



Break down these dangerous barriers to medication safety

Take an in-depth look at your own ED

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Statement of Financial Disclosure:
Stacey Kusterbeck (Author), Coles McKagen (Associate Publisher), Joy Daughtery Dickinson (Senior Managing Editor), and Darlene Bradley (Nurse Planner) report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies related to this field of study.

MARCH 2009

VOL. 12, NO. 5

A patient's chart is unavailable. Verbal orders are not yet written in the patient's chart. The identification bracelet is not yet on your patient. These are three reasons that an ED nurse may fail to comply with one of The Joint Commission's National Patient Safety Goals (NPSGs): the requirement for use of at least two patient identifiers.

A new survey of 2,200 ED nurses representing 131 EDs reveals that these and other barriers to compliance with the medication-related NPSGs are quite common.¹

Leaders of the Emergency Nurses Association (ENA) chose to study this topic because emergency nurses identified compliance with the medication-related goals as a "particular challenge," according to **Denise King, RN, MSN, CEN**, immediate past president. King says to her knowledge, no other study has examined the NPSGs in this way.

"Emergency nurses should utilize the findings to take an in-depth look at their own ED" to identify barriers to compliance and develop an action plan, she says.

The ED at the University of Kentucky Medical Center in Lexington, like many others, has found compliance with the patient identification and universal protocol goals a particular challenge, says **Mary Rose Bauer, RN, MSN**, one of the study's authors and quality improvement coordinator for emergency/trauma

EXECUTIVE SUMMARY

Emergency nurses report significant barriers to compliance with The Joint Commission's medication-related National Patient Safety Goals. To improve compliance:

- Give additional education on the medication-related goals to nurses during staff meetings and competency days.
- Take two weeks to retrain staff on a single goal.
- Make the patient's medication list available for subsequent ED visits.

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services at the center. “Both of these were shown to have multiple barriers to implementation in this study,” she says.

Bauer says the following practice changes were made in her ED to remove barriers to compliance:

- **Additional education on the medication-related goals is given to ED nurses during staff meetings and competency days.** “A monitoring program has been initiated that looks at compliance and provides feedback to the staff,” says Bauer.

- **As part of “Patient Safety Days,” ED managers take two weeks to retrain staff on one of the medication-related goals.** “This effort is designed to get all staff the same current information and incorporate it into their practice,” says Bauer.

At the University of California — San Diego Medical

Center ED, the most challenging NPSG was medication reconciliation, according to **Tia Moore**, RN, CEN, clinical nurse educator of the ED. (*Editor’s note: This goal is being evaluated by The Joint Commission and will not affect surveys in 2009.*) “As we have many ‘frequent fliers’ that present with their large bags of medications, it became increasingly time-consuming to have to re-document all of their medications with each visit,” she says. “A simple five-minute triage could turn into a 30-minute ordeal if the patient had a large amount of medications.”

To help speed up the process of initial triage, nurses rewrote the triage page within the computerized charting system. Now, the patient’s medications transfer with their chart for every ED visit. Now all nurses have to do is verify during the initial triage that the patient still takes the same medications, including the dosing and frequency. Then, any additional medications are added, and those no longer taken are deleted.

The new process takes more time for initial entry of the medications if the patient has not been seen in the ED previously, acknowledges Moore. “While it does indeed take more time to do this, we are making sure that any potential medication-related interactions or allergy concerns are documented from the beginning,” says Moore. “Once the initial input is made, the speed of reviewing for dose accuracy is significantly improved should the patient again present to the ED.”

Likewise, the patient’s discharge paperwork interfaces with the triage medication page and automatically prints the name of each medication, rationale for use, proper timing, and any potential side effects. This paperwork gives nurses another chance to review the information with patients before they leave the ED. “If the patient is admitted, then the admitting team has a form that they fill out, manually, with the existing medications being taken by the patient,” says Moore. “This

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ED Nursing® (ISSN# 1096-4304) is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to **ED Nursing**®, P.O. Box 740059, Atlanta, GA 30374-9815.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

This activity has been approved for 10 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 10 Contact Hours.

This activity is authorized for nursing contact hours for 24 months following the date of publication.

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Editor: **Stacey Kusterbeck**.

Associate Publisher: **Coles McKagen**
(coles.mckagen@ahcmedia.com).

Director of Marketing: **Schandale Kornegay**.

Senior Managing Editor: **Joy Daughtery Dickinson**
(joy.dickinson@ahcmedia.com).

Senior Production Editor: **Nancy McCreary**.

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Editorial Questions

For questions or comments, call Joy Daughtery Dickinson at (229) 551-9195.

SOURCES

For more information on compliance with the medication-related National Patient Safety Goals, contact:

- **Mary Rose Bauer**, RN, MSN, Quality Improvement Coordinator, Emergency/Trauma Services, University of Kentucky Medical Center, Lexington. Phone: (859) 323-6460. E-mail: mrbaue2@email.uky.edu.
- **Tia Moore**, RN, CEN, Clinical Nurse Educator, Emergency Department, University of California, San Diego Medical Center. E-mail: thooley@ucsd.edu.

is a triplicate form that follows the patient through their hospital stay, and upon discharge, serves as a record of the medications that the patient should be taking.”

Moore says the ED’s new system already has prevented one potential allergic medication reaction. A nurse was reviewing the medications and allergies listed on the triage page with her patient. The nurse was told that during a previous visit, the patient had an allergic reaction to cephalexin, and that the medication needed to be added to the list. “The patient presented with cellulitis, and had that allergy not been noted, might have received cephalexin as an antibiotic,” says Moore.

Reference

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These factors ID children at high risk for acidosis

Interventions can be started earlier

A 3-year-old boy with gastroenteritis presents with dry mucous membranes, and his mother tells you he has been sick for several days. This child is at high risk for acidosis, according to a new study.¹

In the study, of 118 children ages 3 months to 7 years with vomiting and/or diarrhea who came to a pediatric ED, 25% had acidosis. Three factors predicted acidosis with 90% sensitivity: being younger than age 9, dry mucous membranes, and illness for more than two days. These findings could be used to develop a triage assessment tool, suggest the researchers.¹

The study’s lead author, **P. Jamil Madati**, MD, director of emergency medical services at Rady Children’s Hospital in San Diego, says he was pleasantly surprised by two things: That a simple tool can predict a group of patients at high risk for acidosis, and “that triage nurses were also pretty good at predicting which kids were more likely to be acidotic on clinical appearance alone.”

The take-home message for ED nurses: There is a

EXECUTIVE SUMMARY

If a child with gastroenteritis is younger than 9, has dry mucous membranes, or has been ill for more than two days, he or she is at higher risk for acidosis, according to new research. To improve care of these patients:

- Give oral rehydration at triage or when the patient arrives in the treatment room.
- Look for lack of alertness, poor color, abnormal breath sounds, retractions, nasal flaring, cool skin, delayed capillary refill, and poor pulse strength.
- Assess whether the child is breathing too fast or too slow.

group of children with gastroenteritis that can be identified early in their ED course and have certain interventions initiated without having to wait for a room or a physician. “These days, EDs are faced with overcrowding and long waits,” says Madati. “If an ED nurse can initiate a treatment early for certain high-risk patients, this can and will help with the overall flow of patients through the ED.”

Consider oral rehydration

Madati says most patients “do fine with oral rehydration alone or a combination of [ondansetron] and oral rehydration. Having worked in three different EDs in my career, I think there is an overwhelming predominance or inclination for practitioners to want to place an IV and give patients IV fluids,” he says. “I would like to see more patients being treated by oral rehydration rather than by IV.”

Madati says he hopes his study “forces people to think about instituting a relatively simple intervention such as oral rehydration early — in triage or upon arriving in treatment room — and thus, be able to rehydrate and discharge them quickly to outpatient follow-up.”

For children presenting with simple, clear-cut gastroenteritis, Madati says oral rehydration therapy can be started while the patient is in the waiting room. “The difficult part is that a small percentage of patients presenting with vomiting and/or diarrhea may have other [gastrointestinal] problems — appendicitis or pancreatitis — that would require them to be NPO,” he says. For this reason, your triage assessment tool needs to be broad enough to include most patients with gastroenteritis, but specific enough so that you don’t end up giving oral fluids to a child who may need to be NPO for a CT or surgery.

SOURCES

For more information on pediatric patients with gastroenteritis, contact:

- **Kerry Gold**, RN, CCRN, CEN, MICN, Pediatric Liaison Nurse, Emergency Department, University of California — Los Angeles Medical Center. E-mail: KTSakonas@mednet.ucla.edu.
- **P. Jamil Madati**, MD, Division of Emergency Medicine, Rady Children's Hospital, San Diego. Phone: (858) 966-8036. Fax: (858) 966-7433. E-mail: jmadati@rchsd.org.

“It is difficult to get all physicians to agree on which patients to include in this triage tool and which should not,” Madati acknowledges.

Signs such as bilious emesis, abdominal distention, significant blood in vomit or stool, significant abdominal pain associated with the illness, and lethargy should alert you that there might be something else besides gastroenteritis causing the patient's symptoms, he says. For severely dehydrated children, Madati says rapid fluid resuscitation — preferably intravenous fluid — should be quickly initiated to prevent a negative outcome.

In addition, Madati says he'd like to see ED nurses teaching parents and caregivers how to syringe feed, how much fluid to give, and how frequently to administer fluid. “When the patient is discharged, parents will actually have a skill set and tool to prevent their child from getting dehydrated in the future, thereby cutting down the number of unnecessary visits to the ED,” he says.

Reference

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Is a dehydrated child's life possibly in danger?

Use these assessment tips

Severely dehydrated children are “in imminent danger” due to cardiovascular collapse, increased acidosis, and metabolic abnormalities, all of which can lead to significant morbidity and in some cases mortality, warns **P. Jamil Madati**, MD, director of emergency medical services at Rady Children's Hospital in San Diego.

If your assessment shows a dehydrated child is not alert, has poor color, is not consolable, or has abnormal breath sounds, retractions, nasal flaring, cool skin, delayed capillary refill, poor pulse strength, or poor muscle tone, then “this is a child that needs immediate intervention,” according to **Kerry Gold**, RN, CCRN, CEN, MICN, the pediatric liaison nurse for the ED at University of California — Los Angeles Medical Center.

“More information, such as low blood pressure, is considered a late finding and should be treated immediately as well,” she says.

Assess weight loss, whether eyes appear sunken, mucous membranes, skin color, skin turgor, anterior fontanelle in infants, pulse, blood pressure, urine output, and mental status, says Gold. If the child's dehydration is severe, perform these interventions immediately, she says:

- Open the child's airway if needed.
- Assist with ventilations as needed.
- Initiate circulatory support as needed.
- Place oxygen and/or initiate rapid fluid replacement. Give an initial fluid bolus of normal saline at 20cc/kg. “Reassess after the initial bolus and repeat as warranted,” says Gold.
- Initiate cardiac, pulse oximetry, and blood pressure monitoring.
- Anticipate the need for labs and diagnostic tests: blood glucose, complete blood count (CBC), electrolytes, urinalysis, stool cultures, and X-rays.

In cases that are mild to moderate, you'll need to consider oral or intravenous (IV) fluid replacement. (**See Clinical Tip, p. 53, with a solution for difficult IVs.**)

“There has been a push recently for fluid replacement via nasogastric tube,” says Gold. She points to a study that compared the use of rapid nasogastric tube rehydration with rapid IV rehydration in cases on uncomplicated, acute, moderate dehydration in pediatric patients ages 3-36 months with suspected viral gastroenteritis.¹ The study found that a nasogastric tube was as effective with fewer side effects.

Many signs and symptoms, such as breathing too fast or too slow, also can be seen “at a glance” before you even check a child's vital signs, Gold says. When you assess the child's appearance, consider alertness, distractibility, eye contact, speech or crying, motor activity, consolability, and color, she adds.

Gold also says to assess breathing for abnormal audible breath sounds, retractions, and nasal flaring. Assess circulation for skin temperature, pulse strength, and capillary as part of your “at-a-glance assessment.” She recommends asking these questions at triage:

- What time was the onset of symptoms?
- What is the frequency of stool and emesis? What is

the consistency and color? Is there any blood or mucous present? What is the child's fluid intake and urine output?

- Is there any weight loss?
- Is the child taking any necessary medications that they are unable to keep down, such as anti-rejection medications for a transplant patient?
- Are there any other associated findings: fever, vomiting, abdominal pain, rashes, rhinitis, or cough?
- If the child is crying, are tears present?
- Has the child been in contact with any illness?
- Has the child had any recent travel?

"The ED nurse typically spends much more time at the bedside with the patient and family members and are therefore often the ones to pick up on any changes in the patient's status," says Gold.

CLINICAL TIP

Consider intraosseous line for difficult IVs

In severe cases where an intravenous (IV) line is unable to be started, an intraosseous line can be placed to initiate immediate fluid resuscitation, says **Kerry Gold**, RN, CCRN, CEN, MICN, the pediatric liaison nurse for the ED at University of California — Los Angeles Medical Center. To secure placement of the intraosseous needle, use a paper drinking cup, cut to fit and taped in place or with gauze padded on the sides.

"This can help to keep the needle from being dislodged," says Gold. "For fluid replacement, use a syringe and stopcock and manually push fluids, as these lines often do not flow without some pressure. A pressure bag can also be used."

Gold, who works in a tertiary care center with a large population of special needs children, also has used gastrostomy-tube rehydration in this population when viral gastroenteritis was suspected and peripheral IV access proved to be a problem.

"This is a route that many do not think of to use," says Gold. "ED nurses tend to think of IV hydration first. Other routes are often overlooked as we have been taught in the past to focus on the IV route." ■

She once overheard a new resident commenting to the nurse how "good" a 22-month-old trauma patient was being by holding still and not crying for his IV start. "The nurse tactfully explained that while this made her task easier, it was definitely an abnormal and concerning finding in a child of this age group," says Gold.

Reference

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Get a better med history — A life may be at stake

Nearly half of older patients use prescription and over-the-counter (OTC) medications together, says a new study, and one in 25 is at risk for a major potential drug-drug interaction. The researchers also found that 29% of these patients use at least five prescription medications.¹

Bleeding and hyperkalemia were the most common type of drug-drug interaction adverse effects identified in the study. Commonly used medications that can cause these reactions include aspirin and warfarin, ginkgo and aspirin, and warfarin and simvastatin, says the study's lead author, **Dima Qato**, PharmD, MPH, a research associate at the University of Chicago.

The study's findings underscore the fact that ED nurses always should ask patients about *all* the medications they use: prescription, OTC, and dietary supplements, she says. "If the patient or caregiver does not have this information, nursing staff should contact the patient's

EXECUTIVE SUMMARY

Elderly patients are at high risk for a major drug-drug interaction; 29% use at least five prescription drugs, and almost half use prescription and over-the-counter drugs together. To reduce risks:

- Consult pharmacists, previous charts, paramedics, and physician offices to obtain a complete medication list.
- Don't assume that patients take their prescriptions as indicated on the bottle.
- Ask specifically about ibuprofen, transdermal patches, and whether patients have supplemented pain control medications with alcohol.

providers and pharmacies to obtain it,” says Qato.

Karen Hayes, PhD, ARNP, assistant professor at the School of Nursing at Wichita (KS) State University, says obtaining a complete list of medications “is important, because we give many medications during treatment or at discharge from the ED. Any new medication given may interact or compete with current medications,” she says.

Anticholinergics, psychotropics, analgesics, sedatives, and drugs with a narrow therapeutic windows such as digoxin and warfarin, are the most worrisome, says Hayes.

Elderly patients often see multiple physicians with little communication between providers, says **Amanda Person**, RN, MSN, ED nurse at Methodist Healthcare North in Memphis, TN. “With this in mind, various medications may be prescribed that are similar in mechanism of action or interact with one another,” Person says. (See story on specific questions to ask elderly patients about medications, right, and clinical tip about home medications and elders, p. 55.)

At St. Joseph’s Hospital in St. Paul, MN, “We do just about everything to get a good list,” says **Joan Somes**, PhD, MSN, RN, CEN, FAEN, ED educator. ED nurses call the pharmacy, look up old charts, instruct paramedics to bring in every pill bottle they can find, provide cards to patients to list their medications, and call physicians’ offices. Recently, a pharmacy technician was hired at St. Joseph’s ED.

“This person’s entire job is to find out the patient’s meds, and fill out the medication reconciliation required by The Joint Commission,” she reports.

SOURCES

For more information on medications and elder ED patients, contact:

- **Karen Hayes**, PhD, ARNP, Assistant Professor, School of Nursing, Wichita State University. Phone: (316) 978-5721. E-mail: Karen.Hayes@wichita.edu.
- **Amanda Person**, RN, MSN, Emergency Department, Methodist Healthcare North, Memphis, TN. Phone: (901) 516-5211. E-mail: amanda.p414@comcast.net.
- **Dima Qato**, PharmD, MPH, Research Associate, University of Chicago. E-mail: dimaqato@uchicago.edu.
- **Joan Somes**, PhD, MSN, RN, CEN, FAEN, Staff Nurse/Department Educator, St. Joseph’s Hospital, St. Paul, MN. Phone: (651) 232-3000. E-mail: somes@blackhole.com.

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Ask these 6 questions of every elderly patient

Omissions of medications taken by older patients can be life-threatening for patients in your ED, warns **Joan Somes**, PhD, MSN, RN, CEN, FAEN, ED educator at St. Joseph’s Hospital in St. Paul, MN. Ask these questions when taking an elder patient’s medication history:

• What over-the-counter medications, herbals, vitamins, and supplements do you take?

Drugs such as laxatives, antacids, antihistamines, nonsteroidal anti-inflammatory drugs, decongestants, and diuretics may affect the absorption and efficacy of other drugs, or cause dangerous drug interactions and side effects, warns **Amanda Person**, RN, MSN, an ED nurse at Methodist Healthcare North in Memphis, TN.

• How much, how often, and when do you take your medications?

“Don’t assume that patients take their prescriptions as indicated on the bottle,” says Person.

Older patients might take the first few samples given by their primary care physician and never fill the prescription, as the drugs are too expensive. “With the financial crunches out there, we find many of our older patients will scrimp on their meds. They take them less often or if they feel they ‘need’ them,” says Somes. “We can’t assume they are taking their drugs correctly and often end up doing drug levels to determine if the patient is ‘therapeutic’ with whatever med they are taking.”

• What do you take each medication for?

“When patients are unclear about drug indication or dosage, medicines may be taken symptomatically, and excessive or subtherapeutic amounts may be consumed,” says Person. “Further inquiry with elderly clients gives the opportunity for the nurse to identify education needs and provide potentially life-saving intervention.”

• Have you supplemented pain control medications with alcohol, or other drugs.

“This is not unreasonable. Asking about cocaine and ‘meth’ is becoming important as the baby boomers age,” says Somes.

• How much ibuprofen are you taking?

Ibuprofen is “one of those drugs we really need to check about” because it is found in so many combinations in over-the-counter medications taken by older adults, Somes says.

CLINICAL TIP

If elder has poor response, suspect home medications

Medications taken by elderly patients at home might not allow an increase in the patient's heart rate or vasoconstriction, leading to poor response in the shock state, says **Joan Somes, PhD, MSN, RN, CEN, FAEN, ED educator** at St. Joseph's Hospital in St. Paul, MN.

"Many of the meds are geared to keeping the blood pressure and heart rate lower. Thus, when the patient tries to compensate for shock or dehydration, they cannot due to the medications trying to keep the heart rate and blood pressure lower," she says. "People often don't understand this about old people and hypotension." ■

If toradol is given in the ED, this can lead to renal and hepatic failure in the older adult, especially if administered in the "routine" amount and on top of the ibuprofen or other nonsteroidal anti-inflammatory drugs the patient is taking, warns Somes.

• Do you have any transdermal patches?

"We are seeing more and more patients with fentanyl patches, and many patients don't tell us about them," says Somes. "If I had my way, they would make all medication patches lime green, so nurses can see them. All too often, the clear patch is easy to miss." ■

Visits for abuse rise 44% for prescriptions/OTC drugs

Potential for overdose is 'high and could be deadly'

Abuse of prescription and over-the-counter (OTC) drugs is bringing more patients to the ED, according to a new report from the Drug Abuse Warning Network. The study found that ED visits related to abuse of pharmaceuticals alone, with no other type of drug involved, increased 44% from 2004 to 2006.¹

Here are key findings in the report:

- An estimated 741,425 ED visits involved

nonmedical use of prescription or OTC pharmaceuticals or dietary supplements.

- Most of these visits (54%) involved multiple drugs. About one-fifth (19%) of all nonmedical-use ED visits involved alcohol, a fifth (21%) involved pharmaceuticals in combination with an illicit drug, and 6% involved pharmaceuticals in combination with alcohol and an illicit drug.

- Central nervous system agents (most frequently, opiate/opioid analgesics) and psychotherapeutic agents were the most frequent drugs reported.

Prescription or OTC drug overdoses aren't always caused by purposeful abuse, notes **Helen Sandkuhl, RN, MSN, CEN, TNS, FAEN, director of nursing for emergency services** at Saint Louis (MO) University Hospital.

"We see patients who have pain taking both acetaminophen with [propoxyphene napsylate and acetaminophen], not knowing that they are getting way too much acetaminophen at one time," she says. "This is especially important if they are taking both every four to six hours."

One of Sandkuhl's recent patients was having uncontrolled post-surgical pain and was taking his prescribed pain medication as well as pain medication from a previous surgery.

She says the abuse of dextromethorphan in cold preparations, however, is "significant in the tweens and teens, as well as taking prescription drugs for attention deficit disorder from friends to get a boost."

When taking a patient's medication history, ED nurses are "like detectives, and sometimes they get the story in pieces," Sandkuhl says.

Assess whether the patient has a social history of deteriorating family behavior, involvement with the law, or is obviously intoxicated. "This gives you the opportunity to expand the conversation to possible causes, which may very well be related to abuse of medications," she explains.

Explain to patients why mixing herbal drugs and

EXECUTIVE SUMMARY

ED visits specifically related to abuse of pharmaceuticals rose 44% from 2004 to 2006, according to a new report. To improve care of these patients:

- Explain why mixing herbal supplements and prescription drugs can be dangerous.
- Be sure you don't administer a medication to a patient who already has similar drugs on board at arrival.
- Tell patients why you need to know all the medications they are taking.

prescription drugs can be dangerous so they don't leave herbal supplements out of their history, Sandkuhl says.

"The last thing that we as nurses want to do is administer a similar medication to an ED patient who already has similar drugs on board at arrival," she says. "The potential for overdose is high and could be deadly." (See **Clinical Tip, below, for what to say to patients when taking a medication history.**) For example, kava should not be mixed with antidepressants, sedatives, or alcohol, and ginkgo can result in a serious bleeding disorder if taken with aspirin, warfarin, or heparin, says Sandkuhl.

Nighttime sleep aids should not be mixed with sedatives or tranquilizers, she warns. "If someone comes to the ED requiring conscious sedation for a procedure, it is important to know if they have taken any OTC medications prior to giving IV conscious sedation drugs," Sandkuhl adds. "This could enhance the effects of the OTC drugs."

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Office of Applied Studies. *Drug Abuse Warning Network, 2006: National Estimates of Drug-related Emergency Department Visits.* DAWN Series D-30, DHHS Publication No. (SMA) 08-4339. Rockville, MD; 2008. ■

Give this diagnostic test if appendicitis is suspected

Early acute appendicitis may be difficult to diagnose

The results of a CT scan changed the treatment plan for almost one-third of ED patients with suspected appendicitis, says a new study from the University of Washington Harborview Medical Center in Seattle.¹

Sometimes it is difficult to diagnose an early acute appendicitis because the initial lab work might be normal, says **Esther Stoltzfus**, RN, CEN, assistant nurse manager at Bixler Emergency Center in Tallahassee, FL. Depending on the anatomy of a patient, it also might be difficult to visualize the appendix, she says.

Researchers compared the treatment plans of 100 adult ED patients with symptoms of appendicitis before and after CT, and they found that the plans changed for 29% as a result of the CT findings. In many instances, CT ruled out appendicitis when the treatment plan prior to the scan was surgical consultation. The CT findings, in these cases, eliminated the potential for unnecessary surgery on patients with a normal appendix.

Look for these symptoms, says **Katrina Haake**, BSN, RN, an ED nurse at Methodist LeBonheur Germantown (TN) Hospital: Pain in the right lower quadrant of the abdomen, fever, nausea, vomiting, and lack of appetite. Signs of appendicitis include a firm abdomen, rebound pain, complaints of increased pain

CLINICAL TIP

Say this so your patient doesn't omit any meds

When asking patients to name all of the medications they are taking, they might be embarrassed or just forget to mention certain drugs.

"An example is the patient who is on prescription antidepressants," says **Helen Sandkuhl**, RN, MSN, CEN, FAEN, director of nursing for emergency services at Saint Louis (MO) University Hospital. "They fail or are hesitant to tell you they are taking antidepressants because of the stigma associated with the diagnosis of depression."

For this reason, always explain *why* you need to know. Sandkuhl recommends saying, "It is important that we discuss the drugs you are already taking before we attempt to give you other drugs. Before taking any new medications, prescription or over the counter, it will be paramount to know how the combination is going to affect you."

"That usually does the trick," says Sandkuhl. ■

EXECUTIVE SUMMARY

The treatment plan for 29% of ED patients with suspected appendicitis changed after a CT scan was given, which in some cases eliminated the possibility of unnecessary surgery. Suspect appendicitis if your patient:

- complains of pain in the right lower quadrant of the abdomen, fever, nausea, vomiting, or lack of appetite;
- reports increased pain when riding to the hospital and hitting bumps in the road, and decreased pain with knees are drawn up or lying still;
- is walking bent over and avoiding bouncing movements.

CLINICAL TIP

Be on the lookout for the ‘appendix walk’

There is a way to recognize the potential for appendicitis before your patient even says a word.

“Triage assessment begins with watching a patient walk in,” says **Katrina Haake**, BSN, RN, an ED nurse at Methodist LeBonheur Germantown (TN) Hospital. “Often, a nurse can spot the ‘appendix walk.’ The patient is bent over and scuffling to avoid bouncing movement to decrease pain.” ■

when riding to the hospital and hitting bumps in the road, and the patients feeling better if their knees are drawn up, says Haake. (See **Clinical Tip on the ‘appendix walk,’** above.)

“Often the pain is lessened when a patient lies still, as I have seen on occasion with pediatric patients,” Stoltzfus says.

Appendicitis can be life-threatening when the appendix ruptures and infection sets in, says Stoltzfus. “This would be especially problematic in immunocompromised or suppressed patients, such as a chemotherapy patient,” she says.

Reference

1. Nathan RO, Blackmore C, Craig J, et al. Therapeutic impact of CT of the appendix in a community hospital emergency department. *Amer J Roentg* 2008; 191:1,102. DOI: 10.2214/AJR.07.3466. ■

Study says chronic pain is poorly managed in ED

Care is ‘very different from acute pain’

When 103 ED patients, 34 ED physicians, and 44 ED nurses were surveyed, they all agreed on one thing: Treating chronic pain in the ED is a “low priority.”¹

“It was not surprising to learn that the ED practitioners surveyed attached a low priority to chronic pain,” says **Barth Wilsey**, MD, the study’s lead author and associate

clinical professor of anesthesiology and pain medicine at the Pain Academic Office of the University of California — Davis Medical Center in Sacramento. “However, it was surprising to learn that providers thought the potential for addiction, dependence, diversion, and forged prescriptions was low in the ED, given the findings in another one of our studies where we learned that patients who came to the ED seeking pain medications had a high propensity for prescription opioid abuse,” he says.²

This study, published in the same issue of *Pain Medicine*, revealed that 81% of ED patients showed a propensity for prescription opioid abuse, as determined by their scores on the Screener and Opioid Assessment for Patients with Pain (SOAPP). (Editor’s note: This tool, along with background information and scoring instructions, can be obtained at no charge at www.painedu.org/soap.asp.)

However, Wilsey says as pain neither can be verified nor disproved in the brief time interval allotted to the ED visit, you should err on the side of the patient. “Provide a small allotment of opioid medications that will last until the patient can be seen by a continuity provider,” he recommends.

Managing chronic vs. acute pain

Chronic pain is difficult to manage in the ED, says **Vicki A. Alverson**, RN, BSN, a clinical nurse specialist at the Emergency Care Center at Covenant Healthcare in Saginaw, MI. “It is very different from acute pain,” she says.

With acute pain, there is often an obvious source or injury causing the discomfort, but with chronic pain, it might be difficult for nurses and physicians to evaluate the exact cause or source for the pain, says Alverson. “Chronic pain individuals can also present with behaviors and personalities that make it difficult to manage their care,” she says. “But *all* patients should be treated with compassion and respect. We must provide comfort measures to all individuals that seek our care.”

EXECUTIVE SUMMARY

Chronic pain is a low priority in the ED, according to a survey of emergency nurses, physicians, and patients. To improve care of these patients:

- Ask patients if they have insufficient heat or problems obtaining medications.
- Assist patients with getting prescriptions if needed.
- Explain test procedures, and answer all questions to relieve anxiety.

Take holistic approach with chronic pain cases

A woman reports an increase in pain all over, increase in fatigue, and increase in dyspnea. What do you do for this patient?

“Her most pressing complaint was the pain,” reports **Vicki A. Alverson**, RN, BSN, a clinical nurse specialist at the Emergency Care Center at Covenant Healthcare in Saginaw, MI. “She told me it had been getting worse over the last four days, and ‘I can no longer stand it.’”

The woman went on to state that she thought her fatigue and shortness of breath was due to the fact that she starting smoking again to help her deal with the pain at home. Alverson also learned that her patient was distressed because the pain made her unable to attend church. She had just completed a round of chemotherapy for lung cancer, and her pain medications weren’t relieving her pain. She also perceived a lack of support from her family.

When treating this patient, Alverson took all these physiologic, cognitive, and situational factors into account. “We provided Mrs. Jones with intravenous pain medications. When she was discharged, we changed her to oral pain medication to help her until her follow-up appointment with her primary physician,” she says. “We also did intravenous hydration and performed diagnostic lab tests to determine if there was any other physiologic factor that could be affecting the pain.”

Alverson reinforced the need for the patient to stop smoking, and she encouraged her to find other support systems such as friends from her church group or a close neighbor. “We also discussed eating nutritious foods and keeping well-hydrated to help reduce fatigue,” she said. ■

Assessing the physiological indicators of pain — elevated heart rate, elevated blood pressure, and increased work of breathing — is important, but don’t forget to stop and look at your patient, says Alverson. “Is this patient crying or diaphoretic? What is the position of their body?” she asks.

Alverson says like many ED nurses, she treats a significant population of low-income individuals with limited resources. “Ask these patients whether they have sufficient heat, as cold weather can precipitate many chronic conditions, and whether they have the finances available to get medications,” she advises.

Identify any environmental or psychological issues that might be increasing or precipitating the pain, such as stress, fear, or lack of knowledge. “Helping to reduce

or eliminate these factors may help to provide comfort for chronic pain patients,” says Alverson. (See story, left, about taking a holistic approach.) For example, at Covenant Healthcare’s ED, patient advocates assist patients with getting prescriptions and make arrangements with local homeless shelters if needed.

Many times, if you can reduce a patient’s anxiety, it will help to reduce their pain level as well, says Alverson. “Educational and teaching can be a beneficial intervention to reducing a patient’s anxiety,” she says. “Explaining all tests and procedures, answering questions, and active listening are important.”

References

1. Wilsey BL, Fishman SM, Ogden C, et al. Chronic pain management in the emergency department: A survey of attitudes and beliefs. *Pain Medicine* 2008; 9:1,073-1,080.
2. Wilsey BL, Fishman SM, Tsodikov A, et al. Psychological comorbidities predicting prescription opioid abuse among patients in chronic pain presenting to the emergency department. *Pain Med* 2008; 9:1,107-1,117. ■

Could performing an MSE get an ED nurse sued?

Nurses potentially can ‘get into some serious trouble’

[Editor’s note: This is the second of a two-part series on medical screening examinations (MSEs) performed by emergency nurses. This month, we cover the potential liability risks of nurse-performed MSEs and how to avoid legal problems. Last month, we reported on benefits seen by two EDs that have implemented this practice.]

If an appropriately trained ED nurse can legally meet the criteria to perform medical screening examinations required by the Emergency Medical Treatment and Labor Act (EMTALA), why don’t more EDs have nurses doing this? Very likely, it’s because of the potential liability risks.

“The idea of using staff nurses to perform screening makes me uncomfortable from a liability standpoint,” says **Patricia Iyer**, RN, MSN, LNCC, president of Flemington, NJ-based Med League Support Services, a legal nurse consulting firm specializing in malpractice and personal injury cases. “I can see the practice morphing into what could be construed as the practice of medicine.”

Nurses are not permitted by license to make medical diagnoses, notes Iyer, who adds that a patient who is seen by a triage nurse and a physician receives “two

EXECUTIVE SUMMARY

If an ED nurse performs medical screening examinations required by Emergency Medical Treatment and Labor Act (EMTALA), potential legal risks include overlooking signs and symptoms that warrant a physician exam and allegations of patient abandonment. To reduce risks:

- Have only a nurse practitioner who is extensively educated for this role perform the exams.
- Have nurses closely follow clear guidelines for how to function in this role.
- Avoid the appearance of any situation in which payment method dictates the level of service recommended.

layers of protection.” “To let a patient go out the door without being seen by a physician sounds risky to me, unless the health care provider was a nurse practitioner who is specifically and extensively educated for this role,” says Iyer.

A nurse with excellent critical thinking skills might function well in this role and be appropriate a large part of the time, but still is likely to run into a situation beyond his or her skills, says Iyer. “Relying on gut feelings is not enough,” says Iyer. “The nurse without excellent critical thinking skills could get into some serious trouble by overlooking signs and symptoms that warrant a physician exam. My conclusion is that the plaintiff attorneys could have a field day with the practice when the bad outcome occurs.”

Mary Ann Shea, JD, RN, a St. Louis-based attorney at law, registered nurse, and former emergency nurse, says that when she hears about this practice, “the alarm that goes off for me is to be very careful to not set oneself up for an allegation of patient abandonment.”

However, Shea says that this risk can be avoided by having clear guidelines for how to function in this role, thorough education of all staff performing MSEs and those involved in the process, meticulousness by the nurse in following all the guidelines, and “exercising good, sound nursing judgment at all times.”

Shea says the key to surviving any legal challenges to the appropriateness of the recommended treatment

includes clear, thorough and complete documentation of the following:

- presenting symptoms and history;
- your recommendation for the recommended level and location of treatment;
- patient’s understanding of all the options and agreement to the recommended transfer to another service or venue.

“Remember, it is not necessarily a deviation from the standard of care to channel a patient to a different level of service,” says Shea. “It would be a deviation to deny necessary treatment without providing viable options.”

If appropriate options are provided and the patient rejects those options, Shea says that the risks of refusing treatment must be explained. Your documentation also should make it clear that the patient was made aware of the risks of refusing the treatment recommendations.

Requesting a copay for nonemergency treatment requested in an ED is not a deviation from the standard of care, if the patient voluntarily has chosen this option over other treatment recommendations that were available and feasible, Shea says. “Always avoid any situation, or the appearance of any situation, in which the payment method might appear to be dictating the level of service recommended,” says Shea. “Denial of necessary treatment due to inability to pay is never acceptable in an ED setting.” ■

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.

After completing this semester’s activity with the **June** 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

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CNE objectives/questions

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.
9. Which is recommended regarding care of pediatric ED patients with gastroenteritis?
 - A. Age and length of illness are not relevant for predicting which children are at higher risk for acidosis.
 - B. More patients should be treated by intravenous (IV) instead of oral rehydration.
 - C. Oral rehydration should not be done at triage.
 - D. In severe cases in which an IV is unable to be started, an intraosseous line can be placed to initiate immediate fluid resuscitation.
 10. Which statement is true regarding medications and older patients?
 - A. Drugs such as laxatives, antacids, antihistamines, nonsteroidal anti-inflammatory drugs, decongestants, and diuretics might affect the absorption and efficacy of other drugs.
 - B. If toradol is given in the ED, this drug can lead to renal and hepatic failure in the older adult, especially if administered in the "routine" amount and on top of the ibuprofen or other nonsteroidal anti-inflammatory drugs the patient is taking.
 - C. Medications taken by elderly patients at home might not allow an increase in the patient's heart rate or vasoconstriction, which can lead to poor response in the shock state.
 - D. All of the above
 11. Which is true regarding appendicitis?
 - A. Patients might report decreased pain when lying still.
 - B. A CT scan rarely changed the treatment plan for ED patients with suspected appendicitis.
 - C. Initial lab work is never normal with early acute appendicitis.
 - D. Patients will report increased pain with knees drawn up.
 12. Which is always considered a deviation from the standard of care, regarding ED nurses performing medical screening examinations required by EMTALA?
 - A. Channeling a patient to a different level of service.
 - B. Basing the level of service recommended on the patient's payment method.
 - C. Providing appropriate options, which are then rejected by the patient.
 - D. Requesting a copay for nonemergency treatment requested in an ED, even if the patient has voluntarily chosen this option over other treatment recommendations that were available and feasible.

Answers: 9. D; 10. D; 11. A; 12. B.

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