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Preparation pays off for EDs in DC as millions visit for inauguration

Planning for special events varies based on expectations

When Sen. Edward M. Kennedy (D-MA) was brought to the ED at Washington (DC) Hospital Center on Jan. 20, 2009, following a seizure, the department was well prepared.

"Given traffic flow and ingress and egress, if something happened at the Capitol [where Kennedy was stricken], we knew we would be the quickest [place to move]; we knew they'd be coming our way," says **William J. Frohna**, MD, vice chairman of the ED.

The office of the attending physician of the U.S. Capitol had alerted the facility that there was an event going on (a post-inaugural luncheon), Frohna recalls, but he actually found out about Kennedy's health problem a split second before being alerted by that office. "My wife [who had been watching CNN,] texted me and told me about it even before we got the heads-up call," says Frohna, noting that he was just about to begin his shift. "As I got that text, our physician had just gotten off the line with the attending physician at the U.S. Capitol."

Several EDs in the district had TVs available to monitor inauguration events. Incidents such as these show they have more than just entertainment value.

Washington Hospital Center's ED had a special area designated for VVIPs (very

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April 2009 issue of *ED Management* to feature best cost-cutting strategies

The next issue of *ED Management* will include a special focus on the cost-cutting strategies that have successfully trimmed thousands of dollars for ED managers. We'll take a look at several key issues, including:

- streamlining your department's supply chain;
- determining if part-time personnel can help your efficiency;
- renovating the ED to make it more cost-efficient;
- cost-sharing with local fire departments and EMS.

Don't miss this special issue of the best ideas from EDs across the country!

VIPs); it only had one interior entrance and one exterior entrance, with controlled access and security. "It's an area that is normally part of what we call MedStart, a medical shock, trauma, and acute resuscitation area," Frohna explains.

It has five bays staffed with dedicated trauma nurses 24/7, as well as trauma physician coverage. The outside entrance comes from the helipad, and ambulances also can drop off patients there. The in-hospital entrance is keypad-activated. Because of the medical nature of Kennedy's condition, the chief of neurosurgery was made immediately available, and an ED physician was ready to treat the senator when he arrived.

As for the media, Frohna notes that any information to be released from the ED had to be approved by the hospital's media relations department and the senator's family. However, he adds, because of tight security, "the media assembled outside our boundaries and were beyond the realm of our control" and did not interfere in the case.

While other EDs in the city did not have similar high-profile situations, they nonetheless made they own detailed preparations, in some cases preparing for the worst. "After 9/11, we realized that anything can happen, and that you need total preparedness," says **Fernando Daniels III**, MD, the interim emergency medicine director for the ED at United Medical Center. "We set up an outside decontamination tent, prepared our bioterror equipment, and made sure everything was ready from that standpoint," he says. "We also made sure we did refresher training for our nurses on how to put on protective equipment." **(Daniels and his staff treated the inauguration as a four-day event. See the story on p. 27.)**

Fortunately, that equipment never was needed. However, other preparations Daniels and his team made did come into play. "We absolutely expected a heavier census, so we discharged all patients who were stable to make available as many beds as possible," he says. "We moved our fast-track area into our primary clinic area [providing eight additional beds] and doubled staffing of RNs, techs, and PAs." An additional

Executive Summary

While your city may never host a presidential inauguration, preparations made by EDs in Washington, DC, can help inform you about your own disaster planning in general, and in particular your plans for handling special events associated with large crowds. Consider the following strategies:

- When it comes to potential problems, plan for the worst.
- Consider your proximity and traffic access to the event when projecting how many additional patients you should expect.
- Have a special area available to receive and treat VIPs.

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physician also was scheduled for peak times, he says. An additional triage area for fast-track patients was set up so there were two operating simultaneously, "which really expedited patient care."

Security also was enhanced. "Only cars with ID could get on site, and we checked [incoming] patients' IDs before they could get into the parking area," says Daniels. "All employees had to display their ID, and we placed security out front."

Although the patient load during the inauguration was double the normal census, this preparation paid off, says Daniels. "Waiting times actually went down," he shares.

Location and traffic patterns had a lot to do with how EDs were affected, adds **Leena Salazar**, RN, BSN, director of the ED at The George Washington University Hospital. "We added a nurse or two, figuring we'd see a lot of orthopedic stuff, but we did not get a lot of patients because of traffic hindrances," she says. "It was actually less than our normal census, so we were not able to really test our surge preparedness." **(ED managers generally were pleased with the results of their preparedness efforts. See the story on right.)** ■

Inauguration seen as four-day event

At Washington Hospital Center in Washington, DC, the presidential inauguration was not seen as a one-day affair.

"You not only had the weekend events preceding the inauguration, but also the [Martin Luther King Jr.] holiday and the inauguration, so it was a four-day break of routine care availability for patients with private physicians," notes **William J. Frohna**, MD, vice chairman of the ED. "You had to account for that, and then plan and prepare for anywhere from 1 million to 4 million visitors."

To do that, he says, he interfaced with hospitals inside and outside the District of Columbia, had liaison with the Secret Service, as well as local and regional EMS. The Secret Service, he notes, "kept us in touch with the latest crowd estimates."

During events such as this, it's not uncommon for the census to actually go down, Frohna says, but "we basically bumped physician staffing up about 20% for Sunday through Tuesday, which brought us up to as many as five." In addition, administrative leadership physicians were in scrubs to see patients as needed, and the hospital's emergency medicine residency program enabled him to add an eight-hour shift of resident coverage during what were expected to be peak hours.

In addition, notes Frohna, the ED had a head start on preparing to deal with disasters with its ongoing "ER One" program. **(For more information, see "ED of the future' girded for disasters, *ED Management,* March 2008, p. 33.)**

Finally, Frohna credits the medical resources deployed on the national mall with easing the burden of local EDs. They had warming tents and nearly 50 areas for treating patients on the scene," he says. "We had remarkably fewer individuals who had cold [exposure] injuries," Frohna says. "We had more medical conditions exacerbated by the elements, such as asthma, chest pain, or people who forgot their meds on the busses." ■

Managers generally pleased with results

By and large, ED managers in the Washington, DC, area were happy with how they prepared for the recent presidential inauguration.

"We're absolutely pleased with how things went," says **Fernando Daniels III**, MD, the interim emergency medicine director for the ED at United Medical Center. "If anything, we learned how to improve our own throughput process."

In particular, says Daniels, he enjoyed the dual fast-track principle he instituted from noon until 10 p.m. and is considering instituting a double fast-track permanently. "We will be renovating our space and meanwhile will look at temporary space to move the current fast-track to have space to expand the ED," he says.

At Washington Hospital Center, "Overall, we were very well prepared, although some fine tuning is

needed," says **William J. Frohna**, MD, vice chairman of the ED. "It would be nice to have a passive way to access real-time information for the ED because rumors flow." For example, he notes, at one point the department was concerned there were crush injuries coming from an area where people had broken down barriers.

The ED was alerted by the hospital command center, which received information from a hospital employee who happened to witness the event. "We received the report, which was not erroneous, of multiple potential injured victims," says Frohna. However, he adds, the ED did no receive any casualties for several probable reasons:

• Minor injuries self-treated and self-triaged away/at home, especially given the response time of EMS to the scene due to size of crowds.

• Medical facilities and personnel on site and on the mall provided sufficient first aid.

• Medical direction took patients elsewhere as their injuries were considered less severe (not requiring a trauma service) and designated routes for EMS away from the mall/scene were established and were not headed toward Frohna's facility.

For those potential crush injuries, "we asked how many beds we needed to have, but then we never received them," he says. "I'd like a way to access the system to know when real medical situations are coming in."

He'd also like to see case management capabilities in the ED proper. "For example, we needed to marry up patients with their busses that were going home, and that's something we should look at in the future," he says. ■

Care Initiation Area yields dramatic results

In February 2008, 12% of the patients who presented to the ED at Gaston Memorial Hospital in Gastonia, NC, left without being treated. By the end of January 2009, that figure had dropped to 1.3%. In that same time period, hours on diversion dropped from 107 to zero, and the average turnaround time fell from 247 minutes to 184 minutes, even though even more patients were being seen (7,677 vs. 7,810.) Press Ganey patient satisfaction scores for the ED's arrival section jumped from the 68th percentile to the 99th percentile.

How could such dramatic improvements be made in such a short time? The ED team credits the Kaizen (Japanese for "continuous improvement") methodology, pioneered by Toyota, that helped it identify inefficiencies, and the introduction of a new Care Initiation Area (CIA) and a physician in triage. **(For more on Kaizen methodology, see the story and resource box, both on p. 29.)**

Executive Summary

The ED at Gaston Memorial Hospital in Gastonia, NC, has achieved dramatic results in key department metrics with a Care Initiation Area (CIA) and a physician in triage. Here's how the ED arrived at this winning solution:

- Leadership was trained in and implemented the Kaizen method, which eliminates redundant or inefficient process steps.
- Simulation software helped determine additional space needed by analyzing arrival patterns and other key data.
- After only two days of meetings, new ideas were implemented and tested.

"We decided we needed a care initiation area because we were redesigning processes," explains **Kathleen Besson**, RN, BSN, MBA, NEA, BC, director of emergency services, who notes that the triage area had been identified as a bottleneck.

"In looking at ways to improve our processes, we wondered if there was an opportunity to use space not being utilized any more and turn it into the CIA," Besson says. "We used simulation software we had here in the building to analyze arrival patterns, decide peak arrival times by the hour, and patient disposition, so we could estimate how many patient spaces we needed in the CIA so patients could come right there in instead of the waiting room." The creation of the CIA, including equipment, cost about $800, she says.

The new process works like this:

• The patient presents, and triage and registration are completed at the "reception podium" of the ED.

• The patient goes to the 16-chair ambulatory CIA, which is in an open area in the middle of the ED. Therealso are four EMS care initiation bays.

• In the CIA, the patient is seen by a nurse and a physician, diagnostic testing is completed, pain is treated, and the patient is monitored.

• If the patient is not sent home from the CIA, he or she proceeds to a room in the ED.

• Tests are returned.

• Intervention is ordered and delivered.

• Disposition proceeds.

• The patient is admitted, placed in a hallway bed, or sent home.

Sonya Carver, RN, the ED's clinical manager, says,

Source/Resources

For more information on Kaizen methodology and improving ED flow, contact:

- **Kathleen Besson**, RN, BSN, MBA, NEA, BC, Director of Emergency Services, Gaston Memorial Hospital, Gastonia, NC. Phone: (704) 834-2440.

A definition and discussion of Kaizen methodology, along with an illustrative diagram, may be found at www.12manage.com/methods_kaizen.html.

A guide to Kaizen methodology is available at fac.swic.edu/turnerke/Kazien-Guide.pdf.

"In Kaizen, you have your current state, and you have the future state you need to move to. You map out to the tiniest detail exactly what happens with the patient, even to the point of saying, 'The patient walks in the front door.'"

The reason for examining the processes in such detail "is that you can very easily see if there's something that is repetitive and ask yourself why you do that — very minute details you do not think about day by day," she says. **(The ED team shared their results in an impressive presentation before the hospital board. See the story, right.)** ■

Kaizen methodology means rapid changes

While the Kaizen methodology, developed by Toyota, involves examining processes in minute detail, it ironically can lead to rapid improvement in ED processes, says **Sonya Carver**, RN, clinical manager/days for the ED at Gaston Memorial Hospital in Gastonia, NC.

"In one instance, we had a one-day meeting and then did that work product immediately," she says.

Kaizen already had been adopted by the facility to be used for process improvement when the ED set out to improve its triage process, Carver says. "We looked at what was wasteful in our triage design — for example, serial processes as opposed to parallel processes — and developed the methodology that triage is a *process* and not a place," she explains. With Kaizen methodology, the focus is on the customer, which in an ED can be the staff or the patient, Carver says, "so, it can be used to improve staff work flow so you work smarter and not harder," she explains. "If you can do more with less, like walking fewer steps to a piece of equipment, you eliminate waste and improve quality."

Carver was trained in Kaizen by the hospital's organizational improvement department. **Kathleen Besson**, RN, BSN, MBA, NEA, BC, director of emergency services, says, "You learn how to lead a group through a Kaizen event and also how to complete documentation so you can come out and have data — before and after, what you have gained — and actually put a dollar or time-saving figure to it. It's a very data-driven, deliberative process, and every project goes through the same steps."

'A two-meeting process'

The facilitator has to make sure they have the right people on the team, then assess the process, establish goals, work through each step, and see what the best opportunities for improvement are, Besson says. "When you come out of the meetings, you implement the changes fairly quickly. It doesn't take months or meetings regurgitating the same things over and over," Besson says. "At most, it's a two-meeting process."

Jodie Cook, RN, ED clinical manager /nights/weekends, who took the lead in staff education, says, "We educated the staff through staff meetings and e-mails, and informed them of the process and what everyone's responsibilities would be. We had a book in the CIA [the Care Initiation Area, one of the Kaizen solutions] describing the new process, and a place in the unit where staff could put suggestions and comments." In addition, she says, the leadership team would meet and debrief after each Monday and Tuesday to see how things were going. "We talked with the charge nurses to see what worked and what didn't," she notes. ■

Don't hide your light, share success with board

Many EDs have success stories to tell, but how many have told them directly to the hospital board? That's exactly what the ED team at Gaston Memorial Hospital in Gastonia, NC, did, and what a story it was. Using Kaizen methodology, they racked up impressive results in patients who presented to the ED who left without being treated, hours on diversion, turnaround time, and patient satisfaction.

The quality of the presentation did justice to the ED's accomplishments. Not only was there a full-blown computerized slide presentation outlining their goals, implementation, and results, but the presentation

Source

For more information on ED board presentations, contact:

- **Wayne Shovelin**, CEO, Gaston Memorial Hospital in Gastonia, NC. Phone: (704) 834-2121.

was made by several key members of the ED team. "I moved my board meeting to the auditorium so all the staff could come," says **Wayne Shovelin**, the hospital CEO. "They had about 15 people, including half a dozen ED physicians, which spoke volumes about our culture."

Kathleen Besson, RN, BSN, MBA, NEA, BC, director of emergency services, says, "From my perspective, I had been called to present to the board along with our medical director several times, but I felt pretty uncomfortable because I was not the only person creating the improvement. I told the board I wished they could hear from the staff."

It's important for the board to "meet the people who do great work," and it's also important for ED staff to see the board and the people who are expecting so much from them, Besson says. "The board is just a scary bunch of people nobody knows," she notes. "It was important for the board to understand all the effort that went into the initiative and for the staff to receive recognition."

Besson created the slides, and then each presenting staff member took responsibility for the areas they had championed and knew very closely. "Preparation did not take all that long because we had been using a lot of the data elements all along," she explains.

Jodie Cook, RN, ED clinical manager, who took the lead in staff education, says, "We were all nervous wrecks going in, but when we were done, every single person was so glad, so proud to hear the presentation, to experience the response and talk to board members one on one. When we put the whole package together, you could see what we all had done as a team. The staff members that had come and listened were just amazed."

So was the board, says Besson. "One board member actually had tears in his eyes," she recalls. "Last week, the same board member asked me how to get the word out to the community about all the things we were doing in the ED."

Besson said that wasn't necessary, based on the jump in patient satisfaction rates. "We had all those patients who had the opportunity to see what we do here, and that's the best marketing you can do," she says. ■

ED slashes average wait time by more than an hour

Team studies facilities, creates own model

No ED cuts its average door-to-doc time from 93 minutes to 20 minutes by accident. The success story at Memorial Hermann Memorial City Medical Center in Houston was the result of discovering a patient flow model at another facility that was superior to theirs, and then continuing to search out additional models to come up with their own system that best addressed their specific needs. The result was a model they call ExcelERate, which includes a more detailed nurse assessment up front, parallel processes, and the carving out of an intake area within the ED. **(An initial "quick look" at patients is a key to this process. See the story on p. 31.)**

"We reoriented our entire space, putting dividers screens in four rooms to duplicate our capacity," explains **Michele Bell**, RN, MBA, chief nursing officer at Memorial Hermann. The department now has 10 intake and procedure rooms; five continuing care rooms with stretchers; four rooms with two recliners each, separated by curtains, with 13 spaces for continuing care and 13 acute care beds; and an overflow room that has 10 chairs.

The changeover began when **Jim Parisi**, RN, Memorial Hermann Healthcare System executive of emergency services, went to Phoenix to visit Banner Estralia Hospital at the invitation of its client, Cerner. Banner Estralia was using Cerner IT systems and had gone paperless. "We took a tour of the hospital that in started in the ED — and we just stayed there," he recalls.

What impressed Parisi was that the busy ED

Executive Summary

The ED at Memorial Hermann Memorial City Medical Center was able to cut its average door-to-doc time from 93 minutes to 20 minutes by adapting flow models from other facilities and creatively reallocating existing space.

- A nurse takes an initial quick look at the patient and then directs him or her to the appropriate area.
- Subacute patients go to an intake area, where nurse and physician conduct parallel processes.
- Top nurses assigned responsibility of making sure processes run smoothly.

‘Quick look’ starts rapid flow process

The ED at Memorial Hermann Memorial City Medical Center in Houston has slashed its door-to-doc times from 93 minutes to 20 minutes with the help of an internal process it calls ExcelERate. The process begins with a “quick look,” explains **Jim Parisi**, RN, Memorial Hermann System executive of emergency services.

“The nurse will just ask the patient their name, their age, and what’s bothering them,” he explains. “If it’s an acute problem, like chest pain, you are taken to the back, just like in our old model.”

For less serious cases, however, the ED has created an intake area. There, the nurse completes the assessment, and the doctor comes in shortly thereafter. “Since the doctor sees the patient faster on the front end, they can order more labs right then,” says Parisi. “If the patient has mild abdominal pain — for example, the doctor orders lab, IV, maybe an X-ray — but instead of staying in that bed, they go to ‘continuing care,’ where they wait for the labs to come back and prepare for discharge directly.” ■

(60,000-70,000 visits a year) “seemed so well organized and relatively quiet.” He started asking lots of questions, and when he came home, he met with TeamHealth, which provides ED coverage for the system. “We agreed that while this would not do everything for us, their ‘split-flow’ process had the most chance of anything we had seen to help us,” says Parisi.

Then, a team that included physicians, nurses, and representatives from the lab, radiology, and administration visited the Banner facility. “As an interdisciplinary team, they had to envision how this would work in our physical plant,” says Parisi.

Children’s hospitals toured

The research didn’t end there, says Bell, who joined the team on the Phoenix trip. “We also saw several children’s hospitals in Cleveland, because we will be putting in a children’s ED in June, and then we kind of combined the best of all the models,” she notes.

Because the staff already had had extensive experience with Six Sigma methodology, the conversion process also was facilitated by Black belts and Green belts, “so we knew we could show measurable improvement,” says Bell.

That they have accomplished: Parisi says the left-without-treatment rate had been as high as 9%-10%, “and now it is way less than 2%.” That improvement, adds Bell, also is reflected in the department’s Press Ganey patient satisfaction scores. “We started in very low digits and now run anywhere from 80 to 95,” she reports. ■

Sources

For more information on reducing door-to-doc time, contact:

- **Michele Bell**, RN, MBA, Chief Nursing Officer, Memorial Hermann Memorial City Medical Center, Houston. Phone: (713) 242-3000.
- **Jim Parisi**, RN, Executive of Emergency Services, Memorial Hermann Healthcare System, Houston. Phone: (713) 448-5555.

Staffing critical to help speed flow

When the ED at Memorial Hermann Memorial City Medical Center in Houston was preparing to implement its new flow model, ExcelERate, it was clear that the revised ED processes could not be run by just anyone, says **Michele Bell**, RN, MBA, chief nursing officer at Memorial.

“The ED brought in six coordinators — RNs — who are on 24/7,” she says. “They are the *best* nurses.” These individuals, she notes, are responsible for keeping the rest of the staff and the lab moving. They are constantly running to the front and checking the waiting room as well, because, Bell says, “I want it empty all the time.”

Speed is the toughest part of the model, she says. “The staff voted on their strongest leaders who they thought could do this model,” Bell says. The entire ED staff are evaluated on three metrics: turnaround time, door-to-doc time, and customer satisfaction. “They can earn up to an additional 2% of their salary,” she says.

Not every staff member was thrilled with this new approach, Bell concedes. “We lost a lot of them and replaced them,” she says. “There are some people you just know are not going to change.”

For some staff, however, it was just a case of needing

to see the model in operation. "The nursing director for the ED was dead set against it at the beginning," recalls Bell. "It's very hard for an ED nurse to focus on treating people quickly."

However, she says, that nurse manager now is "very proud of our performance." ■

ED's turnaround time cut by almost 30 minutes

Process 'pulls' patients out of waiting area

By implementing a Lean process change that it calls TAPP (Team Assessment Pull Process), the ED leadership in the Children's Healthcare of Atlanta system has realized a 25-minute reduction in median overall turnaround time, from 192 minutes to 167 minutes, excluding its fast track. The ED also achieved a 16-minute median improvement in door-to-provider time, from 44 minutes to 28 minutes, at its Scottish Rite campus. In addition, median length of stay has dropped from 136.5 minutes to 122 minutes. **(ED team members took a course in the Lean process methodology at a local university. See the stories right and p. 33.)**

TAPP works like this: The patients are greeted in the waiting room by a patient access greeter. A registered nurse is sitting next to the greeter from 9 a.m. to 3 a.m. They are then assigned an acuity level by the triage nurse. "From there, they show up on our [ED automation software program] board as a patient in the waiting room," explains **Cresta Pollard**, RN, BSN, assistant nurse manager. "Then, when a doctor is ready for a patient, they put their name as well as their communication number on the board."

The nurse will do the same, she explains. Once a second team member has signed up, they will call the first via the facility's internal phone system (ASCOM) and say he or she is ready for the patient. The nurse or

Executive Summary

A proactive team approach to "pulling" patients from the waiting room has cut 25 minutes off the average turnaround time in the ED at the Scottish Rite campus of the Children's Healthcare of Atlanta system.

- Once assigned an acuity level, the patient is pulled back into a room and met by a nurse/physician team.
- A computerized board and internal phone system allow team members to coordinate their arrival in the patient's room.
- A flexible group of three 17-bed "pods" are opened and closed, depending on the census.

ED team goes 'back to school'

Before it could successfully implement a Lean process change that it calls TAPP (Team Assessment Pull Process), the ED leadership in the Children's Healthcare of Atlanta system had to be educated in the process. The need for this education was clear, recalls **Marianne Hatfield**, RN, BSN, CENP, system director of emergency services.

"We had actually moved into a new facility and increased our capacity by one-third without improvement in our turnaround time, so we knew we had to look at our processes," Hatfield says.

They had used a Six Sigma approach in previous years and had found it to be a little slow, says **Jeff Rehberg**, BIE, ME, senior quality consultant, "So, in early 2008, we approached Georgia Tech to learn more about their lean methodology because we had heard good things about it," he says.

A team of 18 from the system attended the class at the Georgia Tech Innovation Institute and then spent three days with Tech representatives on site doing mapping, observations, collecting quick data, and doing some trials and tests on TAPP, which they had studied at the institute. "Then they backed out and let us move forward. I went to Lean Champion training [advanced training provided by Georgia Tech] and pulled that exercise into the children's ED and other hospital units, and I continue offer a one-day class to the ED and house staff," Rehberg notes.

Part of the philosophy in Lean is the elimination of waste, Hatfield says. "Our 'waste' was searching for doctors, deciding on which patients took priority, and having more than one person do the same thing," she says. By pairing nurses and doctors into teams, she says, "We improved communications for the team and streamlined visits for the patients."

Rehberg says, "The whole concept of 'pull' is that you take on work when you're *ready* for work rather than having it *pushed* on you. This evens out work for the nurses." ■

The Five S's helps improve efficiency

The ED management team at Children's Healthcare of Atlanta system has used several valuable Lean tools to implement successful process changes that have streamlined work flow. One of the most effective is an approach called Five S's. Its five pillars are:

- **Sort:** Remove from the workplace all items that are not needed for current operations and activities.
- **Set in order:** Arrange items needed so they are easy to use, and label them so they are easy to find and store.
- **Shine:** Keepg the workplace tidy, sweep floors, clean equipment, and generally make sure everything stays clean.
- **Standardize:** Adopt a method of working to ensure the first three pillars are maintained.
- **Sustain:** Ensure and make it a habit that everyone adopts and carries out the correct procedures.

"It's really a way of organizing all supplies and equipment as efficiently as possible, and having them in an appropriate place," explains **Jeff Rehberg**, BIE, ME, senior quality consultant. "We basically took one patient room and asked ourselves what we needed and how could best organize it, then replicated it throughout the rest of the ED."

As a result, when a staff member enters any patient room in the ED, "they should be able to find almost anything they need blindfolded," he says.

Jennifer Berdis, RN, BSN, manager of clinical operations, says, "So, for example, the left-hand side of the bed is for the caregiver, so the monitor is there, and under the monitor is a basket with a pulse oximeter and electrodes, and under that is a bin to house air curettes, gauze, bandages, and things we most frequently need. It allows you to take fewer steps within the room itself in order to complete an exam." ■

a tech then will get the patient and tell the doctor what room they are going to. The doctor will meet the nurse in the room, where they will obtain a history, conduct a physical exam, and communicate the plan of care. The nurse will carry out the orders.

Before this change, the work in the ED had been "scattered and frantic," says Pollard. "We would have three to four patients at a time and put them into rooms, but they could be waiting an hour or more for a doctor; you might have orders on all four working at the same time, start with one patient, then go to another, and by the time you got to the last one, it could be an hour before it was all done."

Jennifer Berdis, RN, BSN, manager of clinical operations, says, "The nurses actually had to make decisions about what patient was a priority, while every doctor felt *their* patient was a priority, so the nurse was stuck in the middle. Now they do not have to make that decision because they are only working with one patient until they are done with orders."

The "pull process" refers to the fact that each patient is pulled by the nurse into the pod, or treatment area, where they meet their team. There are three pods in the department (including fast track), each with 17 rooms. The number of pods that are open and the number of team members varies according to the census. At full census (3 p.m.), there are approximately six nurses and three physicians per pod.

James Beiter, MD, the medical director, says, "The intention was to have the physicians stay within a team and a pod, but because we will open and close certain areas in the ED, it's hard to keep us in one area; we go where help is needed. It has not been as strict as it has with the nurses." ■

Sources

For more information on pulling patients out of the waiting room, contact:

- **James Beiter**, MD, Medical Director, Emergency Department, Children's at Scottish Rite, Atlanta. Phone: (404) 785-2273.
- **Marianne Hatfield**, RN, BSN, CENP, System Director of Emergency Services, Children's Healthcare of Atlanta. Phone: (404) 785-4968.

'Unwinnable' case holds lessons for ED managers

Medical facts often secondary, insists attorney

The malpractice case had all the makings of a large jury verdict: It was emotionally charged, with a tragic outcome for the patient, who was a quadruple amputee.

Executive Summary

Emotions often are a critical component of a malpractice case, but you can use them to your benefit, according to an attorney who won a case for his client, an ED physician, who seemed destined to lose.

- Communicate to the jury how compassionate you are and how important it is for you to provide the best possible care.
- Create a strong sense of teamwork among your ED staff.
- When documenting, be thorough, but stick to the facts. Leave out opinions or complaints about other providers.

The plaintiffs alleged that the ED physician failed to diagnosis a "classic" presentation of a kidney stone that led to septic shock while the patient was still in the department. They further alleged that the ED physician failed to properly treat the shock and then provided improper information to the internist over the telephone, which caused him not to come into the hospital on a timely basis. The plaintiffs went on to say that all negligence by the subsequent treating physicians was causally connected to the ED physician since they relied on the department's alleged medical mismanagement and wrong diagnosis.

However, on Jan. 12, 2009, the Fort Lauderdale, FL, jury found no liability against the ED physician, the ED nurses, an internist, and a surgeon.

Compassion before competency

While the clients were clearly represented by talented attorneys, one member of the winning team says cases such as this contain important messages for ED managers and their staff. The first and most important is that compassion comes before competency, notes **James J. Nosich**, Esq., of the Coral Gables, FL, law firm McGrane Nosich. "I believe that it's easier to win when the jury looks, No. 1, at whether the ED doc is compassionate; and two, whether they are competent," he explains. "A lot of people perceive that you get bad treatment in the ED, so if you can convince the jury that they or their family member would want the defendant as their doctor, I think they would win almost every single time." **(Nosich says creating a sense of teamwork in the ED also can help reduce liability. See the story on right.)**

Nosich says he can't recall having an ED physician client who was *not* compassionate, so the real issue is communicating that compassion. "You have to show that at all times — while the time you spent with the patient was short — it was concentrated and caring, and that you wanted the best thing for the patient," he says. "You really have to explain emergency medicine, what these people are about, why they do their job, and why they like it." Nosich can't remember a single case he lost because the ED physician did not spend enough time with the patient.

Careful documentation is critical

Of course, medicine *is* an important part of any malpractice case, and careful documentation can bolster your defense, adds **Arthur L. Diskin**, MD, FACEP, vice president and global chief medical officer for Royal Caribbean Cruise Lines, who formerly oversaw the management of numerous ED physician groups and was a client of Nosich. "It's critical to document the content of your conversation, whether with the patient, the family member, or the attending physician," Diskin says. "With this type of complex case, especially involving a critical patient, what the doctor writes in the medical record is really far more than just somebody putting their signature on a piece of paper."

So, for example, the physician should document to the attending how seriously ill the patient is and all the medical findings. "That's much better than 'discussed case with Dr. Smith, who will admit patient,'" Diskin notes. ■

There is no 'I' in ED team care

Winning a malpractice case takes more than success in the courtroom: It also requires ongoing best practices on the part of the ED manager to educate

Sources

For more information on preparing for a malpractice trial, contact:

- **Arthur L. Diskin**, MD, FACEP, Vice President and Global Chief Medical Officer, Royal Caribbean Cruise Lines, Miami. Phone: (305) 539-6091.
- **James J. Nosich**, Esq., McGrane, Nosich & Ganz, Coral Gables, FL. Phone: (305) 442-4800.

and prepare the staff for possible lawsuits. One important thing for the manager to remember is that they are not an island, offers **James J. Nosich**, Esq., of the Coral Gables, FL, law firm McGrane Nosich.

"They have to understand that their role is limited in the ED to the team they have," Nosich explains. "They need to do their best to always try to educate physicians, nurses, techs, and midlevel providers that they are all on the same team and they all have one goal in mind, rather than trying to do it all themselves or blame other people on the team." More time should be spent "on having the best team you can," he says.

How to document

Teach your staff to document in a factual and nonconfrontational manner, says **Arthur L. Diskin**, MD, FACEP, vice president and global chief medical officer for Royal Caribbean Cruise Lines Ltd., who formerly oversaw the management of numerous ED physician groups and was a client of Nosich. "Document thoroughly the facts and sequence of events, without documenting arguments with other medical people in the medical record, like, 'I called the guy five times, and he still did not respond to my call,' or 'I told him the patient needed to be admitted, and he said I was an idiot,'" he says.

Nosich cautions, however, that great documentation does not outweigh great teamwork. "There have been cases where there was great documentation, and the ED still got sued, and vice versa," he says. "But remember: You don't control what the nurses do; but if they do something bad, you can get sucked into a suit, so everybody has to be on the same page and work on the same team." ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. **The semester ends with this issue.** After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME *questions*

31. According to says Fernando Daniels III, MD, which of the following strategies helped prepare his ED for a potential surge of patients during the presidential inauguration?
A. Discharging all stable patients
B. Doubling RN staffing
C. Adding physicians at peak times
D. All of the above

32. According to Sonya Carver, RN, how long did it take between the initiation of a Kaizen session and the implementation of new process changes at her facility?
A. One to two days
B. One week
C. One month
D. Six months

33. According to Kathleen Besson, RN, BSN, MBA, NEA, BC, when the ED successfully completed a process improvement initiative, who should make the presentation to the board?
A. The nurse manager
B. The medical director

COMING IN FUTURE MONTHS

- How to overcome barriers to NSPG implementation
- ED survives a weeklong ice storm
- Pre-discharge education reduces readmissions by 30%
- Where do parents prefer their children wait for a bed?

C. All of the key ED team members
D. The CEO, after reviewing the results with the ED manager

34. According to Jim Parisi, RN, the triage nurse will ask the patient some key questions during the new "quick-look" process. Which of these questions will they *not* ask?
A. What their name is.
B. How long they have had their symptoms.
C. How old they are.
D. What their chief complaint is.

35. According to Jeff Rehberg, BIE, ME, senior quality consultant at Children's Healthcare of Atlanta, in the 5 S's system to improve work flow, "sort" refers to:
A. Organizing patients according to chief complaint.
B. Creating teams of physicians and nurses.
C. Eliminating redundant equipment.
D. Keeping medical equipment on the left side of the patient's bed.

36. According to James J. Nosich, Esq., the most important element in an ED physician's defense against a charge of malpractice is:
A. medical competence.
B. compassion.
C. complete documentation.
D. dispassionate documentation.

CNE/CME answers

31. D; 32. A; 33. C; 34. C; 35. C; 36. B.