollen for the last three days. "She stated that the pain was worse when she tried to stand on her toe to get a glass out of the cupboard, so she came to the hospital," says **Curran Krupar**, RN, one of the ED nurses who cared for the patient. "Her only medication was birth control pills."

She was taken to a bed immediately, and a venous duplex was done, along with lab work and a chest CT, looking for a DVT and a pulmonary embolus in her lungs. "Both studies found a clot in her right calf and also in her right lung," says Krupar. "Due to the critical thinking on the nurse's part and asking the right questions, this patient had a high index of suspicion for a DVT and was moved into an ED bed immediately for treatment." The woman was discharged after four days in the hospital and went home on anticoagulation therapy.

Some signs of DVT are very subtle, such as mild pain or swelling, but these can be life-threatening. "Our ED sees a fair share of patient's with DVTs, and patients that are at risk for a DVT," says Krupar. **(See story on questions to ask if you suspect DVT, below.)** ■

Questions to ask if you suspect DVT

Here are assessment tips to use at triage if you suspect that your patient might have deep venous thrombosis (DVT):

• If the patient complains of lower leg or calf pain, do a further assessment of the extremity. "The calf is touched for temperature and firmness, and observed for redness," says **Curran Krupar**, RN, ED nurse at EMH Medical Center in Elyria, OH.

• Ask the patients to pull their toes toward their head.

"We are looking for pain in the calf when this is performed. This is called a Homan's sign," says Krupar.

• If a patient presents with a calf that is swollen, hot to the touch, and painful, especially when bringing their toes toward their head, and complains of being short of breath, be concerned that a piece of the clot may have broken off and traveled to the lungs. "This is considered a life-threatening condition," says Krupar.

At Baylor Medical Center of Irving (TX), ED nurses frequently work up anyone who presents with any one or more of the following symptoms, says **Lois Nicholas**, RN, ED nurse:

— extremity swelling of unknown cause;
— extremity pain of unknown cause;
— extremity redness.

These questions are asked at triage:

— Is there any history of medical illnesses such as peripheral vascular disease?
— Have you had recent long-distance travel?
— Have you increased your exercise level recently?
— Do you have any cardiac history?
— Have you recently had a cast removed?
— Have you recently had surgery?

• If DVT is suspected, a simple blood test is run to determine the possibility of a clot being present somewhere. "If the D-Dimer comes back positive, an ultrasound is done of the extremity, and if a pulmonary embolism is suspected, a CT scan of the chest is done," says Nicholas.

• Ask about birth control pills specifically.

Krupar says to ask "Do you use birth control pills or have you taken them in the last month? If you have used birth control pills previously, when did you stop taking them?" ■

Is your patient hiding something from you?

Omissions can be life-threatening

The middle-aged man on medication for erectile dysfunction who is given beta-blockers for chest pain. The diabetic patient on glucophage who gets a CT scan with contrast. The toxic ingestion patient who refuses to tell you what drug was taken and when. These are all examples of "nondisclosures" that could harm your patient.

EXECUTIVE SUMMARY

If patients aren't truthful about their medical history or symptoms, this can be dangerous. To obtain a more accurate history:

- Ask about psychiatric medications and erectile dysfunction medication specifically.
- Explain that you want to avoid harmful medication interactions.
- Encourage the patients to answer questions in their own words.

Clinical Tips

Double-check whether patient is taking Viagra

If your heart attack patient is taking erectile dysfunction medication and doesn't tell you, it could cost him his life.

"The room is full of people, and questions are being fired left and right. At times, the emphasis on Viagra is not as strong as it should be," says **Ina Helton**, RN, unit expert for the ED at UAB Hospital in Birmingham, AL.

If the patient has taken Viagra and is given nitroglycerin to treat chest pain, his blood pressure can drop very low, and this even can cause cardiac arrest, says Helton.

Many men are ashamed to admit they take the medication, and they might deny it if asked directly, she says. For that reason, you have to be very clear with the patient about the life-threatening consequences that could result from mixing nitrates and erectile dysfunction medication, Helton says. "In our ED, part of our chest pain assessment includes asking if the patient has taken Viagra in the last 24 hours," she says. "There have been a few patients who presented with chest pain with the onset during sex. For these times, questioning about taking Viagra is a little easier because they have already brought up the subject." ■

"Ultimately, we are only as good as the information given to us by patients, pre-hospital caregivers, or family members," says **J. Miller Morrow**, RN, BSN, CEN, ED nurse at St. Luke's Baptist Hospital in San Antonio.

Watch for these signs that a patient isn't being truthful, says **Imelda Prado**, RN, clinical care coordinator for the ED at Swedish Covenant Hospital in Chicago: He or she is unable to look at you, gives varying stories, friends and family give you conflicting information, or the patient doesn't give you clear details of the illness or complaints. Other warning signs include lack of direct eye contact or looking over to family members or friends before answering questions posed to them, says Morrow. Try these techniques:

• Ask specifically about psychiatric medications.

Patients may be afraid if they admit taking medications used for treatment of behavioral disorders or a psychiatric history that they will be looked down on by staff, says **Freda Lyon**, RN, BSN, MHA, service line administrator at Bixler Emergency Center in Tallahassee. "Patients are often embarrassed," she says. "The emergency nurse has to be perceived as nonjudgmental."

When asking questions about mental health history and medication history, be sure to explain the importance of mediation interactions, says Lyon. "Ask the patient if they have a list of the medications they are on from their last physician or hospital visit," she suggests. "When all else fails, look at the patient's visit list." **(See story on patients taking erectile dysfunction medications, left.**)

• Ask open-ended questions.

Prado recommends asking things such as, "How can I be of help?"

"Encourage the patients to tell their own story in their own words and talk about whatever is important to them," she says.

• Refer to the patient's previous medical records.

"If these are available, this can be an invaluable tool," says Morrow. Say, "I see you were taking _____ last time you were here. Are you still on that?"

• Remind the patient that their responses and their entire medical record are protected under federal patient privacy law.

• Talk to the patient privately.

Ina Helton, RN, unit expert for the ED at UAB Hospital in Birmingham, AL, says, "At any time, you can ask a visitor or a family member to step out of the room." **(For more information on assessment of substance abuse, see "How to get an honest answer on cocaine use," *ED Nursing,* August 2008, p. 116.)** ■

Could a child in need of help walk out of your ED?

Don't let child 'seize the opportunity to elope'

A child who was involuntarily committed managed to walk out of the ED at All Children's Hospital in St. Petersburg, FL, right past a security guard and out the main hospital doors.

"All this could have been prevented if the patient had their clothing removed and a sitter or assigned staff was with the patient," says **Scott Phillips**, RN, clinical nurse leader.

Luckily, the patient was retrieved by a staff member

EXECUTIVE SUMMARY

Children with psychiatric complaints are at risk for leaving EDs without treatment, especially during traumas or codes involving other patients, or periods of high volume. To prevent this:
- Place the child in a room across from the nurse's station.
- Flag the patient's chart and the door of the room.
- Have a sitter remain at the bedside at all times.

four miles away in a residential neighborhood. "This outcome was fortunate for all involved," says Phillips.

In another case, the sitter assigned to a 17-year-old was not trained adequately to stop the determined teen from leaving. "The nurse who was responsible did not have him in a room that was visible to all staff, security was not notified, the patient's clothes were not removed, and there was no identification bracelet given," says Phillips.

Since the ED isn't a secure unit, the patient had direct access to the exit. "He left and was not retrieved," says Phillips. "I have been told of a person at another ED who eloped and actually committed suicide by lighting himself on fire in a Dumpster."

Vulnerable times for the ED include traumas or codes involving other patients, or periods of high volume. "When your staff is distracted and the patient seems normal and compliant, that is the time the patient seizes the opportunity to elope," says Phillips.

The ED nurse is the one who can "prevent the situation from getting out of control before it actually does," says Phillips. Here is the new process used to prevent pediatric psychiatric patients from leaving without treatment:

1. The patient is placed in a room across from the nurse's station.

2. A pink sticker is placed on the chart and outside the door to alert other staff members to keep an eye out for him or her.

3. Security is informed of the arrival of the patient. "Security presence is increased, and everyone in the department is put on alert," Phillips says.

4. The patient is asked to change into a hospital gown, with the clothing placed in a bag to be held at the nurse's station.

Misty N. Eiler, RN, BSN, clinical nurse leader in the hospital's emergency center, says, "This makes it much easier to spot an eloped patient outside the hospital and keeps them from wanting to leave without their belongings."

Patients also are placed on pulse oximetry and cardiac monitors, especially for ingestions. "This makes it more difficult to leave the room, with all the wires. If the patient tried to leave, it would trigger the monitors to alarm at the nurse's station for someone to check on them," says Eiler.

If there is not a parent present, a sitter remains at the bedside at all times while the patient remains in the ED.

Compliance is 100%

The ED's program already has proved to be successful, says Phillips. "Security and nursing staff have been 100% compliant. This has decreased the opportunities that crafty psych patients often see as a chance to leave the hospital," he says.

The ED nurse has the "hardest and most important role" in this process, says Phillips. "The role of the ED nurse is to prevent any hostile interaction and aggression as long as possible from both the patient and staff," he says.

In the near future, card access will be required to get in and out of the ED. "This will further enhance our security and safety for the psych patient population," says Phillips. ■

ED care of peds psych patients is inconsistent

A child's race and ethnicity is irrelevant when it comes to treatment of pediatric psychiatric patients, correct? Not necessarily, according to a new study, which found that minority children are more likely to receive severe mental health disorder diagnoses in the ED than white children.[1]

Researchers looked at records of 2,991 patients from a pediatric psychiatric ED over a one-year period, and

EXECUTIVE SUMMARY

Minority children are more likely to receive severe mental health disorder diagnoses in the ED than white children. For consistent care, remember these things:
- Assessment should include altered mental status, difficulty breathing, and risk of harm to self or others.
- A recent head injury could cause confusion and disorientation.
- Dehydration can cause an electrolyte imbalance.

they found that 4.5% of African-American and 4.9% of Hispanic/Latino children and teens were given diagnoses of psychotic disorders, compared with only 2.5% of white children and teens. Also, only 34.9% of white children and teens received diagnoses of behavioral disorder, compared with 50.3% and 46.4% of African-American and Hispanic youth, respectively.

As an ED nurse, you have a "central role in reducing mental health disparities," says **Jordana Muroff**, PhD, LICSW, the study's author and assistant professor at Boston University's School of Social Work. She recommends giving ED nurses inservices on cultural considerations in the clinical decision-making process, with attention to interviewing skills and the diverse populations being served by the ED.

Scott Phillips, RN, clinical nurse leader at All Children's Hospital in St. Petersburg, FL, says, "The pediatric psych patient is hard to deal with in any situation. But the ED nurse can make the difference in *every* situation."

Give consistent care

The pediatric psychiatric patients often come in "waves" through the Emergency Center at All Children's Hospital in St. Petersburg, FL, reports **Misty N. Eiler**, RN, BSN, clinical nurse leader. "We tend to see more during the school year related to peers, workload, or conflicts with parents related to their activities."

First identify any emergent symptoms such as altered mental status, difficulty breathing, or statements that the child intends to, or has, harmed himself or herself. "This will determine triage status," says Eiler.

After the patient is brought back to a room, the primary nurse does a secondary evaluation and obtains a more extensive medical history. This assessment includes:

- overall appearance — whether the child looks disheveled;
- speech characteristics;
- eye contact;
- general behavior with or without parents;
- interaction with staff;
- previous history.

"It is fairly uncommon for a pediatric patient to have been diagnosed with psychiatric illnesses other than ADHD [attention deficit hyperactivity disorder]," says Eiler. Unless a parent states that the child or adolescent has ingested medication, other underlying medical conditions must be considered. Ask these questions:

- Has the child recently had an accident and bumped his or her head? "This could be causing confusion and disorientation," she says.
- Has the child recently been vomiting? "The dehydration may be causing an electrolyte imbalance," says Eiler.

"Many of these conditions can be ruled out by a head CT or basic lab work," she says. If these results are negative, you might need to order urine drug screen, acetaminophen, and salicylate levels.

"We sometimes have ingestions that come in by EMS [emergency medical services]. When they return to baseline, we can then determine if it was an intentional overdose or recreational drug use," says Eiler. "A social work evaluation is always done for these kids as well."

Reference

1. Muroff J, Edelsohn GA, Joe S, et al. The role of race in diagnostic and disposition decision making in a pediatric psychiatric emergency service. *Gen Hosp Psychiatry* 2008; 30:269-276. ■

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

The semester ends with this issue. You must complete the evaluation form provided in that issue and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Your ED will widen the treatment window for stroke
- New tool to ID life-threatening kidney injury
- How to get pain medications to patients much quicker
- Tips to obtain better medication history from geriatrics

CNE *questions*

21. Which is recommended to reduce risks involving medications and older adults in the ED?
A. Patients will "clear" drugs more slowly.
B. Doses typically need to be higher.
C. Drugs usually have a faster onset.
D. Patients will "clear" drugs more quickly.

22. Which of the following should you suspect a patient is taking with a slow heart rate?
A. Beta-blocker
B. Calcium channel blocker
C. Digitalis
D. Any of the above

23. Which is true regarding assessment of patients with possible deep venous thrombosis?
A. Patients will have shortness of breath or chest pain.
B. Patients might have a complaint only of anxiety that they cannot explain.
C. Mild pain or swelling is not life-threatening.
D. A concerning sign is if the patient's calf feels cool to the touch.

24. Which is part of the process ED nurses follow for pediatric psychiatric patients at All Children's Hospital in St. Petersburg, FL?
A. Security is not contacted unless the patient is physically violent.
B. The chart and door of the treatment room are flagged to alert other staff members to keep an eye out for them.
C. The chart is not flagged in any way.
D. Patients are not placed on pulse oximetry or cardiac monitors routinely.

Answers: 21. A; 22. D; 23. B; 24. B.

CNE objectives

Participants who complete this activity will be able to:
- **identify** clinical, regulatory, or social issues relating to ED nursing;
- **describe** how those issues affect nursing service delivery;
- **integrate** practical solutions to problems and information into the ED nurse's daily practices, according to advice from nationally recognized experts. ■

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