



Management

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Pilot explores organ donation in the ED — Challenges raised

Goal is to help offset nationwide shortage of available organs

It is not current practice in most EDs, and it is not without controversy. In fact, one ethicist has called the practice “ghoulish.” However, a government-funded pilot program at University of Pittsburgh Medical Center (UPMC) — Presbyterian Hospital and Allegheny General Hospital, both in Pittsburgh, is seeking to make organ donation from the ED a reality, while at the same time addressing the ethical challenges that have been raised and the logistical challenges that can lower the odds for success.

Using a \$321,000 grant from the Department of Health and Human Services, the EDs at these facilities have started identifying donors among patients who doctors are unable to save and taking steps to preserve their organs so a transplant team can rush to try to retrieve them.

“Obviously transplants can be lifesaving, and with large numbers of people waiting for organs and a smaller supply of donated organs for those participating recipients, we are always looking for an opportunity to increase donation,” notes **Clifton Callaway**, MD, PhD, associate professor of emergency medicine, University of Pittsburgh School of Medicine, vice chair of emergency medicine at UPMC, and the project leader.

In the past at UPMC Presbyterian, when organ donors died in the ED,

EXECUTIVE SUMMARY

A pilot program for ED organ donation at University of Pittsburgh Medical Center (UPMC) — Presbyterian Hospital is seeking much-needed organs, while maintaining optimal medical care for the living and avoiding potential conflicts of interest.

- Separate teams are involved with organ donation and with patient care, creating a “firewall” to prevent conflicts of interest.
- After failed CPR, a minimum of two minutes of no-CPR time is allowed to pass after death is pronounced to be certain there is no occult cardiac activity.
- Infusions of cold fluids are used to give enough time for the transplant surgeon to arrive and determine if any organs can be procured.

staff notified the local organ procurement organization and expected some effort would be made to determine if the patient could make a donation, says Callaway. "It turns out, however, that since there was no mechanism in the ED to temporize and buy time, and no transplant surgeon was standing by, it was not even considered" by the organ procurement organization, he says.

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In the pilot program, those issues are addressed. "What we created was a new set of logistics for activating the donation after a circulatory death emergency," says Callaway.

Now, he says, when there is an unexpected death in the ED, instead of "leisurely" filling out paperwork and the "death packet" of paperwork and then contacting the organ procurement organization, staff members have been directed to attempt to make the call immediately to see if the patient is a donor. "Our first call is to them," Callaway says. "We don't know [if the person is an organ donor] prior to death."

While donor status might be designated on a driver's license in Pennsylvania, "because that often is not found with a potential donor, that information is also recorded electronically in a registry when you get your driver's license," he says. The organ procurement organization can access that registry electronically to search for an individual. "The registry also allows persons who do not have a driver's license — e.g. blind individuals or those with a history of seizures — to designate their status," he adds.

Steps when patient is a donor

If the person is a donor, staff are paged. A separate team comes in from wherever they are: elsewhere in the hospital, on campus or off. The team includes one physician, one perfusionist, a social worker, and one procurement organization specialist, who is the donation coordinator. Callaway notes that when he is part of the team, he is not assigned regular duty in the ED.

"When I arrive, I confirm the person is in fact a potential donor, that they have in fact been declared dead, and then prepare the [femoral, arterial, and venous] lines," says Callaway.

The goal of the perfusionist is to keep the organs as cold as possible. The team attempts to cool down the recently deceased person using infusions of cold fluids to buy time and convert the warm ischemic time into cold ischemic time. "This gives enough time for the transplant surgeon to arrive and see if they can procure any organs," says Callaway.

Transplant surgeons typically like to have access to organs within five minutes of death, if possible, he says. Beyond 30 minutes or an hour, transplantation might not be possible. "If the patient can be made cold, we can open a time window so the surgeon can do the transplant an hour and one-half or two hours later, which can be physically possible," Callaway says.

Ethicists and others have raised several objections to this type of process. For example, they question whether patients who designate themselves as organ donors anticipate such a situation. Family members might wonder whether the ED staff did all they could to save their loved one, because they know that time was of the essence, they say.

Callaway says everything possible has been done to avoid potential conflicts of interest. “The ethical debate is intriguing, but I think it does not completely appreciate the type of donation we’re talking about here in the ED. I feel this is the least ethically ambiguous process you could imagine,” he says. “In terms of an unexpected death, that’s what I, and I believe most people, think about when they signed up to be an organ donor.”

What’s more, he says, the patients are pronounced dead only after a maximal resuscitation effort. “They are not brain dead; this is real, total, absolute death,” Callaway says. “If the program did not exist, we would walk away, with the next step being a call to the funeral home. There is nothing ambiguous about it.”

Callaway emphasizes that with an entirely separate team involved with organ donation and not involved with patient care, “that’s a firewall to prevent conflicts of interest.”

Still, **Leslie M. Whetstine**, PhD, MA, a bioethicist and an assistant professor of philosophy at Walsh University in North Canton, OH, has concerns. “This doesn’t really alleviate the problem of a family’s discomfort at having the body of a loved one violated without consent,” Whetstine says. “The situation is controlled when you have a patient, if competent, who decides they no longer want to be on life support, or their surrogate is making that decision. Death is the outcome they foresee.”

In these cases or organ donation, “Someone is walking down the street one day. The next thing you know the family is told, ‘There’s nothing we could have done, but we’ve cannulated them, and we’d like to take their organs now,’” she says. “That, I think, is a little bit ghoulish.”

In addition, claims Whetstine, the protocol calls for a declaration of death two minutes after the heart has stopped. “You really ought to be waiting minimum of 10 minutes,” she says. “The possibility of return of spontaneous circulation has been documented in patients who have had CPR.”

Callaway debates this comment because, he says, “it confuses our protocol with donation after an anticipated death. In fact, to be eligible for our protocol, a potential donor would have their heart

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stop unexpectedly and then have CPR conducted for a period of time determined by the emergency medical team with the intention of restoring pulses.”

This CPR is conducted as long as deemed appropriate by the emergency care team, and could be 60-90 minutes in some cases, he says. “After there was no return of pulse for that entire time, and further medical treatment was determined to be futile, a potential donor would be pronounced dead by the emergency medical team,” Callaway says. “A minimum of an additional two minutes of no-CPR time is allowed to pass after death is pronounced to be certain there is no occult cardiac activity, before we would make any preparations for donation.”

In point of fact, he says, logistics create a natural delay of 10-15 minutes after death is pronounced. “All together, this sequence of events means that one, aggressive attempts to restore pulses with CPR were made *prior* to initiating the Condition T [to call a transplant team into the ED], and two, death is declared many minutes — even 60-90 minutes — after the potential donor’s heart stopped.” (*Ethical criticisms are not the only challenge faced by the program. Thus far, it’s been difficult to preserve the organs for a sufficient length of time to keep them viable. See the story below.*) ■

So far, organs are not suitable

Organ donations in the ED present significant logistical challenges, as can be seen in a pilot program being carried out at University of Pittsburgh Medical Center (UPMC) Presbyterian Hospital and Allegheny General Hospital, both in

Pittsburgh.

“We have had a number of donors — fewer than 10,” says **Clifton Callaway**, MD, PhD, associate professor of emergency medicine, University of Pittsburgh School of Medicine, vice chair of emergency medicine at UPMC, and leader of the project. “Unfortunately, when we have executed the process, it has not resulted in organs that were suitable for transplant. “

Warm ischemia time under 30 minutes

Callaway says he attributes that lack of suitability to the total amount of warm ischemic time that had passed. “The total time duration to get the body cool and the organs out has been too long,” says Callaway. “Ideally you want to have warm ischemia time of less than 30 minutes, but if you include CPR, we have had times of longer than an hour.”

Achieving this goal “is logistically difficult,” he says. “We’ve been able to have cold fluids started within 40 minutes or so.” To improve those times, he says, the team has been seeking to streamline steps in the process, improve page operator response, and the speed with which the ED calls the local organ procurement organization.

“It’s probably very analogous to reducing door-to-balloon time,” says Callaway. ■

CLINICAL TIP

Infusion techniques can aid other EDs

The cold infusion techniques being used in a pilot program on ED organ donations represent a skill set that could be expanded into emergency procedures, says **Clifton Callaway**, MD, PhD, associate professor of emergency medicine, University of Pittsburgh School of Medicine, vice chair of emergency medicine at University of Pittsburgh Medical Center (UPMC) Presbyterian Hospital, and the project leader.

“In certain procedures you have cardiothoracic surgeons placing patients on ECMO [extracorpor-

real membrane oxygenation] rescue for severe cardiogenic shock,” he says. “Having worked through such procedures with these other departments and now having placed these types of cannulae myself [for cold infusion], we should consider it an area and type of heroic procedure well within our scope of practice. Perhaps certain centers should explore it.” ■

Patients can text EDs for wait times

Average door-to-provider time also posted

EDs at a number of Hospital Corporation of America (HCA) hospitals in the Southeast are using “new media” to inform patients of their average wait times over the past several hours. These times have been posted on hospital web sites, digital billboards, and most recently, via text messaging.

“The copy on the web site [www.gulfcoast-medical.com] says these wait times represent a four-hour rolling average taken every 30 minutes for the time from arrival to the time patients are being met by a health care professional,” explains **Scott Pennington**, RN, the ED education coordinator at Gulf Coast Medical Center in Panama City, FL. The copy also states that the times are given for informational purposes only.

EXECUTIVE SUMMARY

Making it possible for patients to text the ED for wait times, as several Hospital Corporation of America (HCA) facilities have done, takes more than just technology. As Gulf Coast Regional Medical Center has shown, it takes a good deal of staff preparation and internal and external education. Two years ago, the arrival- to-triage time was 45 minutes, and now it’s three minutes; time-to-physician was greater than an hour, and now it’s 30 minutes.

- Because wait times were to be made public, process improvement initiatives were instituted to lower wait times.
- ED nurses received education about the corporate flow measures by which their performance would be evaluated.
- A public education campaign was designed to ensure that prospective patients understood exactly what the posted wait times meant.

SOURCES

For more information about making ED waiting times available through electronic media, contact:

• **Sheila Bradt**, BSN, ED Director, and **Scott Pennington**, RN, ED Education Coordinator, Gulf Coast Medical Center, Panama City, FL. Phone: (850) 747-7900.

“Part of our message is we want to give the patient as much information as we can so they can make an informed decision before they ever leave for the ED,” says Pennington. “Of course, we also tell them that if there is a medical emergency, they should call 911.”

Sheila Bradt, BSN, director of the ED at Gulf Coast, says this approach has engendered several significant changes. “We’ve seen an uptick in our census of between 10% and 20%,” Bradt says. “We have a unique situation here where our competitor owns the ambulance services, so we have seen the growth exclusively from walk-ins, not EMS.”

Anecdotal evidence indicates a connection between the wait time texting and the census increase. “We’ve seen patients who sat waiting in our competitor’s lobby text our wait times, come here, and never go back,” says Bradt.

In addition, she says, patient satisfaction rates have risen, according to surveys taken by The Gallup Organization. In 2007, 51% of the ED patients surveyed said they were “always” satisfied with their treatment; in 2010, that figure had risen to 61%.

Finally, says Bradt, these new processes have had an impact on the staff in terms of their commitment to meeting targeted flow times. “There’s a lot more sense of urgency on the part of the staff since our performance is being measured and the public can see it,” she explains.

Laying the foundation

Changes like these cannot occur in a vacuum or without extensive preparation, the ED leadership explains.

“In preparing for our wait times to be out there for the public to see, we looked at what processes we needed to improve on — what we were already doing, and what we could do better,” Bradt notes.

So, for example, the department instituted “immediate bedding with triage.” A quick registration is done in the front by the RN greeter, who also conducts a rapid triage. Full registration is conducted in the back in a fashion that is consistent with EMTALA guidelines.

“We’ve also changed our staffing patterns after studying historical data,” Bradt says. “And we don’t just look at the previous year. We review it every couple of months, so we are constantly changing staffing to meet flow demands.”

HCA has several key measures its EDs seek to meet, and Bradt is pleased with the performance

of her ED since the process improvement began. “Two years ago our arrival to triage time was 45 minutes, and it’s down to three minutes,” she shares. “Time-to-physician was greater than an hour, and now it’s down to 30 minutes.” (*The ED staff received inservices about the measures preceding notification of the public about wait times. See the story below.*) ■

Education precedes publicized wait times

Before the ED at Gulf Coast Medical Center in Panama City, FL, could begin informing the public about its wait times, the public and the ED staff had to receive targeted education, says **Scott Pennington**, RN, the ED education coordinator.

“We had to educate the public on wait times and what they stood for, so they understood it represented time from sign-in to providers, which was averaged over the previous four hours,” he explains. “We wanted to give prospective patients a realistic idea of what the time meant. We wanted to be clear.”

Pennington worked closely with the marketing department to accomplish this goal. There were notifications through print and broadcast media outlets. Media representatives also were brought on-site to see and hear from staff and physicians. The staff and physicians also appeared on local radio and TV news programs. In addition, the hospital’s advertising campaign addressed the new notification processes.

Pennington adds that Gulf Coast Medical also has an active community health educator. Regardless of the announced topic, he says, the educator would always include an explanation of the ED wait time as part of the presentation.

Digital billboards were placed in the ED waiting room to remind people what the wait time actu-

ally was. "I think this is very valuable because it answers some questions the patient may have," says Pennington. "An educated patient is definitely the way to go."

In addition, Pennington educated the nurses about the key Hospital Corporation of America (HCA) flow measures they were to strive for, to help ensure positive performance numbers when they were shared with the public. "The key was to let the nurses know what the times were and to encourage them to find out what they could do to reduce the waiting times," he says.

Sheila Bradt, BSN, director of the ED, says, "There was also new staff scripting. If a patient calls and asks for the waiting time, their response is always, 'the average wait time in the last four hours has been . . .'" ■

CLINICAL TIP

Faster flow means better quality

The faster you work on patients who initially present in your ED, the better care they are likely to receive, says **Sheila Bradt**, BSN, director of the ED at Gulf Coast Medical Center in Panama City, FL. "The best place to treat patients is in the back," Brandt says. Placing patients in a care area improves satisfaction, reduces medical "surprises," and allows diagnostic testing and treatment to begin more quickly, she notes.

Programs such as LEAN have tools that allow reduction in processing times, Brandt says. "If you cut out wasteful steps, you improve your quality and customer satisfaction," she says. ■

Peds program reduces ED visits by 55%

'Medical home' includes parent education

A program designed to find a "medical home" for complex pediatric patients can reduce the

EXECUTIVE SUMMARY

A program designed to find a medical home for children with complex medical issues has resulted in a 55% reduction in ED visits. Leaders of the program, conducted by the Division of Pediatric Cardiology at the David Geffen School of Medicine at the University of California Los Angeles, say there were several key program components that led to a reduction in unnecessary ED visits, including the following:

- A family liaison, who provides administrative services such as access to scheduling, record retrieval and distribution, and maintenance of lists of potential providers, community schools, regional health centers, etc.
- An "All about Me" binder for patients that includes an initial problem list, a medication list, a list of physicians, notes, and lab results.
- An initial one-hour visit with the patient to develop lists of problems and introduce them into the program.

number of ED visits by 55%, according to a study published in the March 11, 2010, online edition of the *Journal of Pediatrics*.¹

Study data was collected between 2004 and 2007 from the Pediatric Medical Home Project at UCLA for Children with Special Healthcare Needs, which was founded at Mattel Children's Hospital at UCLA in Los Angeles in 2003. Researchers examined emergency department, urgent care, and inpatient encounters for 30 medical home patients for one year prior to enrollment in the program and for one year after enrollment. The average number of ED visits per patient decreased from 1.1 + 1.7 before enrollment to 0.5 + 0.9 after enrollment.

The program has several key components, says **Thomas S. Klitzner**, MD, PhD, chief of the UCLA Division of Pediatric Cardiology, executive director of the medical home project and lead author of the study. Klitzner also notes that this pilot program looked at significantly complex children; they had to have had visits with at least two pediatric subspecialists to participate in the program. "Any child seeing more than one specialist is likely to require that," Klitzner says. "Once you are dealing with such a patient, if they can have a medical home program to help co-manage their conditions through coordination of visits and family support, you will improve the quality of health for that child."

The researchers conducted an initial one-hour

visit with the patient to develop lists of problems and introduce them into the program,” Klitzner says. “We also developed an ‘all about me’ binder.” This binder includes not only the initial problem list, but a medication list, a list of physicians, notes, and lab results. “The physician gives it to the patient to carry with them on future visits,” says Klitzner. “There’s also a place to put business cards and family information.”

One of the most important elements was the hiring of an administrative assistant to be the family liaison, Klitzner says. “We have two of them, both of whom speak English and Spanish, and they become the primary contact for the families,” he explains. Most of their work involved providing administrative services such as access to scheduling; record retrieval and distribution; and maintenance of lists of potential providers, community schools, regional health centers, and other resources, Klitzner says.

Why ED visits dropped

Why does such a program reduce ED visits?

“We interviewed the parents and they gave us a number of answers, most important of which was that they felt empowered and more comfortable with their child’s condition and had a centralized person they could go to,” says Klitzner. “Parents would start the week with up to 10 visits and by the liaison putting more than one on the same day at the same location, they were able to reduce the need for outpatient visits.”

This population was entirely Medicaid, he adds. Often the father had the family car at work during the day, and the only available place to go when the child needed medical care was the ED. “By using this ‘telephone triage’ program, we found they could get scheduled,” says Klitzner.

Leslie Hamilton, MD, medical director of the medical home program, says, “The families can also call the care coordinator with simple things like meds refills. Also, since they get to know us very well, they’re able to talk through certain situations and find more appropriate triage to determine what needs be seen urgently, what requires subspecialty follow-up, and so on.”

Carlos Lerner, MD, medical director of the UCLA Children’s Health Center in Los Angeles, says, “We also provide better health maintenance so the children are less likely to get sicker. We’re not just dealing with putting out fires, but global care of a child, making sure that their prescriptions are always filled, nutrition is addressed, and the

SOURCES

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- **Thomas S. Klitzner**, MD, PhD, Chief of UCLA Division of Pediatric Cardiology, Los Angeles. Phone: (310) 825-7148.

community support structure is also addressed.”

Klitzner says, “I don’t believe a program like this will ever eliminate ED visits for these kids. They’re way too sick. But it will limit their visits to those that are appropriate.” (*How can ED managers use this approach to reduce peds visits in their department? See the story below.*)

REFERENCE

1. Klitzner TS, Rabbitt LA, Chang R-KR. Benefits of care coordination for children with complex disease: a pilot medical home project in a resident teaching clinic. *J Ped* 2010; 155:1-4. Doi: 10.1016/j.jpeds.2009.12.012. ■

Program, concepts can help EDs

While a program that found medical homes for pediatric patients with complex illnesses reduced their ED visits by 55%, is this a model that is translatable to a large number of EDs? Absolutely, says **Thomas S. Klitzner**, MD, PhD, chief of the Division of Pediatric Cardiology at the David Geffen School of Medicine at the University of California Los Angeles, and executive director of the Pediatric Medical Home Project at UCLA for Children with Special Healthcare Needs.

“I think this model of intense care coordination for complex children can reduce utilization of the ED and allow for easier discharges,” Klitzner says. “Our goal is to disseminate this program widely.”

For the ED to ensure the community is prepared to implement the program, “the most important first steps are for us to develop a cadre of primary care providers to go into the community and provide this kind of care,” he says.

Even without such a formal program, there are

steps ED managers can take to minimize unnecessary peds visits, says **Leslie Hamilton, MD**, medical director of the medical home program. “Communicating with outside pediatricians is very important,” Hamilton says. “So is parent empowerment.” So, for example, the ED provider should make sure the parents know the phone number of their child’s pediatrician, as well as those of their subspecialists.

“This way the ED physician can contact the subspecialist and create a plan, say, for seizure medicine, so if they start a new prescription they won’t run out” and have to return to the ED, says Hamilton. The ED provider also should educate the parents and child about the medications, she says. “So, for example, if the child sees seven doctors and is on 14 different meds, you must empower them to know that this particular medicine, for example, is for breathing — for a refill you should call the pulmonologist, and here is their number. They want to see you in one week.” ■

ED, researchers learn to co-exist

System enables parties to focus on their tasks

In most EDs, the last thing a provider wants is an extra, non-clinical individual “getting in the way.”

“I remember an ED physician picking me up and carrying me across the room and saying, ‘Let me take care of my patient!’” recalls **Christopher Lindsell, PhD**, director of research in University Hospital’s Department of Emergency Medicine in Cincinnati.

However, that action is highly unlikely to happen in this ED, even though there’s at least one researcher in the department 24/7. The reason is that a detailed system has been worked out to allow the ED to continue functioning with minimal interruptions, while allowing the researchers the access to patients that they require.

Arthur Pancioli, MD, executive vice chairman of emergency medicine and professor of emergency medicine at the University of Cincinnati School of Medicine, said, “It grew out of the concept of a rich and yet incompletely explored domain for research, but clinical demands of the team down there that did not really allow much flexibility [for them to delve] into the research domain. We had

EXECUTIVE SUMMARY

University Hospital in Cincinnati has an active research program. However, despite the fact that there is at least one researcher in the ED at all times, managers have managed to minimize disruptions and optimize the efforts of both groups. Here are some of the strategies they’ve used.

- A separate research team handles screenings and enrollments, which removes that burden from the ED staff.
- Researchers never contact patients before triage, primary medical care, resuscitation, and screening have been completed.
- Once the researchers deem a patient appropriate for enrollment, they double-check with the ED provider.

to have an extra team to do the screenings and the enrollments. We have a team of 20 clinical study assistants who tend to be students looking at a future in health care as a doctor or RN, or in the life sciences.” Lindsell notes that each shift lasts about four hours.

How do they keep out of each others’ way? Pancioli says, “They come into the picture after triage. Primary medical care, resuscitation, and screening come first. They are never allowed to impede the medical mission.”

These individuals are hired by the ED, he says. “A nurse coordinator trains them, and they are very well instructed in how to work in the system without being intrusive,” Pancioli explains.

Lindsell says, “One of the first things you have to do is teach them how the patient comes in and leaves the hospital. They don’t understand the system. They are taught about patient flow and enough anatomy and physiology so they understand what the providers are talking about, things like knowing that heart failure can involve leg swelling.”

The students go through 100 hours of instruction, including shadowing others and then working with a preceptor looking over their shoulders, he says. They don’t go out alone until they pass their final tests, Lindsell emphasizes.

A tiered process

The actual process for getting patients enrolled in a research project flows through several levels, Pancioli explains.

“If they find a patient who meets their basic inclusion criteria, they do a second level screening

SOURCES

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that often involves the clinical research nurse/coordinator who is running that trial,” he says. “Then if it looks like it’s a go, they check with the medical care team to make sure it will really work.”

Lindsell says, “They want to make sure the patient sufficiently understands what’s going on around them to consent to enrollment in research.”

This tiered system enables the researchers to cast a broad net “and gives us access to a tremendous number of patients and gives those patients the opportunity to benefit from research,” says Pancioli. For example, he explains, they might become enrolled in a therapeutic trial that gives them access to medications they otherwise would not have been able to receive.

“If this were not done properly, it could be a problem, but it was built by us and is owned by us, and that makes it all right,” Pancioli concludes. ■

Let ED know the benefits of research

One of the ways to make it easier for researchers and ED staff to learn to “live together” is to educate the clinical staff about the benefits of research, says **Christopher Lindsell**, PhD, director of research in the University Hospital’s Department of Emergency Medicine, Cincinnati, OH.

“There are always objections,” says Lindsell, noting that most clinicians do not see research as part of their job and believe they are there solely to save patients’ lives. “The way to get around that is to explain that research is what gives them the medicines they need to practice in the right way and to learn how to be even better at saving lives,” he says.

In addition, the ED at the University Hospital already has reaped several concrete benefits from the research done in the department, he says:

- In-house researchers make life easier for doctors and nurses. Before there was a dedicated research team, the research fell on their backs.
 - Research offers opportunities for nursing education. “We have a weekly meeting that we have opened to all ED nurses, whatever their rank, to learn about all research,” notes Lindsell.
 - The research division runs a quality improvement initiative.
 - The Greater Cincinnati/Northern Kentucky Stroke Team, which exists because of research, will go to any hospital in the city and treat stroke patients.
 - Lindsell’s team is performing pre-hospital research, in which paramedics perform the enrollment.
- “The amount of documentation and information on the patient [that the ED receives] far exceeds what they had previously been receiving,” Lindsell says. ■

CLINICAL TIP

‘Time is brain’ in ED research

The need to treat stroke patients as quickly as possible is no less critical in research programs than it is in a more traditional care environment, says **Arthur Pancioli**, MD, executive vice chairman of emergency medicine at University Hospital in Cincinnati, OH, and professor of emergency medicine at the University of Cincinnati School of Medicine.

“I work to facilitate therapeutic trials of neurological emergencies,” Pancioli explains. “Once you’ve determined a patient has had an acute ischemic stroke, you start tPA as soon as possible.” Once that has been done, he says, the researchers can offer additional drugs, devices like angiography, or work inside the brain using endovascular techniques. “But if they don’t show up on time, there’s no chance for benefit,” he emphasizes. ■

Zero tolerance culture can prevent ED violence

[Editor's note: This article is the first in a two-part series on preventing violence. In this story we examine the keys to a zero tolerance policy. In next month's issue, we will discuss key recommendations from the Occupational Safety and Health Administration and the importance of communicating effectively with patients and their families.]

Little progress has been made in curbing violence against ED nurses, asserts one behavioral expert, who says that the problem will continue to be a challenge until ED managers and hospital administrators adopt a policy of zero tolerance.

Exactly what does that term mean? "It means agreeing that no level of violence is acceptable, and that there is some consequence for every act of violence that occurs," says **Jean Henry**, PhD, an assistant professor of health science at the University of Arkansas, Fayetteville, and co-author of a chapter titled "Prevention of Workplace Violence," in the book *Leadership and Nursing Care Management* (W.B. Saunders, 2010.)

Part of the problem is that we often think of violence as falling into three obvious categories: verbal abuse, i.e., cursing at someone; yelling, i.e., adopting an aggressive tone; or actual physical assault, she says. "However, between those three can be threatening gestures — physical things that are done without making contact," Henry notes. "Someone may make a scowling face or simply move toward you."

Those types of acts also must be included in your zero tolerance policy, she says. "What's more, verbal abuse can be subjective," Henry says. "Some may wish to include choice of words or tone of voice."

EXECUTIVE SUMMARY

Violence in the ED remains a challenge for managers, but one expert says you can help prevent many incidents by adopting a policy of zero tolerance.

- Include threatening gestures among the actions that will not be tolerated.
- Have a formal, written plan. This step will give your policy more weight with your staff.
- Implement a risk management system to identify and eliminate areas of weakness.

A successful approach to preventing violence in the ED starts with having a formal plan that lays out many of the definitions outlined above, Henry says. "You have to have things in writing," she says. "If it is not formalized, people will not take it seriously."

The ED manager's first order of business should be prevention, followed by a description of responses, Henry says. Prevention incorporates security, safety, and surveillance, she says. "Cameras are obvious. People can see them," Henry says.

Cameras and/or closed-circuit video should be placed in all open public access areas of the ED, with particular attention to waiting areas, intake desks, and other non-treatment areas of interface between staff and patients, says Henry. "Public safety should be considered a higher priority than privacy in these situations," she says. Henry adds that security cameras can be a costly option, depending on the type of surveillance equipment selected. "Some facilities outsource this aspect of security," she notes.

Staffing is another issue that managers must address, Henry says. "You should also have adequate staffing to accommodate what you know to be a heavier load on certain days or times of days," she says.

Change the physical environment of the ED, if necessary, "so it looks like a pleasant place to be if you're stranded there for hours," she recommends.

Henry cites the following suggestions by the Occupational Safety and Health Administration (OSHA), found www.osha.gov/Publications/OSHA3148/osha3148.html, for changing the ED environment:

- Use lighting, colors, and patterns that have been shown to reduce stress.
- Install bright, effective lighting, both indoors and outdoors.

COMING IN FUTURE MONTHS

- How "standing-room-only" ED made it work
- Are masks as good as N95s for H1N1?
- ED adds specialized nurses to treat seniors
- Nurses in rural EDs receive trauma training

- Use minimal furniture in interview rooms or crisis treatment areas and ensure that it is light-weight, without sharp corners or edges.

All of these prevention steps convey the message that your ED is a place that above all else is trying to prevent violence, Henry says.

Implementing a risk management system also is a critical component of violence prevention, says Henry. “This involves a work analysis, looking at staffing patterns, different staff duties, where people are stationed, how the furniture is arranged, access entry points, security measures, cameras, who’s on duty, and so forth,” she explains. “All these things can put you at risk if they’re not done correctly.”

Mandatory training for staff

Staff education also is critical, adds **Phillip Knotts**, RN, administrative supervisor of nursing at Patient’s Hospital in Pasadena, TX. “We started [a violence prevention] program the first of this year,” Knotts says. “We sent all staff to mandatory inservices because of rising violence.”

The program, facilitated by an in-house educator, included the need for staff to work together professionally and how to handle family and patients when they get disturbed. (“In the ED, preventing violence is a whole ‘nother thing, with the turnover of new patients all day every day and people coming in already upset,” says Knotts. “We covered how to focus family members on the problem — on what we’re trying to do for the patient.” ■

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. After completing the semester’s activity with the **September** issue, 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. For information on the CE/CME program, contact customer service at (800) 688-2421 or customer service@ahcmedia.com. ■

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

13. How much time can be gained for the transplant surgeon by using cold perfusion in a deceased ED patient who is an organ donor, according to Clifton Callaway, MD, PhD, associate professor of emergency medicine at University of Pittsburgh School of Medicine and vice chair of emergency medicine at University of Pittsburgh Medical Center — Presbyterian Hospital?
A. One-half hour
B. One hour
C. 90-120 minutes
D. More than two hours
14. Several caveats are included on the Gulf Coast Medical Center web site where ED wait times are listed, according to Scott Pennington, RN, the ED education coordinator. Which of the following is not one of them?
A. The wait times represent a four-hour rolling average.
B. Patients are guaranteed to see a provider within 30 minutes.
C. Wait times are given for informational purposes only.
D. Wait time averages are calculated every 30 minutes.
15. What can ED managers and providers do to help reduce inappropriate visits by pediatric patients with complex medical issues, according to Leslie Hamilton, MD, medical director of the Pediatric Medical Home Project at UCLA for Children with Special Healthcare Needs Medical Home?
A. Contact the subspecialist and create a plan for follow-up medications.
B. Make sure the parents know the phone number of their child’s pediatrician, as well as those of their subspecialists.
C. Educate the parents about each of the child’s medications.
D. All of the above
16. Which of the following makes the ED staff more likely to accept the constant presence of researchers in the department, according to Arthur Pancioli, MD, executive vice chairman of emergency medicine at University Hospital?

- A. A separate research team handles screenings and enrollments, removing that burden from the ED staff.
- B. Researchers never contact patients before primary medical care, resuscitation, and screening have been completed.
- C. Researchers always double-check with the ED provider before enrolling a patient in a research project.
- D. All of the above.

17. Which of the following might ED managers tend to omit from their list of inappropriate actions in a violence prevention strategy, according to Jean Henry, PhD, an assistant professor of health science at the University of Arkansas?
- A. Threatening gestures
 - B. Verbal abuse
 - C. Adopting an aggressive tone
 - D. Physical assault
18. According to Clifton Callaway, MD, PhD, vice chair of emergency medicine at University of Pittsburgh Medical Center – Presbyterian Hospital, when a deceased patient is identified as an organ donor, a special team reports to the ED to handle the transplant procedure. Which of the following is not part of the team?
- A. A physician
 - B. A nurse
 - C. A perfusionist
 - D. A social worker

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CNE/CME ANSWERS

13. C 14. B 15. D 16. D 17. A 18. B.