ED NURSING™
A MONTHLY CLINICAL UPDATE ON EMERGENCY NURSING

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IN THIS ISSUE

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If a mistake harms a patient, what happens next in your ED?

Don't take a punitive approach toward your nurses

About two years ago, a psychiatric patient at Providence St. Vincent Medical Center in Portland, OR, hung herself with the belt of her robe after being in the ED for an extended period. The patient survived and had no permanent adverse effects, but the way the incident was handled ultimately made the ED safer.

First, instead of blaming or punishing the ED nurses involved in caring for the patient, a debriefing was done to give them support. "Our ED management team approached this event in a very scientific and nonjudgmental way," recalls **Wayne Schmedel**, RN, an ED nurse at Providence St. Vincent. "We focused on a systems analysis, rather than on specific staff or personalities."

The ED's root-cause analysis revealed inconsistencies in the way potentially suicidal patients were assessed. This "spoke loud and clear that although errors can happen, it is in the best interest of each of our current patients, and even more so with our future patients, that as a team we can learn from our errors," he says.

A recent *Sentinel Event Alert* from The Joint Commission recommends a policy of "transparency" that permits staff to report near misses and mistakes without fear of reprisal. *(Editor's note: To access the complete* Alert, *go to www.jointcommission.org. Under "Sentinel Event," click on* "Sentinel Event Alert" *and then "Issue 43: Leadership committed to safety.")*

If you take a punitive approach, ED nurses will be less likely to report an

EXECUTIVE SUMMARY

If ED nurses can report near-misses and mistakes without fear of reprisal, patient safety is improved because staff members are more likely to be up front about these incidents. A new *Sentinel Event Alert* from The Joint Commission encourages this practice. To improve patient safety:

- Focus on systems instead of specific individuals.
- Ask nurses to present their own errors during staff meetings.
- Address underlying facts and background information.

incident, says **Mary J. Ross**, RN, BSN, CEN, a senior partner at the Emergency Medical and Trauma Center at Methodist Hospital in Indianapolis. Methodist's ED holds a "Safe Passage" monthly meeting on patient safety attended by nurses, physicians, residents, managers, and directors. "If an error occurs, we try and have the nurse who made it present it to the group. The nurse presenting often comes away feeling very supported," she says.

When an error is presented, a "first story/second story format" is used. "The 'first story' is the actual incident," says Ross. For example, an ED nurse recently gave the wrong antibiotic to an admitted patient with pneumonia, even though the correct medication was clearly written on the admission order sheet.

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The "second story" is all the facts and background information that were *not* included in the incident report. "This is obtained by interviewing the nurse or nurses involved in the error. You focus on any and all things that may have led to the error, including staffing, experience, or time of day," says Ross. For the above incident, these additional facts were considered:

- An experienced charge nurse with more than 20 years of experience in the ED was involved. "The nurse who made this mistake was accustomed to always giving vancomycin for pneumonia," says Ross. "This was the type of mistake only a very experienced nurse would have made."
- The area was extremely busy. Three ED nurses were covering a 13-bed area with five patients in the hallway waiting for treatment on the noncritical care side. The third nurse was pulled to perform a sexual assault exam, so the charge nurse took over her assignment.

As part of the ED nurse's presentation on this error, an article on "inattentional blindness" from an Institute for Safe Medication Practices publication was reviewed. *(Editor's note: To read the article, go to www.ismp.org. Click on "Newsletters," "Acute Care Edition," and "Past Issues." Under the 2009 heading, click on "February 26" and then scroll down to "Inattentional blindness: What captures your attention?")*

"This showed everyone that regardless of experience, anyone can make an error. It made the nurse feel a lot better," says Ross. "One recommendation that came out of this was to encourage the nurse to scan the orders to pharmacy and have pharmacy prepare all admission meds. A second set of eyes is always good."

Debbie Stubblefield, RN, an ED nurse at Baptist Memorial Hospital — Desoto in Southhaven, MS, says ED nurses must "shift from the thought process of

SOURCES

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'telling on a team member' to 'that would be a mistake anyone could make unless we change the way we do things.' A clinical error is an opportunity to improve our processes and outcomes, as opposed to assigning blame." ■

Don't be the one to destroy important forensic evidence

Your clinical assessment and interventions might save a gunshot victim's life, but there is another important concern: that of forensic evidence.

"Remember, your patient is the crime scene," says **Ann Heywood**, RN, BSN, CEN, SANE, trauma nurse coordinator for the Emergency Care Center at Champlain Valley Physicians Hospital Medical Center in Plattsburgh, NY.

According to **Sheila R. Briggs**, RN, BSN, BSW, SANE-A, MEI, clinical nurse III, domestic violence and sexual assault educator for the ED at St. Joseph Mercy Hospital in Ann Arbor, MI, when caring for a gunshot victim, "each person is responsible for evidence preservation and documentation."

Heywood adds that "when handling any item that may have evidentiary value, limit the opportunities for that item to be contaminated." She recommends the following:

• When removing your patient's clothing, handle each item with a new set of clean gloves. "Place each item in its own bag, to prevent cross-contamination of evidence. We do not want blood from a shirt contaminating the pants," says Heywood.

• Place each item of clothing in a separate paper bag and document this. "Place the clothing items in bags as they come off the patient. Don't pile the clothing up on the floor," says Heywood.

EXECUTIVE SUMMARY

To avoid contamination of forensic evidence when caring for gunshot victims, emergency nurses must do the following:

- Handle each piece of clothing with a new set of clean gloves and place in separate paper bags.
- Place injury-site dressing in a labeled brown paper bag.
- Place brown paper bags over each hand, marked "right" and "left."

CLINICAL TIP

Swab injury site with sterile swab

Use a sterile swab, moistened with sterile water, to swab a gunshot injury site, says **Sheila R. Briggs**, RN, BSN, BSW, SANE-A, MEI, clinical nurse III, domestic violence and sexual assault educator for the ED at St. Joseph Mercy Hospital in Ann Arbor, MI.

"Normal saline has salt in it, and this will break down potential DNA," she explains. "This swab contains important forensic evidence and should be sealed in an evidence kit envelope or brown paper bag." ■

• Assign one staff member to label and seal each bag of evidence. "You want to minimize the number of staff involved in handling the evidence as much as possible," says Heywood.

Recently, Heywood rolled over a gunshot victim and a bullet fell into an ED nurse's hand. "If a bullet is found, we must promptly secure this vital piece of evidence," says Heywood. Take these steps, she advises:

• With a clean glove, place the bullet in a nonmetallic container such as a urine specimen cup.

• Seal it, label it, and secure it.

• Document the time it was recovered, the time it was secured, who found it, and who picked it up and secured it.

Use these collection tips

Often, a gunshot wound patient arrives with a sterile 4x4 dressing over the injury site. "This particular dressing may contain gunshot residue. It should be placed in a brown paper bag and labeled," says Briggs.

Document the name of the person who collected the items, a description of each article collected, the total number of sealed brown bags, and who released the articles collected to whom. "Also include the police agency involved and the case number, when available," says Briggs. Here are other tips to preserve forensic evidence with gunshot wounds:

• **Prepare the room.**

If you are notified that a gunshot victim is coming to your ED, Heywood says to have brown paper bags,

SOURCES

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clean gloves, sterile urine cups, a camera, and chain of evidence forms available. "Ask a SANE nurse to prep the staff on evidence preservation," she says.

Place brown paper bags over each hand, marked "right" and "left."

"Until it is determined by the medical examiner that this is not warranted, this procedure should occur," says Briggs. "Tape should be placed around the bag, not on the skin of the patient. If the bags become soiled or wet, new bags should be placed over the existing bags."

• Pay attention to "verbal forensics."

"Excited utterance by patients when they are in a hyper adrenaline rush can provide important information," says **Terry O'Shea**, RN, CCRN, an ED nurse at Providence Portland (OR) Medical Center. "Listen to the patient's or the family's babbling or blurting. Take note of what patients and families are saying to each other."

Instead of summarizing what the patient states happened, use direct quotes. These comments made by a patient are considered "excited utterances" and may be admissible in court, says Briggs.

• Roll the patient so that the exit wound is visible.

O'Shea says, "It can indicate the trajectory of the bullet, which can be helpful in evidence. If the bullet did not exit the body, a lot more damage can be present. If a 'blowout hole' is considerably larger than the entrance wound, the patient could bleed to death."

[The evidence collection guidelines used by ED nurses at St. Joseph Mercy Hospital are included with the online version of this month's *ED Nursing*. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com. Also, see related stories on swabbing the injury site, p. 3, and cutting clothing, below.] ■

Follow these steps when cutting clothing

Are you about to cut off a gunshot victim's clothing to visualize the extent of their injury? Consider these tips from **Sheila R. Briggs**, RN, BSN, BSW, SANE-A, MEI, clinical nurse III, domestic violence and sexual assault educator for the ED at St. Joseph Mercy Hospital in Ann Arbor, MI:

• Cut in areas that aren't near the point of entry of the gunshot wound. "Take extra care to be precise about the cutting of the fabric," Briggs says.

• Document who cut and removed the patient's clothing.

• If clothing is removed from the patient and discarded to the floor, designate one person to take possession of the clothing worn by the patient.

• Place each single article of clothing in a separate brown paper bag.

• Do not use plastic bags for evidence preservation. "The items need to be able to 'breathe.' In plastic, bacteria will form, and potential DNA will be destroyed," says Briggs.

If you are the person collecting the clothing, document this information on the outside of each bag: The full name of the patient, the medical record number, the date of birth of the patient, the date of collection, a description of the item collected, and the full name of the person collecting the item.

"Care should be taken to fold over the top of each bag and secure it with tamper-proof tape," says Briggs. "The seal of the tape should be dated and initialed by the person collecting and sealing each item." ■

Use these practices to stop stroke treatment delays

Would it surprise you to learn that delays in treatment for stroke patients in the emergency department haven't changed significantly in the past few years?

"We summarized studies that examined delay in the emergency department. Overall, based on 10 studies of 12 different population samples, the analysis indicated no decline" in the time from the patient's arrival in the ED to evaluation, says **Kelly Evenson**, PhD, the study's

EXECUTIVE SUMMARY

Early recognition and training on Stroke Alert protocols are two ways ED nurses have reduced delays in stroke care. Other effective approaches:
- Immediately alert ancillary staff.
- Use standardized treatment orders.
- Follow up on test results.

lead author and a research associate professor in the Department of Epidemiology at Gillings School of Global Public Health at the University of North Carolina in Chapel Hill.[1]

Lorraine Salavec, MS, RN, CEN, patient care manager for the ED at Norwalk (CT) Hospital, says that "the key to reducing delay in the treatment of stroke care is early recognition of signs and symptoms." Norwalk's ED nurses use a two-step triage process to identifying patients with signs and symptoms of stroke.

"A nurse greets all patients, which supports identifying any patient with stroke symptoms. Upon the determination that there is a high probability of stroke, our process for these patients is to call a 'Stroke Alert,'" says Salavec. "This mobilizes all members of the team to allow the patient to be diagnosed and treated expeditiously."

E. Scott Metzel, RN, BSN, MA, neuroscience outreach coordinator at Alaska Regional Hospital in Anchorage, says that at his hospital, ED nurses now are required to complete the National Institute of Health Stroke Scale Certification. "Our nurses have also received education on screening the patient for potential risk for aspirating," he adds. "If the patient has a facial droop, difficulty swallowing, or decreased level of consciousness, it prompts the ED nurse to request a formal speech therapy swallow study. The patient will remain 'nothing to eat or drink by mouth' until that official swallow study is completed."

Alaska Regional's ED nurses have been trained on the use of Stroke Alert Protocols to expedite the CT scan, with a goal of 20 minutes from door-to-CT and 45 minutes from door to the radiologist interpreting the results.

"Once a Stroke Alert is called, ED nurses can shave more time off by making sure the ancillary staff are in place to expedite the CT, lab tests, and neurosurgeon," says Metzel. "This is done through our pager system, so the team is in and ready. It is essential for the ED nurse to follow up on the tests, to ensure we get the results in a timely manner." **(See related story on use of stroke pathways in the ED, above right.)**

Reference

1. Evenson KR, Foraker RE, Morris DL, et al. A comprehensive review of prehospital and in-hospital delay times in acute stroke care. *Int J Stroke* 2009; 4:187-199. ■

Pathways are key to reducing delays

The key to rapidly responding to a stroke patient in your ED, "is to have an automatic, standard process in place," says **Lisa Hardy**, MSN, CRNP, an ED and stroke team nurse practitioner at Huntsville (AL) Hospital. "Having a standard stroke protocol is a must," she says.

Your ED's stroke protocol should include point-of-care labs, standard labs, intravenous (IV) lines, getting the patient to CT within 20 minutes, and preparing for IV thrombolytic administration or possibly radiologic intervention such as MERCI retrieval, says Hardy.

"Rapid assessment and identification of a potential stroke patient is the first step," says Hardy.

Hardy adds that the Cincinnati Prehospital Stroke Scale or the Los Angeles Prehospital Stroke Screen "should be familiar to every ER nurse. Any one of the following symptoms should prompt the nurse to think stroke: facial droop, arm drift or speech difficulties.

SOURCES

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These patients should be immediately triaged to a bed."

Huntsville Hospital became a Joint Commission Primary Stroke Center in September 2008. "Prior to our certification, we put a standard response in place that began in the ED," says Hardy. When a potential stroke patient meets the clinical criteria, a Stroke Alert is activated that pages CT, the lab, the pharmacy, the on-call neurologist, the nurse practitioner, the critical care supervisor, the ED charge nurse, and the neurological intensive care unit.

ED nurses have a goal to get the patients' head CT completed within 40 minutes. "Usually, the nurse practitioner or neurologist is watching the CT as it's performed and can determine whether or not the patient will get tPA [tissue plasminogen activator]," says Hardy. "Since putting into place our standard stroke response, we have been able to quickly identify and reach many more patients that qualify for tPA therapy within the time window. Our nurses know the protocol, treat these patients as emergent, and are able to anticipate what they need to do to help our stroke patients achieve the best possible outcome."

At Indian River Medical Center in Vero Beach, FL, patients who present to the ED with certain neurological symptoms or complaints, including sudden weakness, sudden difficulty speaking, sudden vision changes, difficulty with speech, sudden loss of balance, sudden paralysis, and sudden onset of numbness, are placed on a Stroke Clinical Pathway.

"This is a set of standardized treatment orders that meet certain performance measures," says **Emilia Andrascik**, RN, CEN, preceptor for emergency services. "These measures have been proven to foster better quality of care and outcomes for stroke patients."

ED nursing interventions included in the clinical pathways include assessment of blood glucose, comprehensive neurological assessments, screening patients for potential thrombolytic therapy, and swallowing evaluation. "These are just a few of the nursing and diagnostic interventions that assist the medical team in quickly evaluating symptoms and initiating the Stroke Clinical Pathway," she reports.

Indian River's ED nurses use a "Stroke Alert" process, which is a multidisciplinary team approach to rapid initiation of diagnostic studies. "For instance, if the triage nurse calls a Stroke Alert, the primary nurse begins the Stroke Pathway. The physician is notified immediately that a potential stroke patient has presented for treatment," says Andrascik. "The laboratory and radiology departments both respond, as part of the team to begin diagnostic evaluation."

Once the radiology department is contacted, all stroke patients receive the highest priority for CT scan. "All these measures ensure that the patient is diagnosed as rapidly as possible," says Andrascik. "This significantly reduces any potential delay in stroke care." ■

Could your co-worker be diverting pain meds?

You must take immediate action

An ED nurse recently was arrested on suspicion of stealing fentanyl intended for patients at a Denver hospital. It's not known whether her co-workers suspected the problem and failed to alert management, but unfortunately, that is often the case.

"Many times, ED nurses choose to not recognize telltale signs of a co-worker's challenge. Or, they simply do not know the signs and symptoms or that their colleague has a problem," says **Donna Sparks**, MSN, RN, CEN, director of emergency services at Baptist Hospital Miami.

If you suspect a colleague is diverting narcotics, Sparks recommends having "an immediate, confidential conversation with a trusted manager." If you fail to act, she says, "the person that suffers could be a patient impacted by the impaired nurse's altered judgment."

"There may arise an opportunity for a nurse to honestly confront a colleague who is stealing painkillers," says Sparks. "Some nurses have extensive experience in addictions and know their organizational policy for getting their colleague the help she needs."

However, in most cases, you should confidentially consult with a trusted nursing manager about suspicions regarding the theft of medications, says Sparks.

According to **Sandra Dietrich**, RN, MSN, MHA, clinical director of emergency services at the Hospital of the University of Pennsylvania/Penn Presbyterian Medical Center in Philadelphia, your co-worker could be diverting pain medications if he or she:

• frequently offers to give pain medication for co-workers. "It should be the exception, and not the rule,

EXECUTIVE SUMMARY

If you suspect a colleague is diverting narcotics, your first action should be to report this to a trusted manager. Other necessary steps:

- Insist on visualizing wastage as a witness.
- Ask why a higher dose than ordered was removed.
- Watch for frequent bathroom use or changes in mood or mental status.

CLINICAL TIP

Follow this process for narcotics wastage

One of your emergency nursing colleagues asks you to witness medication wastage, but asks you to sign off without actually observing the wastage. She tells you that it will save time, or that the wastage already was done. What do you say?

"As a witness for medication wastage, *insist* upon reviewing the medication and dose ordered. Then, *visualize* the wastage," says **Sandra Dietrich**, RN, MSN, MHA, clinical director of emergency services at the Hospital of the University of Pennsylvania/ Penn Presbyterian Medical Center in Philadelphia.

When witnessing wastage of narcotics with a colleague, it is imperative that you diligently follow your organizational policy. **Donna Sparks**, MSN, RN, CEN, director of emergency services at Baptist Hospital Miami, says, "This must be done for *every* patient, *every* medication administration, *every* time.

"Many nurses have enabled their trusted colleague's drug diversions by signing that they have witnessed a wastage when they did not, usually because they were busy and trust the colleague. Nurses are accountable to the profession for following ethical behaviors. This includes the witnessing of narcotic wastage according to policies." ■

that the primary nurses have co-workers medicate their patients," says Dietrich;

• offers to dispose of pain medication cartridges or syringes;

• withdraws higher doses of pain medication than ordered, so that wastage needs to occur. "If the dose ordered is lower than the medication removed, ask why the higher dose was removed," says Dietrich. **(See related story, above, on the process to follow for medication wastage)**;

• shows a change in behavior or mental status during the shift;

• frequently needs to use the bathroom, or steps outside of the unit after medicating patients;

• falls asleep during the shift or while documenting;

• displays subtle changes in mood that are blamed on personal problems.

If you suspect a co-worker is impaired, Dietrich says to take these three steps immediately:

• Inform your nurse manager or supervisor about your concerns and observations. Ask them to respond to the unit.

• Ask two co-workers to witness that the employee is falling asleep, preferably including a manager or supervisor.

• Follow your ED's policy on impaired employees. "Once an employee is suspected, the situation becomes an administrative/human resource issue. There are specific guidelines to be followed," says Dietrich. ■

SOURCES

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Do you treat pediatric UTIs inconsistently?

Children with urinary tract infections (UTIs) are treated surprisingly differently across hospitals, according to a new study.[1] Researchers looked at 20,892 children between the ages of 1 month and 12 years old hospitalized for UTIs at 25 children's hospitals between 1999 and 2004. They found significant variability for length of stay and tests performed.

"The high degree of variability in care was surprising," says **Patrick H. Conway**, MD, one of the study's authors and an assistant professor of pediatrics at University of Cincinnati College of Medicine. "The largest area of variability in EDs is the decision whether to admit children from the ED to the hospital. Some EDs admit almost all children under a certain age such as 6 months, whereas other EDs are comfortable sending children home on oral antibiotics."

Cynthia Anderson, RN, BSN, clinical educator for the ED at Children's Hospitals and Clinics of Minnesota in Minneapolis, says, "The ED nurse plays a

EXECUTIVE SUMMARY

To expedite care of a urinary tract infection (UTI) in your pediatric patient, perform a focused assessment. Your questions should cover:
- voiding patterns and pain;
- presence of fever, fussiness or foul-smelling diapers;
- history of previous UTI.

critical role in making sure the child receives proper diagnosis and the right treatment in a timely manner."

Having a focused assessment and a urine specimen are "excellent ways to expedite the care" of a child with a suspected UTI, according to **Cam Brandt**, RN, MS, CEN, CPEN, CPN, education coordinator of emergency services at Cook Children's Medical Center in Fort Worth, TX.

A child with a UTI might present with a chief complaint of "problems urinating," "burning when urinates," or even back or abdominal pain, says Brandt. "Knowing that these are symptoms of several genitourinary complaints, your focused assessment would include questions regarding voiding patterns and pain, and in the nonverbal child, questions responding to presence of fever, fussiness, and foul-smelling diapers," says Brandt. "A history of previous UTI is also a significant finding."

Anderson says to ask these questions if you suspect a child has a UTI:

• Does it burn or is it hot when the child urinates?

• Do they have to go frequently or never feel like they are done?

• Do they feel like they have to go all the time, but it is only small amounts?

• Does it smell funny when they urinate?

• Has the child has ever had a UTI in the past?

Anderson says ED nurses have a protocol order to obtain and send a urine sample to lab for analysis and culture, if the symptoms suggest a UTI and the patient is able to provide a clean catch specimen.

"When the triage team recognizes that this may be a UTI diagnosis, they work to obtain a urine sample so the results are returned quickly. This expedites treatment," she says.

Brandt advises obtaining the first available urine sample, as a child with a UTI might hold their urine until they are incontinent or at the very least, will not be able to wait while a doctor's order is obtained. "Antipyretics for fever are generally given in the child over 2 months of age. The exception is the child 2 months and under," she says. "Fever in the young infant is an emergent finding. UTI is a common cause for fever, and care should be expedited."

Brandt gives two examples to show how the ED nursing assessment differs:

• A 3-week-old presenting with fever and "drawing up knees when urinating" would be considered an emergency.

"The triage nurse would obtain birth history and other information including length of complaint, maximum temperature, and parent's perception," says Brandt. The focused assessment includes a primary survey; vital signs, especially rectal temperature; and a Face/Legs/Activity/Cry/Consolability (FLACC) pain scale. The diaper is checked for the presence of unusual odors, discharge, and/or blood. "Nurses need to prioritize this child to be seen quickly, and anticipate lab work and catheter urinalysis," says Brandt.

• For a 6-year-old with a complaint of pain and burning, the triage nurse would include questions on previous history of UTI, current medications, presence of discharge in the underwear, and questions involving genitourinary trauma, such as the possibility of a straddle injury.

"A urine cup, cleaning wipes, and instructions on obtaining a urine sample should be given to the parent at this time," says Brandt. "Cloudy, dark, or malodorous urine is suspective of UTI."

Reference

1. Conway P, Keren R. Factors associated with variability in outcomes for children hospitalized with urinary tract infection. *J Pediatr* 2009; 154:789-796. ■

SOURCES

For more information about treatment of urinary tract infections, contact:

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Get a better history from a sick or hurt child

What you learn can be lifesaving

The history given to **Melea Anderson**, DNP, MS, RN, CNP, critical care practice lead/trauma program manager at Children's Hospitals and Clinics of Minnesota in Minneapolis, seemed straightforward. The parent stated that the child had had ear pain for the last week, with no fever or other symptoms.

"I performed the physical exam. Upon approaching the child's ear with the otoscope, the child whispered to me, 'Can you see the rock in my ear?' The parent was unaware that the child put a small pebble in his ear while playing at the park a week ago," she recalls.

When obtaining a history on a pediatric patient, include the child, recommends **Elaine Beardsley**, MN, RN, CPEN, ED clinical nurse specialist at Seattle Children's Hospital.

At triage for a 5-year-old boy with vomiting and headache for about 10 days, Beardsley asked the mother when the headache was there. "The mom said throughout the day. The boy added some more information that it is 'most bad' when he wakes up," says Beardsley. Based on that information, I did a more detailed neurological assessment and conveyed my concerns to the physician. The boy was diagnosed with a brain tumor." Here are tips to obtain a better history from a child:

• Ask children to point to the pain.

A child might indicate that their entire abdomen hurts. "But if you ask them to point with one finger to *where* it hurts, they will point to the right lower quadrant, for example," says Lisa Newton, RN, an ED nurse at Phoenix (AZ) Children's Hospital.

•Ask open-ended questions.

"When asking children for information, try to avoid questions that the child could answer with a 'yes' or 'no,'" says Newton.

The best practice is to allow the children to participate to the extent they wish to, says Anderson. "You have some pediatric patients that will give you endless amounts of information, and others that will not say a word and will allow their parents to answer all questions," she adds.

• Ask children to describe their bowel movement.

"Asking a child when they last had a bowel movement cannot always rule out constipation if the answer is today," says Newton. "Often children with constipation will have multiple bowel movements that are like small rocks, or they may have an impaction and stool is squirting around it. When concerned about constipation, I always ask when was the last bowel movement and was it normal, like rocks, or toothpaste."

• Avoid terms that can make children anxious.

"Saying the word 'stitches,' 'needles,' or 'shots,' can be very anxiety-provoking, even in children who have never had a previous experience with sutures," says Anderson. She recommends saying the following instead: "We are going to use some cold numbing jelly to help make your cut not hurt. When we fix your cut, we are going to use some soapy stuff to clean and then squirt it with a special squirt gun to also clean it. When we are all done, you can take the special squirt gun home. When we fix your cut, you will see some string that we use to fix your cut. You will see a scissor that we use to cut the string and another thing that kind of looks like a scissor to hold the string."

• Give a child choices when possible.

Anderson gives these examples: Ask,"Which ear should I look in first: This one, or that one?" or "Do you want to drink your medicine from a little cup, or squirt it in your mouth with a syringe?"

"Either way, they need to take their medicine, but they can choose which way they prefer to take it," Anderson

EXECUTIVE SUMMARY

Include the child when obtaining a history, as information you learn can be potentially life-saving. Some ways to do this:

- Ask children to point to where it hurts.
- Ask the child to describe their bowel movement.
- Let children choose the way they take oral medication.

CLINICAL TIP

To assess a child, listen to mom first

Try this "trick" at triage to assess the breath sounds of toddlers with stranger anxiety:

"Pretend to listen to the mom with the stethoscope first, *then* the child," says **Lisa Newton**, RN, an ED nurse at Phoenix (AZ) Children's Hospital. "If the child only allows me to listen for a short time, I will go back to 'mommy's turn.'" ■

SOURCES

For more information on obtaining a history on a pediatric patient, contact:

- **Melea Anderson**, DNP, MS, RN, CNP, Critical Care Practice Lead/Trauma Program Manager, Children's Hospitals and Clinics of Minnesota, Minneapolis. Phone: (612) 813-8890. E-mail: melea.anderson@childrensmn.org.
- **Elaine Beardsley**, MN, RN, CPEN, Clinical Nurse Specialist, Emergency Department, Seattle Children's Hospital. Phone: (206) 987-4590. E-mail: elaine.beardsley@seattlechildrens.org.
- **Lisa Newton**, RN, Emergency Department, Phoenix (AZ) Children's Hospital. Phone: (480) 206-2194. E-mail: lnewton@phoenixchildrenshospital.com.

says. "This gives them a sense of control." **(See another tip to help with assessment of a pediatric patient, p. 9.)** ■

Don't get sued for missing an abdominal aneurysm

A young mother presented to an ED with abdominal pain, tachycardia, and hypotension, but after 45 minutes, she still had not been seen.

"Her mother went to the triage desk and asked when she would be evaluated, as she was in excruciating pain. The nurse visualized the patient and said she didn't know, as they were very busy," says **Elisabeth Ridgely**, RN, LNCC, a Telford, PA-based emergency nurse and legal nurse consultant. "Witnesses in the waiting area confirmed that the patient was complaining of a lot of pain."

Another 45 minutes or so went by, and the patient still was not seen. A second set of vitals was not taken, and no further information was provided. "The patient at some point had considered leaving the emergency department because of the wait and had inquired about another facility," says Ridgely. "Although there was no indication that the patient actually left this particular emergency department, another three hours went by before she was called to be seen."

By that point, the patient's pain had subsided and she had left just prior to being called. "While en route, she became unresponsive and was taken to another facility by her mother. Upon arrival, she coded. This was approximately four hours after the initial presentation to the first emergency room. She did not survive, and the cause of death was determined to be an abdominal aneurysm."

The ED nurses at the first facility were named in a subsequent lawsuit, and the case is pending.

Abdominal aortic aneurysm (AAA) is a painless dilation of the aorta secondary to weakening of all layers of the aortic wall, says **Melissa Gaines**, RN, education clinical coordinator for emergency services at Sts. Mary & Elizabeth Hospital in Louisville, KY. "Once leaking or dissection starts to occur, the intense abdominal pain can be confused with pain of a renal

EXECUTIVE SUMMARY

Patients with aortic abdominal aneurysm often report sudden, severe abdominal pain radiating to the back, but patients also might present with subtle signs. To improve care, remember that:

- blood pressure must be monitored;
- patients might present with lower back pain and/or flank pain;
- patients might have stable vital signs.

CLINICAL TIP

Suspect AAA for these two pain complaints

"Though prompt recognition of AAA [abdominal aortic aneurysm] rupture by its cardinal signs and symptoms is commendable, it may be too late for the patient," says **James Cortez**, RN, BSN, CEN, an ED charge nurse at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

Identifying the patient who presents with subtle signs and symptoms of an imminent AAA rupture or dissection "is where ED nurses can make a big difference," he says. "A complaint of lower back pain and/or flank pain, with no history of injury or kidney stones, should not be ignored, especially when the patient is a male over the age of 60 and when the patient's pain relief is not easily attained." ■

stone during the triage assessment," Gaines says.

Christopher Cope, RN, associate nurse manager of the ED at Jewish Hospital Medical Center South in Hillview, KY, says, "Warning signs of AAA are sudden severe abdominal pain radiating to the back. Some patients may be in shock when they arrive with hypotension, tachycardia, cyanotic, and altered mental status."

The classic description of AAA is usually "tearing" or "ripping" pain that radiates to the back, leg, or kidney, notes Gaines. "However, nonclassic symptoms could indicate a AAA if a patient is age 60 or older; complains of low back pain; has a history of hypertension, smoking, diabetes, or elevated cholesterol; and a fall or trauma has been ruled out. The back pain will not relieve with position changes."

Gaines recommends monitoring your patient's blood pressure and "carefully administering narcotic pain medication, to avoid manifesting hypotension especially in a leaking rupture."

Subtle signs might result in mistriage, misdiagnosis, and poor outcomes, warns Cope. "Patients can complain of lower back pain, flank pain, abdominal pain, and have stable vital signs that would lead you to think kidney stone or something much less serious," he says. "The patient may end up in the waiting room and could potentially die if treatment was delayed." **(See tip on p. 10 about subtle signs of AAA.)** ■

CNE instructions

Nurses participate in this continuing nursing 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 **December** 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. ■

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.

17. Which should be done to preserve forensic evidence for gunshot victims?
A. Place all pieces of clothing together in a single brown paper bag.
B. Place each piece of clothing in a separate plastic bag.
C. Place the patient's sterile 4x4 dressing in a brown paper bag.
D. Avoid swabbing the gunshot injury site with a sterile swab moistened with sterile water.

18. Which is an effective practice to reduce stroke delays?
A. Giving ED nurses training on the use of Stroke Alert protocols.
B. Avoiding the use of the National Institute of Health Stroke Scale.
C. Having staff other than ED nurses follow up on test results.
D. Using standing orders for blood glucose levels, but *not* for neurological assessments.

19. Which is recommended when witnessing narcotics wastage?
A. It's acceptable to sign off without observing wastage to save time.
B. It's not necessary to review the medication and dose ordered, only to visualize the wastage.
C. Under no circumstances should you sign that you witnessed a wastage when you did not.
D. If a higher dose than ordered was removed, this is not concerning as long as the wastage is witnessed.

20. Which is true regarding patients with abdominal aortic aneurysm?
A. Back pain will be relieved if the patient changes position.
B. Patients with "nonclassic" symptoms are usually younger.
C. Patients will not have stable vital signs.
D. Patients might complain of lower back or flank pain.

Answers: 17. C; 18. A; 19. C; 20. D.

COMING IN FUTURE MONTHS

- Revamp the way you triage pediatric patients
- Use a "stroke packet" to dramatically improve care
- Effective ways to protect yourself from assault
- Avoid dangerous mistakes that harm "boarded" patients

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PS Form **3526**, September 1999 *(Reverse)*

SJMH TRAUMA GUIDELINES

Evidence Collection Guidelines

SJMH Trauma Program
Department of Surgery
Guideline Number **G-210.0**

Effective Date: 12/97
Revised Date: 01/04
Reviewed Date: 12/03

To ensure that evidence is collected and chain of custody is established and maintained, (in cases involving potential criminal and/or civil litigation) evidence will be:

1. Placed in a brown paper bag from evidence kit. (Evidence kits are kept in the ER, OR, and SICU).
2. Properly labeled with **Evidence Sticker**.
3. Sealed with **tamper-proof evidence tape** (after **Property Sheet** listing all contents is attached.)
4. Kept in the continuous and secure possession of one accountable individual until the evidence is either turned over to law enforcement, turned over to the Medical Examiner, or deposited in the evidence locker in the Security Office by a Security Officer.

KEY POINTS

- Persons collecting evidence will have received prior training in the process of evidence collection. **All persons outside of the Emergency Department or Operating Room should contact security to complete this process.**
- Associates will retain all clothing (including shoes), medication bottles, and any other objects accompanied by the patient and place in an evidence bag. Document all items on Property Sheet. **Do not discard or release personal articles to family.** Law enforcement and/or the Medical Examiner (ME) will determine if items are to be returned to the patient or family.
- Persons who collect evidence will be accountable for proper handling and disposition to the appropriate law enforcement agency involved in the investigation. If law enforcement has been called and cannot respond in a timely manner to pick-up the evidence, it should be transported by Security to the evidence locker.
- In the event that evidence must be turned over to another individual, (e.g. turning it over to Security for transport to the evidence locker), the evidence sticker on each evidence bag must be signed by the person taking over. Use additional stickers if necessary.
- Never open a sealed evidence bag.
- Never cut through existing holes or tears in clothing that were possibly made by penetrating objects.
- If evidence is soaked with body fluids, place each article in a double brown paper bag. The paper bag may be placed in a plastic bag prior to transport. The plastic bag should never be closed.
- Do not cleanse gunshot wounds because trace evidence can be cleansed away. Do not wash patient's hands until cleared by law enforcement to do so. Once the patient is admitted to the hospital, the caregiver should verify with law enforcement or Emergency Department staff that evidence collection has been completed prior to cleansing the patient. When evidence collection is complete and permission has been obtained to wash the patient, this should be noted in the patient's chart.
- **Security will be responsible for controlling all access to the evidence locker.**

Disposition and Transportation of Evidence: Living Patient

A. **If a law enforcement officer is present, the sealed evidence bag should be turned over to him or her**. This must be documented in the nursing notes and on the property sheet. The law enforcement officer must sign the property sheet in the space provided and also sign each evidence sticker (on brown paper bag/s).

B. If a law enforcement officer is *not* present, notify the primary agency involved in the case and **request that an officer pick up the evidence**. Evidence waiting to be picked up must be kept in the custody of the accountable person at all times. If a law enforcement officer is not available to pick up the evidence in a timely manner, contact Security to secure the evidence in the evidence locker.

Disposition and Transportation of Evidence: Deceased Patient

A. **Care of the body**. Notify law enforcement officer and Medical Examiner Investigator (MEI) *immediately* upon the patient's death, to complete their investigation. If officers or MEI are not immediately available and the body must be moved, permission should be obtained from the MEI to move the body. All efforts should be made to preserve the body *exactly* as it was at the time of death. To keep evidence intact:

I. Minimize handling of the body.
II. Refrain from traditional postmortem cleansing.
III. Do not disturb debris, powder, glass or other trace evidence in a wound or on the body.
IV. **Invasive lines must be kept in place and secured with tape.** Identify and document all treatment attempts or other invasive therapeutic marks on the patient's body (e.g., incisions and needle punctures). Circle therapeutic wounds with marker and put "TX" next to them.
V. Encase the deceased's hands in paper bags to preserve evidence on hands or fingertips (e.g., gunpowder, skin, blood.)
VI. **No viewing of the body by family unless authorized by MEI and/or law enforcement officer.** If viewing is authorized, document this and who gave authorization in the nursing notes. If the family or other person views the body, an associate must be present to ensure there is no tampering with the body or potential evidence.
VII. The original transport bed sheet should remain under the body.
VIII. When it is necessary to remove any clothing from the body, place it in an evidence bag and secure and label as appropriate. After the patient is pronounced dead, all remaining clothing should be left on the body.

B. Security must accompany the body to the morgue.

DOCUMENTATION:

Do not make forensic interpretations (e.g. "entrance wound" or "exit wound.")
Use descriptive terms (e.g. "Approx. one cm. oval wound.")
Document scissor cuts or tears done by staff on the medical record and property sheet.

Source: St. Joseph Mercy Health System, Ann Arbor, MI.

SJMHS Patient Care Policy

Evidence Preservation, Collection, and Storage

SJMH
Care of the Patient
Policy Number 210.1

Effective Date: 12/01/97
Revised Date: 12/17/03, 05/09/07
Reviewed Date:

Approved by: Garry C. Faja, President & CEO

Policy

The purpose of this policy is to describe the proper preservation, collection, documentation, and disposition of evidence in cases involving potential criminal and civil litigation, and to ensure maintenance of the chain of custody. The chain of custody (who collected, who received) is the path the evidence takes from the time it is retrieved until it has served its purpose in the investigative process. The chain of custody assures that the evidence collected is authentic and in the same condition as when first obtained.

Definitions

Evidence - Describes "data presented to a court or jury to prove or disprove a claim." This also includes physical findings, observations about the patient's behavior, overall appearance, and unusual odors. Physical/Forensic evidence is real, tangible, or latent matter that can be visualized, measured, or analyzed for information. Wounds from penetrating objects, abrasions, contusions, and lacerations are all physical evidence. Any belongings, body parts or fluids, or foreign objects removed from the patient or patient wounds are considered evidence.

Excited Utterance – Verbal responses by the patient or reported accounts of the circumstances surrounding the event and past medical history obtained by EMS, witnesses, family and/or police. These need to be documented in the medical record.

MEI – Medical Examiner Investigator

Trace evidence - Small or microscopic physical evidence.

Procedure

1. The focus of this procedure is preservation of evidence so that those individuals with training in evidence collection and forensics can complete the evidence collection process. Anyone not receiving prior training in the process of evidence collection as outlined in this policy should contact Security before proceeding. **All persons outside the Emergency Center, SICU, or Operating Room should contact Security to complete this process.** For all cases involving alleged sexual assault, contact the Sexual Assault Response Team (SART) 24/7 at 734.817.3463. The SART staff will handle the evidence collection and documentation process.

2. While wearing disposable gloves, associates will retain all clothing (including shoes), medication bottles, and any other objects that accompanied the patient and place **each item** into a **separate** evidence (brown paper) bag. Do not discard or release personal articles to family. The evidence bag will be sealed with tamper-proof red evidence tape and labeled with an evidence sticker (see Appendix B). Information on the evidence sticker should include: the bag number, patient name, patient medical record number, your name, date and time sealed. Be sure to record identifying information about these items on the property sheet (see Appendix C). Every item must be listed on the property sheet and a copy secured to one of the evidence bags. If additional items are found once the evidence bags are sealed, you must begin an additional bag. Begin a new property sheet if needed.

3. Never open a sealed evidence bag once it has been sealed.

4. In the event that evidence must be turned over to another individual, the evidence sticker on each evidence bag must be signed by the person taking over possession of the evidence. Use additional stickers, if necessary, and attach on bag near but not covering the original sticker. **Maintain the legal chain of custody.**
5. Never cut through holes or tears in clothing possibly made by penetrating objects. Instead, cut adjacent to these holes or along side seams. Document on the medical record "clothing cut" (see 11. c.)

6. If evidence is soaked with body fluids, use appropriate infection control measures and place each article in a double brown paper bag. Never place wet items with dry items as this can destroy the integrity of the evidence. Place a "biohazard" sticker on the outside of the bag/s. The paper bag may be placed in a plastic bag just prior to transportation only. This plastic bag should never be closed, as a closed plastic bag generates heat that may contribute to the degradation of evidence.

7. Gunshot Wounds
   a. Do not cleanse gunshot wounds as cleansing may allow trace evidence to be removed (e.g. gunpowder residue). Also, do not wash the patient's hands until you are cleared by law enforcement to do so. If the patient is going to the OR, the nurse should clearly document the wound's appearance prior to cleansing (see 11. b.). Once the patient is admitted to the hospital (e.g. SICU, MICU, etc.), the caregiver should verify with law enforcement or Emergency Center staff that evidence collection has been completed prior to cleansing the patient. Once approval has been given to cleanse the patient, document this in the nursing notes; include the name of the officer or person giving approval.
   b. Penetrating wounds should not be used for the placement of therapeutic or surgical tubes, drains, chest tubes, etc.

8. Criminal Sexual Evidence
   a. As describe in # 1, a Sexual Assault Nurse Examiner (SANE) will handle evidence collection and preservation for all e sexual assault cases. The SANE nurse is available through the SART contact number at at734.817.3463.

9. **Disposition and Transportation of Evidence**: <u>LIVING PATIENTS</u>
   a. Release of information and evidence to law enforcement will be in compliance with HIPAA policies. If questions arise regarding disclosure or release of information or evidence to a law enforcement officer, check with the HIPAA Privacy Officer or with SJMHS Legal Counsel (who can be reached through the operator).

      1. <u>CRIME VICTIMS</u>:
         a. If a law enforcement officer is present, the sealed evidence bag/s should be turned over to him/her. This must be documented in the nursing notes and on the property sheet. The law enforcement officer must sign the property sheet and each evidence sticker (on brown paper bag/s).
         b. If a law enforcement officer is not present, call Security Lead Officer to take custody of evidence (other than biological specimens) and secure in the Security Evidence Locker.

      2. <u>SUSPECT and/or VICTIM:</u> I f the patient is believed to be a suspect in a crime or is both a suspect and a victim, the law enforcement officer must produce a warrant before proceeding with evidence collection.

10. **Disposition and Transportation of Evidence**: <u>DECEASED PATIENTS</u>

   a. Care of the body: Notify law enforcement officer and the Medical Examiner's (ME) office immediately upon patient's death, so they can complete their investigation. To reach the ME office in Washtenaw County, call 734.477.6313, and for Livingston County call 517.545.9655. For SJMH, staff may also go through the hospital paging operator to reach the Medical Examiner Investigator (MEI). If an officer or MEI is not immediately available and the body must be moved, permission must be obtained from the MEI to move the body. All efforts should be made to preserve the body exactly as it was at the time of death and to keep all evidence intact: Minimize handling of the body.
      i) Refrain from traditional postmortem cleansing routines, as cleansing may wash away spatter or blood marks and distort wounds.
      ii) Do not disturb debris, powder, glass or other trace evidence in a wound or on the body.
      iii) Invasive lines (IV lines, catheters, sutures, drains, ET tubes, chest tubes) must be kept in place and secured with tape. Document treatment attempts on the body (e.g. incisions and needle punctures) or

other invasive therapeutic marks so it can be determined whether a wound arose from a procedure or prior to arrival (e.g. circle therapeutic wound with marker and put "Tx" next to it).

iv) Encase the deceased's hands securely in paper bags to preserve evidence on the hands or fingertips (e.g. gunpowder, skin, blood). Each bag should be labeled (right or left) and initialed along with date/time bagged.

v) To avoid intentional or accidental disruption of evidence, no viewing of the body by family, pastoral care, or other visitors will be allowed unless 1.) It is explicitly authorized by the MEI, and 2.) if the MEI is present during the viewing.

vi) The original transport bed sheet should remain under the body.

vii) When it is necessary to remove any clothing from the body, place **each piece separately** in an evidence bag and secure and label as appropriate. After the patient is pronounced dead, all remaining clothing should be left on the body.

b. Security must accompany the body to the morgue.

10. Placement of evidence in the evidence locker
    a. If a law enforcement officer is not present to take the evidence, notify Security Lead Officer to take custody of evidence (other than biological specimens) and secure in the Security Evidence Locker.
    b. All evidence (other than biological specimens) will be signed into the Security evidence logbook and secured in the evidence locker.
    c. Biological specimens will be properly labeled (patient name, medical record number, date, time and initials) and signed in on the Evidence Collection Log, and placed inside the refrigerator in the Security Office.

11. Documentation
    a. The chain of custody must be well documented on the evidence sticker, the medical record and on the property sheet. In the event that the evidence must be turned over to another individual (e.g. in OR, change of shift), the evidence sticker on each evidence bag will be signed by the person taking over responsibility, with date and time. This is done to streamline the chain of custody.
    b. Wounds/Defects. Do not make forensic interpretations (e.g. entrance or exit wound). Refrain from naming the type of injury (e.g. gunshot wound) or using subjective terminology. Use objective descriptive terms (e.g. "approx. 1 cm ovoid wound or defect) to describe body marks. Document observations of wounds/defects thoroughly and include:
        - Exact location
        - Shape and approximate size in centimeters
        - Depth
        - Characteristics of edges
        - Discoloration around wounds, and
        - Note any alterations of body marks made by incisions or surgical skin preps.
    c. Clothing. Document scissor cuts or tears done by staff on the medical record and the property sheet. Document if the patient was wearing clothing in a nontraditional manner (e.g. 'inside out' or 'backwards').

The County Medical Examiner Investigator will be responsible for the disposition of the evidence from the evidence locker in Medical Examiner cases. To contact the Washtenaw County MEI, call 734-477-6313, 24-hours a day, and ask for the MEI on-call for St. Joseph Mercy Hospital. To reach the ME office in Livingston County, call 517.545.9655.

Responsibility

System Integration Leader Safety and Security

References

Davis, G.J. (1994). Your role in death investigations. AJN, September, 39-41.

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Cross References

SJMHS Patient Care Policy No. 225. Care of the Patient at the Time of Death, 06/06.
SJMHS Patient Care Policy No. 226, Medical Examiner Cases: Viewing of Bodies, 11/06
SJMH OR Services Manual. Care and Handling of Forensic Specimen Removed From A Patient., 2-04-02-002 (04/01).
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JCAHO Functional Chapter

SJMHS Environment of Care

APPENDIX A

LOCAL LAW ENFORCEMENT AGENCIES

AGENCY	PHONE NUMBER
ANN ARBOR	734-994-2911
BELLEVILLE	734-699-2395
BRIGHTON MSP	(810) 227-1051
CHELSEA	734-475-9122
CLINTON SHERIFF	517-224-5200
CLINTON POLICE	517-456-4110
EASTERN MICHIGAN UNIVERSITY	734-487-1222
FLAT ROCK MSP	734-782-2434
GENESSEE COUNTY SHERIFF	810-257-3422
GREEN OAK TWP	810-231-9626
JACKSON COUNTY SHERIFF	517-788-4200
JACKSON MSP	517-782-9443
LENAWEE COUNTY SHERIFF	517-263-0524
LIVINGSTON COUNTY SHERIFF	517-546-6220
MANACHESTER TWP.	734-428-7090
MILAN	734-439-1551
MONROE COUNTY SHERIFF	734-241-2727
MONROE POLICE	734-241-3300
MONROE MSP	734-848-2015
NORTHVILLE MSP	248-348-1505
NORTHVILLE TWP	734-971-1954
OAKLAND COUNTY SHERIFF	810-858-4951
PINCKNEY POLICE	734-878-3700
PITTFIELD TWP.	734-996-3011
PLYMOUTH	734-453-8600
ROMULUS POLICE AND FIRE	734-941-1111
SALINE	734-429-7911
SUMPTER TOWNSHIP	734-699-2397
UNIVERSITY OF MICHIGAN	734-763-1131
VAN BURN TOWNSHIP	734-699-8930
WASHTENAW COUNTY SHERIFF	734-971-8400
WAYNE COUNTY SHERIFF	313-224-2222
YPSILANTI POLICE DEPT.	734-483-2311
YPSILANTI MSP	734-482-1213

APPENDIX B

EVIDENCE STICKER

Bag_____of_____
Name_____
Medical Record #_____

EVIDENCE

Sealed by_____Date_____Time_____

Received by_____Date_____Time_____

Received by_____Date_____Time_____

APPENDIX C

PROPERTY SHEET

Location: ☐ EC ☐ OR ☐ SICU ☐ Other_____

Date_____ **Time**_____

PROPERTY COLLECTED	**DISPOSITION OF PROPERTY**			
Describe clothing: **color, stains, tears and any alterations made by medical staff. Also indicate site from which items were removed** (e.g. " *Ring removed from right ring finger, watch removed from left wrist, wallet removed from right rear pant pocket.*")	**With Pt**	**With Family**	**To Law Enforce-ment**	**To Evidence Locker**
1.				
2.				
3.				
4.				
5.				
6.				
Purse/Wallet				
ID/Drivers License				
Cash/Coins				
Credit Cards				
Keys				
Ring/s				
Necklace/s				
Watch				
Earring/s				
Bracelet/s				
Dentures				
Hearing Aid/s				
Glasses/Contact Lenses				
Prosthetics/Misc.				
Specimen/s				

Valuables Envelope ☐ Yes ☐ No Envelope #:_____

Security Signature: _____

Property Collected By:_____ (Associate Signature)

Witness:_____ (Associate Signature)

Property released to Patient/Family_____ (Patient/Family Signature)Witness:_____ (Associate Signature)

PROPERTY RELEASED TO LAW ENFORCEMENT
Associate releasing property:_____ to _____ (Name, Title) (Officer & Agency) _____ on _____ at_____ (Badge #) (Date) (Time)

Patient Name	Medical Record #	ME Case #	# of Evidence Bags	# of Specimens	Date & Time In	Signature	Date & Time Out	Released to: Agency, Signature (If Law Enforcement, include Badge #)

Source: St. Joseph Mercy Health System, Ann Arbor, MI.