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You may be giving poor care to elderly trauma patients

Seemingly minor injuries can be devastating

If your ED patient sustained a few rib fractures, would you expect this to lead to rapid respiratory decompensation, pneumonia, and death? Minor injuries can have profound effects in the elderly, warns **Avery Nathens**, MD, division head of trauma and general surgery at St. Michael's Hospital in Toronto, Canada.

Trauma centers may *not* provide the same quality of care for elderly trauma patients as they do for younger patients, according to a recent study.[1] Researchers analyzed data on 87,754 trauma patients of all ages treated at 132 facilities.

"We showed that a center that is high-performing for the young is not necessarily high-performing for the elderly," says Nathens. "We believe that the elderly require a different approach to care, given the physiology associated with aging and their associated medical problems."

The elderly have decreased pain sensation and delayed cardiovascular response, making abdominal injuries with risk for bleeding difficult to assess, says **Joyce Fuss**, RN, BSN, CEN, FNE, a senior partner at the Emergency Medicine Trauma Center at Indiana University Health in Indianapolis. "Many times, elderly patients will injure themselves at home and delay seeking care, not realizing how injured they are," she says.

EXECUTIVE SUMMARY

Elderly trauma patients require a different approach to care than younger patients, as even minor injuries can have devastating effects in older patients. To improve their care:

- Identify shock with the use of routine blood gases.
- Monitor patients closely for signs of respiratory distress during rapid fluid resuscitation.
- Manage pain with small, frequent doses of short-acting narcotics.

Early action is key

The percentage of elderly trauma patients coming to EDs is "rapidly growing," according to **Donna Sparks**, MSN, RN, CEN, director of emergency services at Baptist Hospital Miami. "ED nurses need a clear understanding of normal age-related physiological changes, and how those changes impact the individual's response to trauma," she says.

For example, an elderly trauma patient may also experience an atypical myocardial infarction, says Sparks. "Anticipate admission of the geriatric patient if two or more ribs are broken," she adds.

Gabriela McAdoo, RN, trauma coordinator at Stanford (CA) Hospital & Clinics, says it is particularly important to recognize early indications for intubation. "This is important due to limited cardiopulmonary reserve for the elder patient presenting in shock," she says. To improve the care of elder trauma patients:

• **Identify shock earlier.**

If elderly patients are on beta-blockers, they might not demonstrate tachycardia in response to blood loss, says Nathens. "They might also present with a normal blood pressure — which, for a hypertensive patient, might be too low to support tissue perfusion," he says.

A good way to identify shock in elderly trauma patients is with the use of routine blood gases, says Nathens. "These can be used to identify a high base deficit or lactate, suggesting poor tissue perfusion," he explains.

• **Identify significant hypothermia.**

This needs to be aggressively treated with body warmers and administration of warm intravenous fluids, says Nathens.

• **Develop protocols for the rapid reversal of the effects of anticoagulation.**

This will allow bleeding to be addressed more effectively, Nathens explains.

• **Avoid missing subtle signs of distress.**

Perform more frequent monitoring, and evaluate treatments more closely for effectiveness, says Fuss. "Remember that more elderly patients die from complications of trauma, than the trauma itself," she says. "Aggressive treatments are needed to prevent some of the comorbidities."

• **Don't be misled by "normal" vital signs.**

Patients with chronic obstructive pulmonary disease might normally have increased work of breathing with increased respiratory rate, says Fuss, making it difficult to determine chest injury or respiratory distress.

Likewise, says Fuss, the vital signs of a patient who has a history of hypertension and takes beta-blockers might appear normal. "But when the nurse evaluates the trending, it will show the presenting blood pressure was initially high and the heart rate lower," she says.

Many times, "normal" vital signs in elders are signs of shock, says Fuss. "It is more important to know the patient's norm and monitor trending," she says. "Knowing what is 'normal' for that patient is key to making an accurate clinical judgment." (**See sidebars on fluid resuscitation and pain management, p. 75.**) ■

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Editorial Questions
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Fluid may be overlooked in elder trauma patents

After a CT scan of an 85-year-old male involved in a motor-vehicle accident showed a Grade 2 liver laceration, the patient was placed in a holding area while waiting for an inpatient bed, recalls **Joyce Fuss**, RN, BSN, CEN, FNE, a senior partner at the Emergency Medicine Trauma Center at Indiana University Health in Indianapolis.

"The patient was brought in with two large-bore PIVs [peripheral intravenous lines]," says Fuss, one of the ED nurses who cared for the patient. "However, due to his age, lack of active bleeding, and noted normal vital signs, both lines were saline-locked. The patient was never given fluid."

Because multiple nurses were caring for the patient, says Fuss, no one noticed the patient had not urinated in more than eight hours, or the trending down in blood pressure and trending up in heart rate. This was because they stayed within the normal range, she adds.

The ED nurse notified the physician, and the patient was given two liters of 0.9 normal saline over the next two hours, says Fuss. "The patient finally voided a minimal amount of concentrated urine," she says. "The patient was then placed on IV [intravenous] fluid, and the blood pressure maintained in the 120s systolic."

Elderly trauma patients require close monitoring during fluid and blood administration for cardiac overload, according to Fuss. "Younger patients are administered fluid and blood rapidly with no hesitation, but many times elderly trauma patients will be under fluid resuscitated to avoid overload," says Fuss. She gives these tips:

• **If the patient has been stabilized and no IV fluid has been ordered, make sure the patient is provided fluid.**

This is especially important if the patient is being kept NPO, says Fuss.

• **Administer fluid and blood through 20g PIVs.**

"This can be done without difficulty until central access is obtained, versus trying to place large-bore PIVs and blowing all access," says Fuss. "Many times, the elderly have fragile skin and veins. This makes it difficult to get in large-bore IVs."

• **Monitor patients closely for signs of respiratory distress during rapid fluid resuscitation when the line is placed in the subclavian vein.**

"A fragile and non-compliant vascular system leads the patient to increased risk for infiltration of trauma introducers," says Fuss. ■

CLINICAL TIP

Use small, frequent doses to manage pain

Manage pain in elderly trauma patients with small, frequent amounts of short-acting narcotics, advises **Joyce Fuss**, RN, BSN, CEN, FNE, a senior partner at the Emergency Medicine Trauma Center at Indiana University Health in Indianapolis. The younger trauma patient will tolerate longer-acting narcotics in higher doses to maintain pain control for longer periods of time, she explains.

"Due to varied clearance times, the elder patient needs more frequent monitoring to evaluate pain control effectiveness," says Fuss. ■

REFERENCE

1. Haas B, Gomez D, Xiong W, et al. External benchmarking of trauma center performance: Have we forgotten our elders? *Ann Surg* 2011; 253(1):144-150.

SOURCES

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Post-arrest patient? Consider therapeutic hypothermia

Advocate for your patient

Is a cardiac-arrest patient failing to wake up and follow commands? "Therapeutic hypothermia is one of the few therapies we can offer," says **Marion Leary**, BSN, RN, assistant director of clinical research at the Hospital of the University of Pennsylvania's Center for Resuscitation Science in Philadelphia.

Leary says that all ED nurses should advocate for any post-arrest patient who is not actively following commands, such as nodding yes or no or giving a "thumbs-up." "Moving arms sporadically, or seeming like they are trying to pull out the endotracheal tube, may *not* actually be following commands," she adds.

In those cases, more than likely the patient would benefit from therapeutic hypothermia, she explains. "Once you decide not to cool, there is no going back if the patient does not wake up in the days following," adds Leary.

Develop protocols

Benjamin Abella, MD, MPH, clinical research director of the Center for Resuscitation Science and assistant professor of emergency medicine at the Hospital of the University of Pennsylvania, says that he is somewhat surprised that EDs have been slow to implement therapeutic hypothermia, "as the evidence has been around for almost 10 years."

One reason for this, he says, is that it requires careful coordination of care between the ED, the intensive-care unit, and cardiology. "If a new therapy occurs very much within the ED, it is a lot easier to implement than something that requires that kind of coordination," he explains.

Also, courses and lectures tend to cover the data on therapeutic hypothermia and not the "nuts and bolts" of clinical practice, adds Abella. "If an ED in 2011 wants to start this, there are a lot of details you need to know," he says. "Who do you cool, and who do you not cool, for example?" (**For information on therapeutic hypothermia course, see resource box below.**)

Abella estimates that about half of EDs are doing therapeutic hypothermia currently. "One of the most important roles for ED nurses is to serve as champions to make the therapy happen," he says. "ED nurses are often the leaders in developing these protocols."

Abella says that when a patient comes into an ED after a cardiac arrest, an attending ED physician may not be aware of the therapy or be comfortable with it. "The ED nurse can say, 'Should we be thinking about hypothermia, for this patient? Have you considered it?'" he says. "It may not be indicated for some patients, but it should at least be considered."

Though the treatment is not as time-sensitive as thrombolytics for stroke patients, says Abella, ideally it should be started within several hours of the arrest. "In most cases, it needs to be started in the ED," he adds. "It's very difficult for ED staff to rationalize that it can be started upstairs, when we all know these patients often take several hours to get where they need to go." (**See related stories on preventing skin breakdown and recommended clinical practices, p. 77, and steps taken by ED nurses, p. 78.**) ■

EXECUTIVE SUMMARY

ED nurses should advocate for any post-arrest patient who is not actively following commands and, ideally, treatment should be started in the ED within several hours of the arrest. Use these practices:

- Get the patient to target temperature within four to six hours.
- Consider paralytics and sedation to prevent shivering.
- Use either a bladder or esophageal probe to monitor temperature.

SOURCES

For more information on therapeutic hypothermia in the ED, contact:

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• *Hypothermia and Resuscitation Training Institute at Penn* is an intensive two-day "boot camp" course offering didactic and hands-on training in post-resuscitation care. To register, contact Audrey Blewer, MPH, course coordinator. Phone: (267) 239-1765. E-mail: Audrey.blewer@uphs.upenn.edu.
Web: http://www.med.upenn.edu/resuscitation/hypothermia/HypothermiaTraining.shtml.

CLINICAL TIP

Therapeutic hypothermia? Prevent skin breakdown

Skin breakdown can occur if your patient is undergoing therapeutic hypothermia, warns **Marion Leary**, BSN, RN, assistant director of clinical research at the Hospital of the University of Pennsylvania's Center for Resuscitation Science in Philadelphia. Always check the patient's skin prior to applying any external cooling wraps, she recommends, and make sure to fill those wraps prior to placing them on the patient.

"If they are placed on the patient before they are filled, they could become tighter when the water is introduced and constrict the patient," explains Leary. ■

Use these clinical practices when cooling ED patient

When your ED patient is undergoing therapeutic hypothermia, don't underestimate how well the ice cools down the patient, says **Louise Anderson**, RN, an ED nurse at Abbott Northwestern Hospital in Minneapolis, MN, where ED nurses have utilized a hypothermia protocol since 2006.

"A nurse once told me she was sure the cooling device was 'broken,' because when she applied the device, the patient was being warmed, not cooled," she says. In this instance, explains Anderson, the patient had gone below the target temperature of 33 degrees Celsius, so the device was warming the patient back to the target temperature. Here are other clinical practices to improve care of therapeutic hypothermia patients:

• **Don't forget about paralyzing and sedating the patient.**

"I have been asked before why we cool down the patients before we start the continuous infusions of sedation and paralyzing meds," says Anderson. "Imagine how it might feel as a patient being cold and not able to move."

The key, says Anderson, is to give the patients intravenous push "bumps" of paralyzing and sedation medication until the continuous drips are available. "Of course, you need a doctor's order for these, but don't be afraid to use them," she says. "As long as you have an adequate blood pressure, don't be afraid to maximize the recommended dosage."

Anderson cared for a patient who was hypertensive, and was admitted to the Cardiac Intensive Care Unit after a cardiac procedure. "They were having a difficult time getting his blood pressure within normal range, even using continuous infusions of antihypertensive meds," she recalls.

The patient had no history of hypertension, says Anderson, and the medical team could not figure out why he was so hypertensive. "As it turned out, the patient was under-sedated," says Anderson. "Once the sedation medication was titrated up, the patient's blood pressure came down to within normal range."

• **Start therapy as soon as possible.**

Get the patient to target temperature within four to six hours of return of spontaneous circulation, recommends **Marion Leary**, BSN, RN, assistant director of clinical research at the Hospital of the University of Pennsylvania's Center for Resuscitation Science in Philadelphia. "When inducing therapeutic hypothermia, paralytics and sedation should be considered to prevent shivering. This will decrease the metabolic work load, which will increase oxygen consumption," she explains.

• **Use a reliable temperature monitoring source.**

Use either a bladder or esophageal probe monitor, says Leary. "A rectal probe is the least reliable of the three modes," she says. "There is a greater temperature lag between that mode and the patient's actual temperature. This could be a concern if the target temperature overshoots." ■

Take these steps to avoid harmful delays

For the best outcomes with therapeutic hypothermia, patients should be cooled within 30 minutes of the return of spontaneous circulation following a cardiac arrest, according to **Louise Anderson**, RN, an ED nurse at Abbott Northwestern Hospital in Minneapolis, MN. "The sooner the patient is cooled, the better the outcomes," she says. Abbott's ED nurses take these steps:

• **All unresponsive, resuscitated arrests have ice placed to their axilla areas and groin areas immediately.**

"We receive many patients from outside and out-of-state hospitals," says Anderson. "The staff have been instructed to immediately apply ice to these patients before they are sent to us."

• **A rectal baseline temperature is obtained on the patient.**

"This is not always the priority when you are caring for an acutely ill patient, but it is crucial to have a baseline temperature recorded," says Anderson.

• **The cooling device is applied to the patient when time allows.**

"If the patient needs to go to a test such as a CT scan, don't delay the CT," says Anderson. "They can go with the ice on, and apply the device when they return."

• **A continuous temperature monitoring device is inserted.**

"We use the esophageal probe," says Anderson. "Studies have shown this to be a more accurate core temperature than the rectal or bladder." ■

Some constant inpatient meds are "foreign" to ED nurses

Prevent harmful drug errors

Editor's Note: This is a two-part series on medication safety for inpatients being held in the ED. This month, we give strategies to reduce errors with inpatient medications. Last month, we gave strategies to avoid missed dosages.

Increased patient acuity and volume put "boarded" patients at high risk for medication errors, warns **Kathleen L. Wurgler**, RN, BSN, an ED nurse at Maine Medical Center in Portland.

Boarding patients "can make an ED nurse very stressed," says Wurgler. "It is our culture to meet a patient, form a plan of care, implement the stat orders, make a disposition, and move on to the next one."

A boarded patient's medications may not be verified by pharmacy, adds Wurgler, because they are not ordered stat. "There may be poor communication between the admitting team and the ED nurse caring for the patient to discuss the plan of care," she adds.

Unfamiliar meds

Medications common to patients in the inpatient setting may be "foreign" to ED nurses, says **David M. Solomon**, RN, BSN, CEN, EMT-P, patient care coordinator in the ED at Catawba Valley Medical Center in Hickory, NC. "It is time-consuming to have to research a seldom-administered medication in the ED that would be simple for the medical/surgical nurse," he says.

Wurgler says boarded patients may need a patient-controlled analgesic for pain control, which is not usually available in the ED. "While we are very familiar with the side effects, the ED nurse would need to get the hospital policy, the machine that infuses with the tubing, and of course, the key from the nursing supervisor," says Wurgler.

If you've never given a certain medication, Solomon says to check drug references on any side effects to look for, and do double checks with another nurse.

More monitoring

Psychiatric medications, such as lithium and thorazine, are dosed by the pharmacy, says Solomon, as these medications are not kept in the ED's automated medication dispenser. Since these patients are typically not placed in rooms with monitors, vital signs have to be taken frequently, he adds, because of side effects such as hypotension, dizziness, nausea, and vomiting.

"Constant patient monitoring is essential for patient safety," says Solomon. "Luckily, most patients taking these medications in the ED are prescribed these medications regularly."

Solomon says it is particularly important to monitor patients for the first and second doses

to know how they are going to react to them. "Observation for one hour is good practice," says Solomon. "Side effects will usually occur shortly after administration."

Because medications may be given over multiple shifts, good bedside reporting is "a must," says Solomon. "Include any adverse or expected reactions to medications," he advises. "Our standard here is to perform one-hour rounding on all patients. This includes some type of interaction with the patient by a staff member." **(See clinical tip on obtaining information on last doses, p. 79.)** ■

SOURCES

For more information on medication safety of "boarded" ED patients, contact:

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CLINICAL TIP

Obtain or verify last doses with patients

To decrease the potential for medication errors in boarded ED patients, **Elaine Marshall**, RN, BSN, MHA, an ED nurse at Rex Hospital, Raleigh, NC, says that ED nurses should obtain and/or verify the time of the patient's last dose.

"When patients are placed on a scheduled dose in the hospital, it is on 'hospital time,' not patient time," says Marshall. "When you ask the patient about their last dose, you will often find that they may have already taken a daily dose, or take it at a different time."

Confer with the pharmacist as to whether the current dose needs to be rescheduled or if it is within the allotted timeframe for a dose, advises Marshall. "Be familiar with the medication type that they are giving. Is it extended release or a standard release?" she says. "It is imperative that the last dose time is known, so the patient is not overdosed." ■

Should tPA be given to elderly stroke patients?

Age is not a contraindication

Before ED nurses at Ridgeview Medical Center in Waconia, MN, administered tissue plasminogen activator (tPA) to a man in his 80s with obvious stroke symptoms, the neurologist was consulted — and also the patient's family members, says **Kathie Pulchinski**, RN, ED nurse manager.

"***This particular*** patient was very high-functioning before his stroke," says Pulchinski. "The family said they knew he would rather risk death than function with the continued neurological deficits he was exhibiting." The man ultimately had a very positive outcome, she reports.

Lauren Brandt, RN, MSN, CNS, CNRN, director of neurosciences at Seton Brain & Spine Center in Austin, TX, notes that age is not a contraindication for treatment with tPA.

"In fact, for the expanded time window, they treat up to the age of 80. Any age can be treated in the three-hour window," she says. "As long as the patient understands what the risks versus benefits are, they can be treated."

Recently, Brandt cared for a 92-year-old woman with a large right-sided stroke. "This person was independent, with a good quality of life," she says.

EXECUTIVE SUMMARY
Always consider older patients with stroke symptoms as potentially eligible for thrombolysis, unless they have a known contraindication. To improve their care:
• Consult the patient's family members.
• Remember that age is not a contraindication.
• Do a thorough history of recent events to determine the "last known well" time.

"She had come in quickly upon onset of stroke symptoms."

The woman met criteria for intravenous tPA, and was offered treatment, says Brandt, but she refused. "When the doctor asked why she would not want to be treated, she said she had had a good life and was ready to go," she says.

After the emergency physician informed her that she most likely would not die from the stroke, but would most likely not get better, she immediately agreed to go forward with the treatment, Brandt says. "She responded remarkably well, and returned almost to baseline," she reports. (**See related story on new research on elder stroke patients and clinical tip on identifying the "last known well" time, p. 80.**) ■

SOURCES

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Study: Consider tPA for elders with stroke

Always consider older patients with stroke symptoms as potentially eligible for thrombolysis, says **Salvador Cruz-Flores**, MD, MPH, professor and director of the Souers Stroke Institute at St. Louis (MO). "Unless they have a known contraindication not to use it, the bottom line is, do not waste time," he says.

A recent study showed that the risk of intracerebral hemorrhage was higher in elderly stroke patients given thrombolysis, based on 1659 patients older than the age of 80.[1] Only 1.05% of elders received thrombolysis, compared with 1.72% of younger patients.

The study showed that while older patients have a higher chance of dying, the use of thrombolysis itself does not seem to be the cause, says Cruz-Flores, the study's lead author. "Patients older than 80 should be evaluated as promptly as a younger patient, and should probably be considered for thrombolysis," he emphasizes.

Previous studies on the use of thrombolysis for stroke have never addressed specifically whether the treatment makes a difference in patients older than 80, according to Cruz-Flores. "The numbers of people in the age group were small, making it very difficult to determine whether the treatment is useful," he explains.

Several studies have looked at people treated with thrombolysis and compared outcomes for individuals older than 80 and younger than 80, adds Cruz-Flores. "Most show that people older than 80 have a higher chance of dying or bleeding compared to the younger counterparts," he says. "However, those treated have also a somewhat better outcome than those not treated." ■

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1. Alshekhlee A, Mohammadi A, Mehta S, et al. Is thrombolysis safe in the elderly? Analysis of a national database. *Stroke* 2010;41:2259-2264

CLINICAL TIP

ID "last known well" for elders with stroke

It is sometimes difficult to find out when an elderly stroke patient was "last known well," according to **Karen Bergman**, RN, neuroscience coordinator at Bronson Methodist Hospital in Kalamazoo, MI. "We must know when they were last known to be well in order to determine where in the [tissue plasminogen activator] time window we are," she says.

Many times elderly people live alone, so no one is with them to witness the onset of the symptoms, notes Bergman. "A very careful and thorough history of recent events will sometimes confirm the 'last known well' time, even though the patient was alone at the time," she says. ■

Patient is suicidal? Inform all others

If ED nurses believe a patient poses a risk of harm to themselves or others, a patient safety checklist is used for "closed-loop" communication with security, says **Alexandra Penzias**, RN, MEd, MSN, CEN, clinical nurse educator in the department of emergency medicine at Tufts Medical Center in Boston, MA. "This ensures that all members of the ED team are aware of the patient's status and plan of care," she explains.

The checklist tells everyone on the ED team whether the patients may wear their own clothing, if they must be escorted when they leave their room or go to the bathroom, and whether the patient may move around in the room, says Penzias. [**The checklist 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.**]

Patients are re-evaluated throughout their stay for changes in risk level, says Penzias. "If the nurse believes the patient is at heightened risk or is in possession of new contraband, the patient may be subject to an additional search," she adds. To alert others in the ED of potentially suicidal patients:

• **Use "visual alerts."**

Saint Louis University Hospital's ED nurses place at-risk patients in disposable blue scrub suits. "This serves as a visual alert in case a patient who is a threat to themselves or others tries to elope," says **Helen Sandkuhl**, RN, MSN, CEN, TNS, FAEN, director of nursing, emergency and trauma services at Saint Louis (MO) University Hospital. "Once the patient is disrobed, the patient's clothing and personal belongings are placed in a secure location outside of the patient's room."

• **Minimize opportunities for elopement.**

Patients may be angry, fearful, or agitated, notes Sandkuhl. "If your seclusion room is already in use, place the patient in an area that is away from exits, allows for easy observation, and an area with decreased stimulation," she says. "An example would be not to place the patient next to the resuscitation room."

• **Give at-risk patients 1:1 observation.**

"The ED practices as a team, so maximize your resources," says Sandkuhl. "Make everyone aware that elopement could be possible while the patient is in the department." (**See related story, p. 81, on assessment of potentially suicidal patients.**) ■

EXECUTIVE SUMMARY

If patients are possibly suicidal, ED nurses should place them under immediate observation, and rapidly remove clothing and belongings. Other recommended practices:

• Place patients in colored scrub suits as a visual alert.
• Place patients where they can be easily observed.
• Avoid placing patients near exits or the resuscitation room.

SOURCES

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Vague complaints? Get more details

Do rapid screening

If your ED patient presents with generalized weakness, is disheveled, unable to make eye contact, has difficulty articulating the history of present illness, or has a history that is discordant with his or her presentation, more detailed questions

regarding the patient's psychosocial well-being may be necessary, according to **Alexandra Penzias**, RN, MEd, MSN, CEN, clinical nurse educator in the department of emergency medicine at Tufts Medical Center in Boston, MA.

"Many patients with undiagnosed mental-health issues will present to the ED with vague physical complaints," notes Penzias. "It is only once the triage nurse has an opportunity to interact with the patient that we can identify some of the signs and/or symptoms of a mood-, thought-, or substance-related disorder."

For this reason, all ED patients are screened at triage for potential suicidality, says Penzias. "Patients deemed at risk are placed under immediate observation by a patient-care safety aide or an ED nurse," she explains.

If the patient is at risk, ED nurses facilitate rapid placement and removal of clothing and belongings, says Penzias. "We explain that all patients must be placed in a gown for medical evaluation, and facilitate a superficial physical search and search of their belongings for actual or potential weapons or other contraband," she says.

Searches are performed by an ED nurse and a member of the security staff, and belongings are catalogued and stored away from the patient until the patient is no longer considered at risk, says Penzias.

Screen all patients

Gregory Torok, RN, an ED nurse at Hennepin County Medical Center, says that all patients older than 18 years old admitted from the ED are screened for suicide risk. "We do not screen intoxicated patients to prevent the risk of false positives," he adds. "Critical patients are not screened due to their medical condition."

Helen Sandkuhl, RN, MSN, CEN, TNS, FAEN, director of nursing, emergency and trauma services at Saint Louis (MO) University Hospital, says ED nurses complete a brief screening tool for early and accurate identification of patients at risk. "This early identification results in improved treatment and patient outcomes," she says.

Recently, Sandkuhl cared for an intoxicated student who didn't initially reveal that he had also ingested an unknown amount of acetaminophen. "Alcohol acts as a depressant and may sometimes make a suicidal patient act out his ideations," she warns. ■

Make elders comfortable during lengthy ED waits

ED nurses must find the time

Do you treat elderly patients waiting in the ED as you would expect your own family member to be treated — as if they were the only ones there?

"If you can't do this because of a more urgent patient, enlist the members of your team to help," advises **Mary M. Pelton**, RN, CEN, an ED nurse at Carteret General Hospital in Morehead City, NC. Here are approaches to make waiting elders comfortable:

• Have patients lie on hospital beds instead of stretchers.

"This prevents skin breakdown and improves comfort," says Pelton. "Take the time to provide pressure relief with pillows."

• Minimize the patient's pain.

"It is much more difficult to eliminate pain once it starts," says **Nadine Holman**, MSN, RN, CEN, an ED nurse at St. Anthony's Medical Center in St. Louis, MO. "The comfort level of a patient has been shown to affect their healing process."

• Anticipate needs, rather than waiting for a patient to ask for something.

"Offering a warm blanket or providing a sling or ice pack are ways to keep patients physically comfortable," says Holman.

• Keep emotional distress to a minimum.

Talking with patients frequently lets them know they have not been "lost in the shuffle," says Holman, and gives them a chance to ask for assistance if needed. "The biggest fear an elderly patient has is that they will be forgotten," she says. "A smile and a kind word can go a long way."

• Make frequent contact with the patient.

"I believe just *seeing* a staff member can relieve stress-induced discomfort," says Holman. "With all the chaos going on in an ED, it's easy to think you have been forgotten. Complaining of physical pain may be the only way a patient knows to

EXECUTIVE SUMMARY

Anticipate needs of elderly patients in waiting areas, such as warm blankets, slings, or ice packs. Other ways to make them comfortable:

- Have patients lie on hospital beds, not stretchers.
- Provide pressure relief with pillows.
- Make frequent contact.

get attention." (**See related story, p. 83, on waiting room chairs.**) ■

SOURCES

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CLINICAL TIP

Your ED's chairs may be harmful to elders

Examine the chairs used in your ED waiting areas, as these can be clinically harmful to elders, says **Rita LaReau**, MSN GNP-BC, geriatric clinical nurse specialist at Bronson Methodist Hospital in Kalamazoo, MI.

"Due to age-related changes, as well as the combination of acute or chronic conditions, the elderly emergency-room population is at high risk for various adverse outcomes. These include falls, pressure ulcers, functional decline, delirium, depression, and death," says LaReau. "Any discomfort related to seating can further exacerbate any of these conditions."

LaReau says that ED waiting chairs should have these characteristics:

• A height of 18 to 19 inches and depth of 18 to 20 inches, with arms extended to the front chair edge;
• Chair arms should be 10 inches above seat height;
• Made of a non-slip fabric, with clearance under the front of the seat to allow feet under the front edge;
• Provide lumbar support;
• Be stable without tipping over, with minimal back recline and backward seat tilt;
• Chair legs that fit with blocks to raise the seat height.[1]

"Make sure that chairs have good arms and firm seats," adds LaReau. "Also, the frail will transfer easier out of chairs which are higher than standard chair height." ■

REFERENCE

1. O'Keefe J. Creating a senior friendly physical environment in our hospitals: The Regional Geriatric Assessment Program of Ottawa. Available at http://www.rgpeo.com/documents/Senior-friendly-fulltext2.pdf.

COMING IN FUTURE MONTHS

■ Obtain life-saving details from your patient at triage

■ Don't leave out crucial information during handoffs

■ Take steps to avoid misdiagnosis of myocardial infarction

■ Strategies for suspected abuse of pain medications

CNE ANSWERS

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

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 June issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue to receive a letter of credit. When your evaluation is received, a letter 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.

17. Which of the following is true regarding care of elder trauma patients, according to **Joyce Fuss**, RN, BSN, CEN, FNE, a senior partner at the Emergency Medicine Trauma Center at Indiana University Health in Indianapolis?
A. The elderly have decreased pain sensation and delayed cardiovascular response, making abdominal injuries, with risk for bleeding, difficult to assess.
B. If elderly patients are on beta-blockers, they are more likely to demonstrate tachycardia in response to blood loss.
C. Routine blood gases should *not* be used to identify a high base deficit or lactate.
D. Longer-acting narcotics in higher doses should be used to maintain pain control for longer periods of time.

18. Which is recommended regarding fluid resuscitation in elders, according to Fuss?
A. Fluid should be administered only through large-bore peripheral intravenous lines.
B. It is not necessary to monitor patients closely for signs of respiratory distress during rapid fluid resuscitation when the line is placed in the subclavian vein.
C. Elderly trauma patients require close monitoring during fluid and blood administration for cardiac overload.
D. Elderly patients are not at increased risk for infiltration of trauma introducers, despite having a fragile and non-compliant vascular system.

19. Which is recommended when treating a post-arrest patient with therapeutic hypothermia?
A. Never administer paralytics and sedation medications until continuous drips are available.
B. Never fill external cooling wraps prior to placing them on the patient.
C. Use a rectal probe to monitor the patient's temperature, instead of a bladder or esophageal probe monitor.
D. Initiate cooling of patients within 30 minutes of the return of spontaneous circulation following a cardiac arrest.

20. Which is true regarding elderly stroke patients and treatment with tissue plasminogen activator?
A. Age older than 80 is a contraindication for the three-hour time window.
B. Patients up to the age of 80 are treated within the expanded time window.
C. Any age can be treated within the expanded time window.
D. Age older than 90 is a contraindication for the three-hour time window.