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Prepare for more — many more — mental health emergencies

A very anxious-looking man told triage nurses At St. Johns Mercy Medical Center in St. Louis, MO, that he had a history of psychiatric disorders. Right away, he was placed in an appropriate room, asked to change into paper scrubs, and all his belongings were placed in a plastic bag.

“Security then came to inspect the belongings of the patient and found a 4-inch switchblade,” says Angelique Eichenlaub, RN, one of the ED nurses who cared for the patient. “If this patient was allowed to keep his belongings and stay in his clothing, there could have been a very bad outcome for either the patient or the staff.”

You might believe the signs of an individual in distress due to a mental health emergency would be hard to miss. But what if your waiting room was crowded with patients waiting to be seen, and your patient denied any intent to self-harm?

Screening for mental health and substance abuse is now the leading cause of ED visits in the uninsured population, according to the recently released 2007 Nationwide Emergency Department Sample from the Agency for Healthcare Research and Quality. ED visits for this group rose 28% between 2006 and 2007, and they rose between 14% and 17% for insured patients.

“Increased numbers of patients with mental health conditions are indeed being seen,” reports Michele Bascom, RN, an ED nurse at The Hospital of Central Connecticut in New Britain. “ED nurses use scripted questions to evaluate suicidality. Positive responses prompt certain actions.”

Sandra Menard, RN, MSN, CEN, an ED nurse at Brigham and Women's Hospital in Boston, says, “On a daily basis, we are seeing an

EXECUTIVE SUMMARY

Visits for screening of mental health and substance abuse are rising significantly in EDs. To avoid missing emergencies:

- Ask if the patient has a plan for self-harm.
- Don't interrupt patients.
- Obtain information from family members.

increased number of individuals presenting to the ED for both mental health and substance abuse. Some individuals have a dual diagnosis, so you are treating the substance abuse and the mental issue concurrently.”

To improve care of these patients, do the following:

- **Ask the right questions.**

Menard says to ask patients this question: “Are you having thoughts of hurting yourself or others?” If the patient answers “yes,” always ask, “What is your plan?”

“Knowing the patient’s plan is instrumental,” says Menard. Also ask about stressors, coping mechanisms such as substance abuse or alcohol,

if the patient has a psychiatric history, and if in the last two weeks there have been any changes in sleeping patterns or lack of interest in activities they once enjoyed, she recommends. (*See tip for your assessment of psychiatric patients, p. 111.*)

- **Shadow the experts in your ED.**

“One simple way to learn how to deal with psychiatric patients is to observe a staff member who always effectively deals with psychiatric patients,” says Menard.

- **Obtain the trust of your patient.**

Kelly Powers, RN, an ED nurse ED at Christiana Care Health System in Wilmington, DE, says that you must be truly at ease when assessing a patient with known or new mental health issues. “If the nurse is uncomfortable or nervous, the client may not trust that they are safe or being taken seriously,” Powers says.

Eichenlaub recommends these practices: Face the patient, look straight at the patient to let him or her know you are listening, do not interrupt while he or she is telling you what brought them to seek medical attention, keep your arms uncrossed, and keep a neutral facial expression.

- **Take information you are told by family members seriously.**

“The majority of individuals in crisis are brought to the ED by others. One pitfall is not listening to family members who state the individual is not acting appropriately,” says Menard.

Your patient might vehemently deny any intent to harm himself, but a family member standing beside them might know otherwise. Powers says, “If the patient arrives with family members or friends, try to find out what has been going on. Ask if there is any history of the same behavior, what treatment they have received in the past or are currently receiving, and what may have exacerbated this episode.”

Keep close watch

After you assess a psychiatric patient, might she wait in a crowded ED waiting area unattended?

“One of the most difficult tasks in a busy triage environment is to keep an eye on the patient,” says Powers. “Make sure someone is constantly with the patient.”

Use mental health aides if possible, or patient care technicians trained in observation, but don’t rely on friends or family. “They can be with the patient but should not be responsible for observing them,” says Powers.

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Editorial Questions

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The Hospital of Central Connecticut's ED has one room visible on camera in the nurses station and in security dispatch, which is used as the psychiatric observation area. "In truth, we can care for any patient in this area, but usually psychiatric patients are placed there," says Bascom. "In addition, a nursing tech observes the patient at the bedside." ■

CLINICAL TIP

Check for this while taking BP

When taking a psychiatric patient's blood pressure, look at the arms for signs of cutting or old wounds, recommends **Sandra Menard**, RN, MSN, CEN, an ED nurse at Brigham and Women's Hospital in Boston.

"Ask how the injuries occurred. The old story 'My cat scratched me' is often used," she says. "Explanations to injuries that do not make sense are a big red flag." ■

Put a stop to errors with weight-based dosage

Young children are at greater risk for dosage mistakes, as they often receive medications available in multiple formulations and concentrations, warns **Jennifer McNamara**, RN, an ED nurse at Children's Hospital Boston.

"Also, children are more sensitive to dosing errors," McNamara adds.

Stacey Peki, RN, an ED nurse at Baptist Children's Hospital in Miami, says that when the ED physician writes an order for the medication based on the child's weight, "there could potentially be errors anywhere in this process, and the patient could receive the wrong dose of medication." (See related story on how to document a child's weight, p. 112.)

To avoid weight-based dosage errors, consider these clinical practices:

- Use intravenous (IV) infusion devices with smart pumps.

"When a nurse provides the patient's weight to the smart pump, the calculations are provided automatically, reducing the risk of human error in this step," says **Andrew D. Harding**, RN, CEN, an ED clinical nurse specialist at Caritas Good Samaritan Medical Center, Brockton, MA.

"Hard limits," the pre-programmed volume of medication which is out of any recommended therapeutic range, can prevent catastrophic harm through intravenous (IV) infusion. "When the smart pump reaches the hard limit, it prevents the infusion from occurring," says Harding.

At Providence St. Vincent Medical Center in Portland, OR, standardized pediatric infusion pumps are pre-programmed with patient weight groups and frequently administered medications, says **Renee M. Rich**, RN, BSN, an ED nurse.

"This allows for an additional system of double checking medications prior to IV infusions," says Rich.

- Use order sheets.

"Almost all medications for pediatric patients must be calculated," Rich says. "ED nurses and pharmacists must dilute stock medications or divide pills."

To prevent dosage errors, ED nurses use standardized medication order sheets. These list the patient's weight in kilograms, old and new allergies, and drug reactions. These order sheets also include the medication name and unit of measurement per kilogram, such as units/kg, mg/kg, and mcg/kg, and the total dose of the medication.

"This system allows for a double check on all ordered medications," Rich says. "Ordering physicians are encouraged write out all instructions and to avoid using abbreviations."

- Avoid use of terminal zero.

"Use '5' instead of '5.0' to avoid 10-fold dosing errors," says Rich. "Use a zero to the left of a dose less than 1." Instead of ".1," "0.1" is what you

EXECUTIVE SUMMARY

Young children are at high risk for drug dosage errors due to multiple formulations and concentrations and the need to convert weight from pounds to kilograms. To prevent mistakes:

- Use intravenous devices with smart pumps.
- Use standardized order sheets.
- Create individualized code medication sheets.

should document.

- Use a template to calculate drugs used during a code.

“Medication administration during a code situation can provide an environment that is prone to medication errors,” says Rich.

To prevent these errors, ED nurses use a template that calculates code medications and drip medications. “These code medication sheets are individualized to each patient,” says Rich. ■

CLINICAL TIP

Chart weight before pound conversion

ED nurses at Seattle Children’s Hospital have caught a few dose-calculated weight errors and have performed a root cause analysis on every single one, says Elaine Beardsley, MN, RN, CPEN, ED clinical nurse specialist.

“Most were identified before the child received any medications or IV [intravenous] fluid,” Beardsley adds.

ED nurses determined that most of the mistakes occurred because the scale wasn’t directly beside the computer, so nurses had to walk across the triage room to enter the weight.

During that time, the parent often asked the ED nurse to tell them the child’s weight in pounds. The nurse then would calculate the weight in pounds, then enter the weight in kilograms on the chart. “Either the pound weight was entered, or the numbers got mixed up, because numbers are difficult to remember,” says Beardsley.

To avoid this, ED nurses don’t do a kilogram-pound conversion until the weight is documented. “Tell the parent that you will answer question after weight is entered to ensure safety and accuracy,” says Beardsley. “Never do mental math.”

She gives these other solutions for this common problem:

- Get a digital reader board above the scale that displays the weight, so you don’t need to commit it to memory.
- Re-design the triage room so that the weight

can be entered immediately.

- Perform your own independent check when signing off the weight. “For example, a 22 kg weight does not make sense for an 8-month old, but 10 kg does,” says Beardsley. ■

You may not be ready for airway emergencies

ED nurses play critical role in identification

If you noticed increased lethargy and confusion in your patient, would you suspect an airway problem?

“These are two very basic signs of hypoxia,” says Tia Valentine, RN, CEN, clinical nurse educator for the ED at University of California -- San Diego Medical Center. “The ED nursing role is very important when it comes to identification, prevention, and caring for airway emergencies.”

Valentine gives the following suggestions:

Use end tidal carbon dioxide monitoring.

ED nurses are using this monitoring more frequently for early recognition of airway emergencies, reports Valentine. “We can trend the numbers and, frequently, show well in advance if someone is going to have issues,” she says. “It helps with the carbon dioxide-retaining patient, as well as the overdose patient.”

Valentine says that end tidal monitoring “is really coming to the forefront with early recognition of airway issues. And, since it can be done via endotracheal tube, bag valve mask or nasal cannula, there is no real reason not to use the therapy.”

- Familiarize yourself with equipment.

“Within the ED, we have some very sophisticated equipment that allows us to aggressively resuscitate patients,” says Valentine. “We even have a jet-vent readily available should the need arise.”

A glidescope is used to visualize the glottis and posterior airway during intubation, and an advanced airway bag contains the cricothyroidotomy and tracheotomy airway devices. (*See related stories on what equipment to check before every shift and what to bring when transporting a patient, p. 113.*)

- Perform routine mock codes.

ED nurses practice insertion of nasal trumpets, oral suctioning, and removal of foreign bodies from the oral and nasal cavities. “We also practice appropriate bag-valve-mask breathing, ensuring

EXECUTIVE SUMMARY

Be ready for airway emergencies before a crisis occurs by being familiar with early recognition and equipment used to resuscitate patients.

- Use end tidal carbon dioxide monitoring.
- Practice removing foreign bodies and bag valve mask breathing.
- Suspect hypoxia in confused elders.

a rate of no more than six to 10 breaths/minute,” says Valentine.

Valentine reports that her ED has performed studies that showed that during resuscitation, “less is more.” “By placing the focus on having a solid seal around the mouth from the mask and using modest inhalation rates instead of rapid breaths, our outcomes are improved,” she says.

• **Don’t assume that an elderly person’s confusion is related to dementia or Alzheimer’s.**

This assumption is a dangerous practice, as the patient’s confusion actually might be due to hypoxia, warns Valentine. “And, as an elderly person is frequently difficult to wean from the ventilator compared to a younger person, basic comprehension of subtle signs of hypoxia are important,” she adds. ■

Equipment glitches can be dangerous

Always check airway equipment at the beginning of every shift, warns **Ann Heywood, RN, BSN, CEN, SANE**, trauma nurse coordinator for the Emergency Care Center at Champlain Valley Physicians Hospital Medical Center in Plattsburgh, NY.

“Ensure that you have a functioning bag valve mask and suction ready for use in your rooms,” says Heywood. “You don’t want to put yourself or the patient in the position that when your patient is boarded and collared and starts to vomit, you have no suction.”

Check the suction set up to ensure its patency before the time of need occurs. Turn it on and verify there is suction at the end of the tubing, says Heywood. “The time to assemble a bag valve mask is not when identifying the patient needs assistance,” she says. “These should be assembled ready for use in every room. Oral airways should be readily available on the headwalls, as well.” ■

CLINICAL TIP

Have a bag valve mask available as back-up

If the bag valve mask is tossed aside when the patient is intubated, retrieve it and bring it with the patient wherever they are going, advises **Ann Heywood, RN, BSN, CEN, SANE**, trauma nurse coordinator for the Emergency Care Center at Champlain Valley Physicians Hospital Medical Center in Plattsburgh, NY.

If the patient is accidentally extubated on the elevator, in transport to CT, or the intensive care unit (ICU), you will need that mask to ventilate with the bag valve until the patient can be successfully intubated again, she explains.

“A transport bag is ideal to use for transfers to CT or ICU for the intubated patient,” says Heywood. “The bag can include extra masks, oral airways, and emergency drugs.” ■

Don’t get fooled by your ‘frequent fliers’

Assumptions are dangerous

A chronic alcoholic with high blood pressure came to an inner city ED sometimes several times a day, always with the complaint of chest pain. After an initial assessment at triage, a quick check by the physician, a dose of his blood pressure medication and a box lunch, he would typically be on his way.

“One day, he came in with his same old complaint of chest pain. The triage nurse that day was particularly harried. The lobby was crowded with patients waiting,” says **Rosemary M. Lowry, MSN, APRN-BC**, an ED manager/nurse practitioner at Providence Hospital in Southfield, MI. Lowry was one of the ED nurses who cared for the patient at a hospital she worked at previously.

The man argued that his chest pain was particularly bad that day and he needed to see the doctor,

EXECUTIVE SUMMARY

Patients who visit EDs three or more times a year increased 28% over a three-year period, says a new report. To ensure a thorough assessment of these patients:

- Assess the patient as though you've never seen them before.
- Ask patients how their complaint is different today.
- Ask patients "What can I answer for you before you leave?"

but instead, the triage nurse had security escort him out of the ED.

Approximately one hour later, a maintenance man saw a man lying by the side of the hospital. He called for medical assistance and the man was wheeled into the resuscitation room. "He was ashen, diaphoretic and barely breathing," says Lowry. "The man was promptly intubated, but by this time his heart had all but stopped. CPR was started, and advanced cardiac drugs were pushed. All the frantic attempts to save this man's life were futile. The man was pronounced dead."

The entire staff recognized the patient as the "frequent flier" who came to the ED every day with chest pain. "When the news made its way to the triage nurse, she felt terribly guilty that she had this patient thrown out earlier," says Lowry. "The ED learned a valuable lesson that day, paid for with the life of a 'frequent flier.'"

ED nurses no longer dismissed the complaints of these patients, says Lowry. "When the department was especially chaotic, a physician would come out to Triage and complete a medical screening for these patients," says Lowry.

If you're seeing more "frequent fliers" in your ED, that's not surprising. Patients who visit EDs three or more times a year grew 28% in just three years, according to a new report on ED patient populations.¹ Here are some tips to improve care of these challenging patients:

1. Never refuse to assess the patient.

"These patients usually come in for what appears to be some minor complaint. The ED staff gets very frustrated with these individuals, believing that they are utilizing time and space that should be reserved for those patients that really need the resources of an ED," says Lowry.

In fact, you need to use the same assessment skills for these patients as you would for any other patient, says Lowry. "The patient needs to be interviewed to ascertain the patient's concern," she says. "Sometimes with further questioning, the real reason for the patient's presentation will

become apparent." (See related stories on how your attitude can harm a patient, below, and an important question to ask, p. 115.)

2. Remember that the ED might be the patient's only option.

It might be that the patient is hungry or needs a dose of a certain medication. "Without a doubt, most 'frequent fliers' are homeless. They simply do not have resources or a support system in which they can rely upon," says Lowry. "While it is possible to provide these patients with free or low cost clinics that will meet the patient's medical concerns, transportation is usually a barrier."

3. Perform your assessment as though you have never seen the patient before.

Mary M. Pelton, RN, CEN, an ED nurse at Carteret General Hospital in Morehead City, NC, says, "What I always find interesting is when someone who does not know the frequent flier or is new to the ED, picks up on the risk factors the patient states." For example, the frequent flyer with chest or abdominal pain that will always be an ESI Level 3 to those who know him, is an ESI Level 2 to the person who does not.

"It is a reminder that, however daunting, we have to treat each visit as the first," says Pelton. She says to ask patients, "When was the last time you had to come to the ED for this complaint?" "How is it different this time?" "What was the outcome of your last visit?" "What was your treatment plan?" and "Have you been able to follow up?"

"We have a crisis in our community of lack of primary care and resources for patients with and without insurance, so this is challenging," says Pelton. "It is frustrating when you can do so little. But, we can always educate."

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Annoyed? That's risky for patients

A woman who was struck by a car and evaluated and discharged from an ED returned several times with the complaint of a headache. Each time, the staff simply documented the previous

workup, which was negative.

“On her fourth visit to the ED, the physician did a repeat CT of the brain, and she was developing a large subdural hemotoma,” says **Laura Aagesen**, RN, BSN, MBA, trauma coordinator at Northwest Community Hospital in Arlington Heights, IL. “After her final visit and the subdural hematoma was discovered, she had surgery and did well.”

This incident, which Aagesen learned about at a conference, shows the danger of a complacent attitude. “Stereotyping a patient due to history of a return visit begins a dangerous practice of substandard evaluation and a risk of further injury or death for the patient,” Aagesen says.

The danger begins with the onset of an attitude the staff immediately develops as soon as they see a patient familiar to the ED, or when the patient states they are returning with an unresolved problem or pain, according to Aagesen. Not taking a patient’s complaint seriously can lead to dangerous practices of not doing thorough examinations or “parking” a patient -- putting them at a low priority,” says Aagesen.

Aagesen says that in the past, when she has reviewed charts of patients with multiple visits to the ED at various facilities, she has often found that the diagnosis they end up with was something they were complaining about during their first visit. “Many times, patients fail to tell you information that can be valuable, such as having a fall a week prior to the recurrent headache or neck pain,” says Aagesen. ■

CLINICAL TIP

Ask this question before patient leaves

It’s probably the most natural question to ask a patient after explaining discharge instructions, but to avoid a repeat visit to the ED, don’t say “Do you have any questions?” advises **Carrie L. Baumann**, RN, BSN, patient care supervisor in the Emergency Department Trauma Center at Children’s Hospital of Wisconsin in Milwaukee.

“The patient will usually just say ‘no,’ just to get home,” she says.

Instead, Baumann says to ask the patient, “What can I answer for you before you leave?” ■

Don’t overlook onset of hypothermia in trauma

A 40-year-old man landed in a small stream after a motor vehicle accident and arrives fully dressed and bleeding from the head. Emergency medical services (EMS) tells you the patient was lying on the ground when they found him. Would you ask the question, “How can this patient lose heat?”

“The better question is, ‘How has he already lost heat?’” says **Shelley L. Sides**, RN, MSN, EMT-I, trauma coordinator at Eastern Maine Medical Center in Bangor. “The patient has already been exposed to heat loss through conduction, convection, and evaporation.”

Sides says that “it is very easy for ED nurses to become so involved in the critical care of a patient that they do not pay as close attention to the patient’s body temperature.” Your goal is to minimize further heat loss and promote re-warming, says Sides.

Crissy Kuhlmann, RN, BSN, CPN, CPEN, trauma services at St. Louis Children’s Hospital, warns, “Hypothermia is often recognized late in the resuscitation of an injured child, especially if the patient is critically ill with distracting injuries. Your priorities simply become lifesaving.”

When caring for an injured child, your assumption should be that they are hypothermic until proven otherwise, says Kuhlmann.

Preventing trauma patients from becoming hypothermic is extremely important to the overall survivability of the patient, says Sides. “Hypothermia in trauma can begin at the time of injury, as the patient begins to lose body heat through different mechanisms,” says Sides.

To prevent hypothermia in trauma patients:

EXECUTIVE SUMMARY

Trauma patients might already have been exposed to heat loss due to multiple factors, and those with severe hypothermia are more likely to die. To avoid delays in diagnosis:

- Cover points of bleeding.
- Cover head with warm blankets.
- Always reassess temperature.

CLINICAL TIP

Look for signs of perfusion

You might not immediately obtain a rectal or oral temperature when a trauma patient comes through the door, but a good initial assessment should include signs of perfusion, such as skin color, warmth, and moisture, says **Shelley L. Sides, RN, MSN, EMT-I**, trauma coordinator at Eastern Maine Medical Center in Bangor.

“Though peripheral perfusion is not a true reflection of core temperature due to vasoconstriction, it may help to clue you in to a patient who is already hypothermic or who is at increased risk of hypothermia,” Sides says. ■

- **Obtain a thorough EMS report.**

You might learn, for example, that the patient was a prolonged extrication from a vehicle in cold weather.

- **Remember that children lose heat more rapidly than adults.**

“Shivering causes them to increase metabolism and exert extra energy,” says Kuhlmann. “It can assist in the development of acidosis, cardiac arrhythmias, and coagulopathies.”

- **Obtain and document a temperature as soon as possible.**

“Remember that the body’s core temperature has an effect on cerebral blood flow,” says Sides. “Monitor your patients for changes in levels of consciousness and neurologic deficits.”

Continuously monitor temperature by inserting a rectal probe to monitor the patient’s core temperature, says Sides. “This might be the easiest way to monitor the patients’ temperature in the ED, especially if this is a sick patient. More internal means of monitoring temperature include temperature-sensing indwelling urinary catheters as well as pulmonary artery catheters.”

Often, reassessment of temperature is not performed, says Sides. “One reading is not enough. Patients are continually being moved, transported, assessed, and exposed to heat loss behaviors.”

- **Pre-warm your ED treatment room.**

“Increasing the ambient temperature can reduce heat

loss,” says Sides. “Apply warm blankets to the patient, or use equipment designed to assist with raising body temperature passively.”

- **Administer warm IV fluids.**

IV fluids can be warmed using a warmer that is thermo-regulated and monitored regularly or by using fluid administration devices that allow warming of fluids, says Sides. “It is also important to note that administration of room temperature fluids can have an effect on overall core body temperature.” (See story on immediate interventions, below, and an important sign to look for, left.) ■

Don’t let this bad outcome happen

A hypothermic trauma patient can rapidly decline, warns **Shelley L. Sides, RN, MSN, EMT-I**, trauma coordinator at Eastern Maine Medical Center in Bangor.

“Research shows that patients who present with severe hypothermia are more likely to die,” she says. “Hypothermia is considered one of the components of the ‘lethal triad’ and can be a causative factor of the other two: coagulopathy and acidosis.”

Sides says that “prevention should begin as they come through the door,” with these interventions:

- **Cover points of bleeding when at all possible.**

- **If patients are wet by any type of fluids, they need to be dried off and covered.**

- **Because any patient with wet hair can lose heat rapidly, keep heads covered with warm blankets.**

Cover patients with warmed blankets. While a severely injured trauma patient should be completely exposed in an attempt to identify any and all life-threatening injuries, leaving them exposed is unnecessary most of the time, says Sides.

“Patients who are left in saturated clothing or undressed and left with one blanket or no blanket at all are at increased risk,” says Sides. “It is essential to maintain a normothermic patient.” ■

Door-to-EKG delays? Get them close to zero

At Tufts Medical Center in Boston, the ED’s protocol encourages any member of the ED staff — a technician, nurse, or physician — to

perform an EKG whenever they find a patient presenting with angina or anginal equivalents.

This step is one of the interventions that has reduced the ED's door-to-EKG times, which can have a significant impact on the outcome of patients with possible ST-elevation myocardial infarction (STEMI), according to **Alexandra Penzias**, RN, MED, MSN, CEN, clinical nurse educator for the Department of Emergency Medicine and co-author of the protocol. [*The protocol used by ED nurses is included with the online version of this month's ED Nursing. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.*]

"All nursing and ED tech staff have been trained and maintain annual competency in performing 12-lead EKGs. Nursing staff have advanced training in dysrhythmia interpretation," adds Penzias.

The protocol states that the practitioner performing the EKG must hand carry it to an attending physician, who does a rapid evaluation/interpretation of the EKG. He or she initials the print-out with an order to activate the STEMI pager and initiate protocolized care for acute coronary syndromes, STEMI, non-STEMI, or dysrhythmia.

"Our protocol encourages a 'closed loop' of communication between practitioners until a diagnosis of, or clearance for, STEMI, non-STEMI, or threatening dysrhythmia," says Penzias.

Triage delays cut

To reduce delays at triage, an ED tech acts as a "pre-triage greeter" during the highest volume hours, typically 11 a.m. to 7 p.m. The greeter gets the patient's name, date of birth, presenting complaint, and a set of vital signs.

"ED techs who act as greeters are also educated regarding our protocol and obtain EKGs on patients presenting to the ED with chest pain or a constellation of symptoms referred to as 'anginal equivalents,'" says Penzias. "We typically hire baccalaureate nursing students and EMTs into

these positions. Their role is critical to the success of the protocol."

To further cut delays, a reclining phlebotomy chair and an EKG machine was placed in triage. "However, because the ED environment is so complex and fast-paced, a protocol and education alone will not guarantee ongoing success," says Penzias. To be sure the ED is providing rapid evaluation and treatment for this population, the ED physician and nursing leadership teams review all STEMI cases every month.

"We evaluate each case for lessons learned and for potential systems issues that are attributed to expeditious or delayed care," says Penzias.

Perform EKG at triage

Even if a treatment room isn't available right away, **Tracy Simmons**, RN, clinical educator for the ED at OSF St Francis Medical Center, says to "get the EKG done at triage and take a look."

"The more time that the patient waits to have their vessel opened equals potentially more irreversible damage to their heart," says Simmons.

Cathy C. Fox, RN, CEN, CPEN, clinical nurse educator for the ED at Sentara Virginia Beach General Hospital, says there is an EKG machine available 24 hours a day in triage, staffed by a nurse. "This is to ensure an EKG is completed within 10 minutes on all chest pain patients upon arrival," she says. "In the event we have two or more patients presenting with chest pain at the same time, another nurse or an ED technician will complete an EKG in one of our three triage rooms."

If a second patient does present to triage with chest pain, the registration attendant calls the charge nurse on a portable phone, and initiates the EKG in any available room.

"We do not delay the EKG by doing vital signs or initiating IV access," says Fox. ■

Make your waiting room safe for elderly patients

(Editor's Note: This is the second of a two-part series on geriatrics. This issue, we cover elder stroke patients and ways to make long waits safer. Last month, we covered care of elders with seizures, traumatic brain injuries and psychiatric

EXECUTIVE SUMMARY

By cutting delays in door-to-EKG times, you can improve the care of ST-elevation myocardial infarction (STEMI) patients. Some effective approaches:

- Place an EKG machine at triage.
- Obtain training in dysrhythmia interpretation.
- Hand carry the EKG to the ED physician.

EXECUTIVE SUMMARY

Providing easy-to-read signage, making patients visible, and offering comfortable seating are ways to protect elders during long waits in the ED. Some good strategies:

- Designate a seating area for elders next to triage.
- Use well-padded furniture.
- Triage elders at higher levels.

complaints, and we gave strategies to reduce risks of medication interactions and handoffs.)

There is a small but growing trend toward creating designated EDs for geriatric patients, but the reality is that in many EDs, elders often wait for hours in general waiting areas due to overcrowding. Here are some low-cost, simple solutions:

- Make your external signage, internal signage, and printed materials easy to read, including large lettering.

Two especially important types of signs are directional and informational, says **Steven Glow**, MSN, FNP, RN, associate clinical professor at Montana State University College of Nursing in Missoula. Directional signs allow elder patients to know where to go first. Informational signs tell patients to inform nurses immediately if they experience chest pain or shortness of breath.

- Make elders visible.

“Design waiting areas so that patients can be seen and heard by the triage nurse,” recommends Glow. “Designate an elder’s seating area closest to the triage nurse, and put comfortable chairs there.”

- Use comfortable, well-padded furniture, such as lounge style chairs.

“This decreases the risk of pressure ulcers and promotes rest during long waits,” says Glow. *(See related stories on triage practices to protect elders during long ED waits, below, and remote monitoring of vital signs, p. 119.)* ■

5 triage practices that help elders

More elderly patients are waiting in the lobby of the ED at St. Joseph’s Hospital in St. Paul, MN, says **Joan Somes**, PhD, MSN, RN, CEN, FAEN, ED educator. This situation is due to a bed shortage due to a temporary move from a

15-bed ED to an area with only 10 beds.

“Our current lobby area is not very large. The triage nurse is responsible for the patients in that area, thus is aware of who each patient is and why they are there,” says Somes.

Here are four changes the ED has made to keep waiting elders safe:

1. A greeter obtains the patient’s name, birth date, and reason for visit.

“They type only that information in the computer,” says Somes. “The confidential information is collected later in the patient’s room. Thus, this admitting clerk is freed up to watch the waiting room.”

In addition to the triage nurse and the admitting clerk/greeter that watches the waiting area, the lobby also has a security guard. “They were initially placed there to increase safety of all patients, but the geriatric patient has benefited most from this,” says Somes.

Security alerts the ED staff immediately if they see older persons who look as if they need help. “They have also learned that if they do need to control an older person, how to do that more carefully to avoid broken bones and skin,” says Somes.

2. Several wheelchairs are kept at the ED entrance.

“Patients make frequent use of them. The greeter tends to put them in wheelchairs as well,” says Somes. “It is easier to identify someone is a patient if they are in a wheelchair.”

3. More frequent reassessment is done.

Level 2 patients are monitored constantly, and ED nurses check Level 3 patients every 30 to 60 minutes. “Charts are kept in a nursing section of the lobby area, so charting of assessments done in the lobby by the triage nurse are facilitated,” says Somes.

4. Older patients are typically triaged at higher

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levels than younger patients, which gets them back sooner.

“Our staff is well-versed in the pathophysiologic changes associated with the older adult that makes them harder to assess and triage,” says Somes. “They look for the subtle clues that indicate life-threatening problems.”

She gives the example of a 90-year-old woman who denies chest pain and presents with mild shortness of breath for several days. That situation would be enough to trigger the triage nurse to be concerned about a myocardial infarction or congestive heart failure, versus a simple pneumonia. “With back or abdominal pain, our triage area is suspicious for an abdominal aortic aneurysm if the patient is older,” says Somes.

5. Make hourly rounds.

Because older patients are typically triaged at Level 3 or higher, says Somes, they are “rounded on” at least every hour, if not more often.

The frequent checks mean that if an elder’s condition changes, their triage level is upgraded right away. “Our staff recognizes that older people have difficulty hearing and moving about. Staff move about the waiting room, if necessary, looking for the patient if they do not answer,” says Somes. ■

CLINICAL TIP

Monitor waiting elders remotely

During long wait times, consider the use of wireless pulse oximetry as one possibility to more closely monitor the vital signs of elders in your ED.

“We certainly use remote pulse oximetry as an early warning system for inpatients,” says **Steven Glow**, MSN, FNP, RN, associate clinical professor at Montana State University College of Nursing in Missoula. “It would help identify someone who is decompensating as manifested by decreased saturation or perfusion.” ■

AHC Media publication wins national competition

Risk management pub awarded

Healthcare Risk Management, published by AHC Media, publisher of *ED Nursing*, took first place honors in the best instructional reporting category of the Specialized Information Publishers Association’s annual journalism awards announced recently.

Healthcare Risk Management, which focuses on ideas, strategies, and recommendations for reducing hospital risk and liability, was honored for a special report in two issues last year on the risks associated with the use of medical helicopters. The award goes to the long-time *Healthcare Risk Management* editor, Greg Freeman, along with Russ Underwood, executive editor, and Karen Young, managing editor, who worked with him on the series. Donald Johnson, senior vice president, accepted the award on behalf of the winners at a presentation in June at the annual SIPA meeting in Washington, DC.

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. ■

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CNE OBJECTIVES/ QUESTIONS

Upon completion of this educational activity, participants should be able to:

- identify clinical, regulatory or social issues related to ED nursing;
 - describe the effects of clinical, regulatory, or social issues related to ED nursing on nursing service delivery;
 - integrate practical solutions to ED nursing challenges into daily practice.
5. Which is recommended to improve assessment of psychiatric patients, according to Sandra Menard, RN, MSN, CEN, an ED nurse at Brigham and Women's Hospital?
A. Don't check for signs of self-harm while taking the patient's blood pressure.
B. Ask family members if they'll agree to be responsible for observing the patient.
C. Avoid making prolonged eye contact with the patient while he or she is telling you what brought them to seek medical attention.
D. Observe a staff member who effectively deals with psychiatric patients.
 6. Which practice is recommended to prevent pediatric dosage errors?
A. Avoid using standardized medication order sheets.
B. Don't convert the child's weight from kilograms to pounds before the weight in kilograms is documented.
C. When documenting, first calculate the weight in pounds, then enter the weight in kilograms on the chart.
D. Always calculate the weight in pounds before converting to kilograms.
 7. Which is true regarding prevention of hypothermia in trauma patients?
A. ED treatment rooms should not be pre-warmed.
B. Room temperature fluids will not have an effect on overall core body temperature.
C. Continuous monitoring can be done by inserting a rectal probe to monitor the patient's core temperature.
D. One temperature reading is sufficient.
 8. Which is recommended to improve care of ED patients with airway emergencies?
A. Use end tidal carbon dioxide monitoring for early recognition.
B. Rapid breaths should be used during resuscitation, instead of modest inhalation rates.
C. Ensure a rate of more than 10 breaths a minute with bag valve mask breathing.
D. Avoid using end tidal carbon dioxide monitoring with nasal cannulas.

Answers: 5. D; 6. B; 7. C; 8. A.