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Caring for a "psych" patient? Careful ED assessment may reveal otherwise!

Life-threatening issues can arise

When a man with a known history of seizures came to the ED at the University of California — San Diego Medical Center very agitated, diaphoretic, and yelling, ED nurses first thought he was having a schizophrenic breakdown, says **Tia Valentine**, RN, CEN, ED clinical nurse educator. "His presentation was definitely *not* like we knew him from prior visits," she says.

The man had a history of schizophrenia, and had been known to be non-compliant with his antipsychotics, says Valentine, but he insisted that he hadn't missed any medication doses this time. "Because everyone was so focused on how he was *acting*, no one thought to consider other medications as potential issues," says Valentine.

After ED nurses reviewed his medications, however, they found out that he was dilantin toxic, with a level of 26. "Had the dilantin level *not* been found, potential life-threatening issues could have arisen," says Valentine. "A psychiatric complaint can often be masked by some other underlying etiology."

If your patient has an altered level of consciousness, or appears combative, confused, or lethargic, for instance, you may wrongly assume he or she has a psychiatric condition when, in fact, it's liver failure, warns **Kerri Helm**, RN, CEN BSN, trauma coordinator at Hendrick Health System in Abilene, TX.

"*Always* think organic before writing it off as mental illness, especially in the elderly," says **Samantha Vining**, MS, RN, CEN, ED nurse manager

EXECUTIVE SUMMARY

Patients may present with symptoms that appear psychiatric, but are actually caused by medical conditions or side effects of medications. To improve your assessment:
- Ask if your patient is taking psychiatric medications.
- Determine the patient's normal mental status.
- Consider low blood glucose if patient appears confused.

at Albany (NY) Medical Center. Urinary tract infections and pneumonia are very common causes of altered mental status in the elderly, she explains, and must be ruled out.

Helm says to ask these "open-ended" questions at triage if your patient has symptoms that appear psychiatric: "What kind of symptoms are you having?" "What kind of medications are you taking?" "What kind of illnesses have you had in the past?" and "Is anyone else in your home ill?"

Ask about chronic illnesses, social history, recent events and problems, symptoms, substance abuse, and the patient's normal mental status, advises Helm.

Has a paranoid-looking patient taken illegal drugs recently? "The paranoia could be related to the drug actions itself," says Valentine. This is usually seen in people who are first-time marijuana smokers and cocaine users, she adds.

"Mental confusion is sometimes considered to be related to mental illness, when, in fact, it could be low blood glucose," adds Valentine. "The alteration to the brain's ability to perceive and make sense of a situation can be directly linked to hypoglycemia." (**See clinical tip below on psychiatric medications.**) ■

SOURCES

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CLINICAL TIP

Psychiatric symptoms? Consider patient's meds

Many medications currently on the market for psychiatric disorders have been demonstrated to cause medical issues, says **Tia Valentine**, RN, CEN, clinical nurse educator for the ED at University of California — San Diego Medical Center.

"Some of the medications alter glucose, so patients can become cranky sooner," she says. "Some medications decrease the ability to sleep."

Acute onset of confusion or weakness may wrongly be attributed to a transient ischemic attack instead of a side effect of psychiatric medi-

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cations, adds Valentine. If your patient has a psychiatric complaint, she advises, "Always ask what meds they are on, and if they took their current dose. Obtain the last dose time of any medication." ■

Protect ED patient if a urinary catheter is placed

Prevent life-threatening complications

Have you just placed a urinary catheter in an ED patient? If so, possible complications include urosepsis, septicemia, trauma to the urethra or bladder, and urethral perforation, warns **Mark Goldstein**, RN, MSN, EMT-P I/C, clinical nurse specialist at the Emergency Center at Beaumont Hospital in Grosse Pointe, MI. Here are tips to avoid complications:

• **Take the time to provide aseptic technique.**

"Take along an extra catheter, just in case the original catheter is misplaced, dropped, or accidentally contaminated," says **Amy Mundisev**, RN, BSN, CEN, ED clinical educator at Trinity Regional Medical Center in Fort Dodge, IA.

• **Don't anchor a Foley catheter unless necessary.**

"Discuss the option of a clean catch or straight catheter with the physician, if appropriate," says **Angel Keene**, RN, BSN, ED nurse at Indiana University Health Goshen (IN) Hospital.

• **Use the smallest size catheter necessary for the patient.**

"This is important for preventing injury to the urethra," says Keene. "A catheter that is too large would keep constant pressure on the urethra."

• **Use the closed system kit that comes with the catheter already attached to the drainage bag.**

"This helps to minimize the chances of contamination," says Keene. "If a separate catheter and bag are being used, be sure the connecting ends remain sterile or that they are cleaned with alcohol."

• **Keep the urine collection bag low.**

Urine that sits in the drainage bag over a period of time can grow bacteria, explains Keene, and if the drainage bag is raised over the level of the bladder, the urine can drain from the tubing and bag back into the bladder.

"Always keep the drainage bag lower than the bladder to keep urine flowing out, and never in," she says.

You can stop UTIs

The most likely complication associated with catheter use is a catheter-associated urinary tract infection (CAUTI), says Goldstein. Bacteremia, a serious and potentially life-threatening complication, will develop in approximately 3% of all catheterized patients, he adds.

"Using infection-control measures, an estimated 17% to 69% of CAUTIs may be prevented," Goldstein says.

Urinary tract infections in patients that are elderly or immunocompromised can be very serious, warns Keene, and potentially lead to sepsis and death. Goldstein gives these tips to prevent CAUTIs:

• Perform hand hygiene immediately before and after insertion, or any manipulation of the catheter device or site.

• Cleanse the perineal area to decrease bacteria in the surrounding area before indwelling catheter insertion. "Avoid vigorous cleansing, which may increase the risk of infection," Goldstein says.

• Insert indwelling catheters using aseptic technique and sterile equipment. The equipment needed for insertion includes sterile gloves, drape, sponges, an appropriate antiseptic or sterile solution for periurethral cleansing, and a single-use packet of lubricant jelly, adds Goldstein.

• Choose catheter materials appropriate for each patient. The short-term use of silver alloy catheters may reduce the incidence of CAUTI and bacteriuria, says Goldstein, and silicone or hydrogel catheters are recommended for patients using catheters longer than 14 days.

• Change indwelling catheters and drainage bags according to clinical indications, such as infection, obstruction, or when the closed system is compromised, rather than at routine, fixed intervals.

• Obtain urine samples aseptically, and only from newly placed catheters.

"After cleansing the needleless sampling port

EXECUTIVE SUMMARY

Prevent complications from urinary catheters by utilizing them only when truly necessary, avoiding shortcuts with sterile technique, and discontinuing them as soon as possible. To reduce risks:
• Keep the urine collection bag low.
• Use the forceps included in urinary catheter kits.
• Start over if you break sterile technique.

with a disinfectant, aspirate the urine with a sterile syringe," says Goldstein. "Avoid irrigation unless needed to prevent or relieve obstructions." **(See related stories on sterile technique and discontinuing catheters below, and asking for help, p. 89.)** ■

SOURCES

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Don't take shortcuts with sterile technique

Katherine Murczek, RN, clinical practice partner in the ED at Advocate Christ Medical Center in Oak Lawn, IL, says good sterile technique is the single best way to prevent infection. Here are three recommendations:

1. Use *all* the components of the urinary catheter kit.

"All too frequently, staff take shortcuts and decide not to use the sterile drape, forceps, or all of the cotton balls," says Murczek. Many don't use the sterile drapes because they believe it impairs their vision, she notes.

ED nurses may find the forceps awkward to use, adds Murczek, and may use only their sterile, gloved hand to handle the cotton ball and clean the patient. Countless times, she says, ED nurses have claimed they can clean a patient without the forceps and not break sterile technique. "They want to believe their fingers touch one side of the cotton ball and the other side touches the patient, leaving them sterile," she says. "I believe this to be absolutely false."

2. Start over if necessary.

Anatomy and patient size sometimes make it difficult to insert catheters successfully the first time, especially in females, says Murczek. "Be willing to admit when you break sterile technique, even to the patient," she says. "Get a new kit and start over, because it's in the best interest of the patient."

3. Pretend you're inserting the catheter in a family member.

Murczek asks ED nurses to pretend it's their parent, grandparent, or child that they're performing the procedure on. "We all expect the best for our family," she says. "We must provide that level of care to every patient." ■

Is catheter use valid? Even if so, discontinue ASAP

A urinary catheter should only be placed when truly necessary, says **Katherine Murczek**, RN, clinical practice partner in the ED at Advocate Christ Medical Center in Oak Lawn, IL. "It should *not* be placed for staff convenience," she says.

Determine if your patient has a valid reason for needing the catheter, says **Angel Keene**, RN, BSN, ED nurse at Indiana University Health Goshen (IN) Hospital. "Being obese and incontinent is *not* a valid reason for an indwelling Foley catheter," she adds.

Never insert a Foley catheter in a trauma patient if blood is present, says Keene, due to the possibility of internal injury to the genitourinary system.

Remove the catheter when it is no longer necessary for the patient, says Keene. "This can definitely be overlooked in the ED," she says. "Nurses do not want to remove a catheter, only to find later that it needs to be re-inserted, so they tend to leave them in."

The longer a catheter stays in, warns Keene, the more risk there is for infection. For this reason, she says, encourage physicians to discontinue catheters for patients if they are able to use a bedpan or bedside commode.

"This may be less convenient at times, but it will be better for the patient in the long run," Keene says. ■

CLINICAL TIP

Ask for assistance with urinary catheter

Patients may need someone to help calm them during catheterization, says **Angel Keene**, RN, BSN, ED nurse at Indiana University Health Goshen (IN) Hospital. "A soothing voice to preoccupy the patient may be all that is necessary to help them hold still and avoid tensing up," she says.

Patients who have altered mental status may be combative during catheterization, adds Keene. "Using an extra person to hold the patient's legs in an open position may be necessary to accomplish the task," she says.

An extra staff person can help to position the patient, says Keene, to assist in maintaining sterile technique. "In large patients, an extra person may be necessary to help the primary nurse visualize the urethra due to excessive skin folds," she says. ■

You may miss potentially violent patients at triage

Stressful situations increase risk

If a patient presents visibly intoxicated and announces his or her intent to harm others, it's easy to make the decision to involve security. However, *any* ED patient or visitor has the potential to become physically violent, warns **Gordon Lee Gillespie**, PhD, RN, PHCNS-BC, CEN, CCRN, CPEN, FAEN, assistant professor and director of population-focused care at University of Cincinnati (OH) College of Nursing.

"I recommend that ED nurses apply universal violence precautions during all interactions with patients *and* visitors," he says. Patients and visitors are more likely to become violent when being told of a psychiatric admission, the death of a family member, or a new diagnosis of a terminal illness, says Gillespie.

"Other stressful situations are new smoking restrictions and limitations for visitor access," Gillespie says. "Crowded environments, long wait times, and ignoring patients and visitors are contributors to outbreaks of physical violence." Gillespie recommends these practices:

• **Don't leave individuals at risk for becoming physically violent in the general waiting room.**

"Some ED nurses have reported that expediting patient care is not fair to other waiting patients," Gillespie says. "However, keeping a 'toxic,' escalating person in the lobby raises the anxiety and stress of *all* persons." This could result in aggression and violence from other individuals, he says, and lead to poor patient satisfaction related to their personal safety perception.

• **Contact the charge nurse.**

He or she can then inform both staff and the ED physician of the person's risk for physical violence, says Gillespie. "Care can then be tailored to prevent further patient or visitor escalation," he says. "The triage nurse can also contact security, a hospital chaplain, or a patient liaison to provide support." **(See related story below on steps to prevent violence.)** ■

Take these steps, prevent violence by ED patients

ID signs of escalation

Is your patient pacing in the room or hallway, avoiding eye contact, mumbling, yelling or talking too loud, constantly staring, or avoiding eye contact? These are all signs that a person is escalating toward physical violence, says **Gordon Lee Gillespie**, PhD, RN, PHCNS-BC, CEN, CCRN, CPEN, FAEN, assistant professor and director of population-focused care at University of Cincinnati (OH) College of Nursing. He gives these tips to reduce risks with potentially violent patients:

EXECUTIVE SUMMARY

Any ED patient or visitor has the potential to become physically violent, so take precautions during all interactions. To reduce risks:
• Don't leave at-risk patients in the general waiting room.
• Inform the charge nurse of a patient's risk for violence.
• Have another ED team member present during your assessment.

• Knock on the door when entering to prevent the patient and visitors from being startled.

"Introduce yourself when entering," Gillespie says. "Sit at least four feet away from the patient, providing distance in case the patient attempts to swing or throw an object at you."

• Have quick access out of the patient treatment room.

Do *not* sit in a corner in the back of the room where a patient or visitor can block you from leaving, advises Gillespie.

• Attempt de-escalation techniques.

"Ask the person what is wrong. Meet this need if possible," Gillespie says. "If you are not able to meet the need, explain your rationale."

If the patient continues to escalate, Gillespie says to leave the room and get assistance. "Someone else may be able to make a personal connection and resolve the stressor," he says.

• Alert the rest of your team that the patient may become physically violent.

Have another nurse or technician assist you in the room while performing your assessment or intervention, advises Gillespie. "If this is not possible, then at least have someone outside the patient door in case you call for help," he says. "Have someone come to the room after five minutes, if you have not checked back in that you are okay."

Security should be aware of your concern, adds Gillespie, so that they are in the department and immediately available if called. "They don't necessarily need to be outside the door, as this can also escalate the situation," he adds. ■

SOURCE

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Should you do an EKG? Err on side of caution!

Get life-saving data in minutes

ED nurses at St. Elizabeth Healthcare — Florence (KY) have cared for several healthy patients under age 35 with no history or family history of heart disease, who were having a cardiac event, reports **Ben Brooks**, RN, BSN.

"We had a 19-year-old healthy woman come into the ED complaining of chest pressure, with vague symptoms," he says. The triage nurse ordered an EKG to be completed, which showed an acute myocardial infarction (MI), and the patient was later sent to the cardiac catheterization lab. "Her MI was the result of a tumor on her heart that was found during the cath," says Brooks

Emergency nurses "must be very liberal" with obtaining EKGs, advises **Jeffery Chambers**, RN, an ED nurse at Massachusetts General Hospital in Boston and member of the hospital's STEMI committee. "An EKG is an easy, non-invasive tool that provides life-saving data within minutes."

James Noland, CRNP, BC-PNP, MSN, CEN, CCRN, an ED nurse practitioner at Huntsville (AL) Hospital, says that many patients complaining of chest pain have an "initially benign appearance. Early recognition with prompt intervention is key to survival."

At Huntsville's ED, patients 30 or older with a chief complaint of chest pain or discomfort, chest pressure or tightness, "heartburn" or epigastric pain, complaints of heart racing or heart too slow, a syncopal event, onset of stroke symptoms in the past 24 hours, difficulty breathing with no obvious non-cardiac cause, and patients older than 45 with severe weakness should get a 12-lead EKG within five minutes.

Heart Alert called

Huntsville's ED nurses make sure that a complete blood count, electrolyte profile, and the first set of cardiac enzymes are drawn and sent to the lab. "The second set is drawn two hours after the

EXECUTIVE SUMMARY

ED nurses should do EKGs even if a patient's initial appearance is benign, since prompt intervention can give life-saving information. Use these practices:
• Do the EKG within five minutes.
• Include patients with severe weakness, "heartburn," and syncopal events.
• Document the patient's last dose of aspirin, if taken at home.

first," says Noland. "If the patient is taking aspirin at home, the time of the last dose is documented."

If indicated, nitroglycerine paste is applied and the patient is given an appropriate dose of morphine. If it is determined that the patient is having an acute MI, or acute ST-segment elevation is noted, the ED physician directs the staff to call a Heart Alert.

"A designated number is called, and the operator is told that a Heart Alert needs to called," says Noland. The paging operator is given the patient's room number, and members of the Heart Alert team are notified via pager.

The ED nurse immediately begins preparing the patient for the cardiac catheterization lab by obtaining two intravenous lines, administering medications, initiating and completing the documentation, and giving the report to the cardiac catheterization lab personnel.

"While in the ED, the patient receives fibrinolysis medications if needed," says Noland. "The interventional cardiologist performs angioplasty and stent placement as indicated." (**See related stories on a pre-triage EKG protocol and pain assessment below.**) ■

SOURCES

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Identify MIs with pre-triage EKG protocol

Pre-triage protocol, says **Judy Drummer**, RN, CEN, MA, director of nursing at the ED at State University of New York Downstate Medical Center in Brooklyn, was established for EKGs. These steps are taken:

1. An EKG associate greets all incoming patients at ambulatory triage, obtains vital signs, and identifies the patient's chief complaint.
2. If the patient complains of chest pain, the EKG associate obtains an EKG and gives it to a physician for reading.
3. If the EKG does not show any indication of a cardiac event, the patient is triaged and taken to the appropriate location.

"The exception is when the triage nurse, after asking all the 'right' questions, suspects the pain might be cardiac in origin," says Drummer. Drummer says to ask these questions:

- Is the chest pain worse with coughing or deep breathing?
- Does the chest pain increase with swallowing?
- Does the chest pain increase with movement?
- Did you lift anything heavy or work out recently?
- Are you on any blood-thinning medication?
- Do you have diabetes mellitus?
- Is the pain constant or intermittent?
- How long you have this kind of pain?
- Does the pain increase when you are walking?

4. If the EKG shows a suspicious cardiac abnormality, the patient goes straight to the acute treatment area for treatment, and is triaged while the physician examines the patient. ■

CLINICAL TIP

Suspect MI? Then ask patient to point to pain

A 72-year-old woman complained of stomach pain, and told ED nurses that the pain got worse even after she took antacid medication, recalls **Judy Drummer**, RN, CEN, MA, director of nursing at the ED at State University of New York Downstate Medical Center in Brooklyn.

The patient had no cardiac history, but when the triage nurse asked her to point where the

pain was coming from, she pointed to her chest, not her stomach, says Drummer. "A stat EKG was done, which showed ST elevation in leads II and III," says Drummer. "The lab result showed an elevated troponin level, and the patient was admitted to the [critical care unit]." ■

ED nurses seeing more dog-bite-injured patients

Dog-bite injuries resulting in hospital admissions have increased drastically in recent years, from 5100 cases in 1993 to 9500 in 2008, according to a recent report from the Agency for Healthcare Research and Quality (AHRQ).[1] More than 316,000 ED visits in 2008 were for dog bites, says the report.

"Hospitalizations seem to be going up, and the vast majority come through the ED," says **Anne Elixhauser**, PhD, one of the study's authors and a senior research scientist at AHRQ. More than half of the dog-bite-related hospitalizations involved a procedure such as wound debridement, stitches, or skin grafting, says the report.

To improve care of patients with dog bites, use these practices recommended by **Leora Wile**, BSN, RN, an ED nurse at Thomas Jefferson University Hospital in Philadelphia, PA:

• Get a detailed history.

Obtain the time of the event, the dog's rabies status, and the location of bites, says Wile, and document whether the bites are abrasions, puncture wounds, or lacerations.

• Have the patient get completely undressed and into a gown.

"There may be bites under clothing, even though the patient's clothing is not damaged," says Wile. Wile cared for a patient with dog bites to the hands who denied any other injury, but she saw the woman was limping. "When the patient was changed into a gown, I noticed a large bruised area with tears in skin on the shin," she says. "There were no tears or rips in her pants. This would have been missed if the patient was not undressed."

• Do a full neurovascular and functional assessment of all extremities with bites on them.

"Dog bites may cause a crushing injury, besides puncture wounds, abrasions, and lacerations," she explains. "Do the same assessment as if the patient had twisted the ankle, knee, elbow, or wrist."

Check movement of extremities, capillary refill, sensation, and pulses, says Wile, due to the potential for compartment syndrome from severe bites. "If bites are in the elbow area or knee, the swelling may limit mobility," she says. "This needs to be documented, so that follow-up exams can have a baseline from the time of injury."

• Irrigate all wounds with copious amounts of saline to decrease the risk of infection.

"Wounds may need to be injected with lidocaine prior to irrigating for patient comfort," says Wile.

• Remember to wear face mask and eye protection to avoid getting fluids splashed in your face.

"Avoid shield-like devices for irrigation to prevent the irrigating solution from returning to the wound," Wile says. "This decreases the effectiveness of the irrigation." **(See clinical tip, p. 93, on treatment prior to the patient's ED visit.)** ■

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EXECUTIVE SUMMARY

ED nurses are seeing more patients with dog-bite injuries, and many require wound debridement, stitches, or skin grafting. To improve their care:
• Always examine the patient undressed.
• Document swelling in elbow and knee areas.
• Ask if the patient irrigated the wound.

SOURCE

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CLINICAL TIP

Ask about treatment for dog-bite injury

If a patient presents with a dog-bite injury, **Leora Wile**, BSN, RN, an ED nurse at Thomas Jefferson University Hospital in Philadelphia, PA, says to find out what treatment, if any, was received by the patient prior to arriving in the ED. "It is important to find out if the patient irrigated the wound prior to arrival," she says. "Rabies is very fragile, and early washing of the wound will help decrease the risk of infection."

Ask if the patient has taken any over-the-counter medications, so no overdoses of acetaminophen occur, says Wile. "Also, some patients may have put a tourniquet on an arm or leg to stop the bleeding, and it may still be on under a jacket or pants," she says. "This would cause you to immediately check the extremity." ■

Suspect prescription drug abuse with these symptoms

If your patient is abusing narcotic pain medications, he or she isn't likely to come out and tell you this. However, ED visits involving misuse or abuse of pharmaceuticals nearly *doubled* during the past five years, according to a new report, totaling about 1.2 million visits in 2009, compared to 627,000 in 2004.[1]

EXECUTIVE SUMMARY

ED nurses are caring for increasing numbers of patients abusing or misusing narcotic pain relievers. Watch for these signs:
- Patients may report severe pain but appear comfortable.
- Higher doses of narcotics may be required.
- Patients may report allergies but are unable to describe the reaction.

ED visits involving nonmedical use of narcotic pain relievers rose from an estimated 144,644 in 2004 to 305,885 in 2008, according to another report — an increase of 111%.[2] The same report found that ED visits involving oxycodone products, hydrocodone products, and methadone increased 152%, 123%, and 73%, respectively, between 2004 and 2008.

Carol Jones, RN, an ED nurse at Geisinger Medical Center in Danville, PA, says that prescription-drug abuse can include many signs and symptoms, including an overstatement of allergies, requests for specific narcotics, or refusal of nonnarcotic medication. She says to watch for these warning signs:

• The patient comes to the ED with a friend who also needs to be seen.

In this case, says Jones, the patient may tell you he or she is looking for a primary provider because he or she "just moved to the area."

• The patient is lethargic, with slurred speech.

• Repeated visits to the ED show a failure to follow-up with the primary provider as advised.

"Listen to the patient and observe the patient," advises Jones. "Review the electronic medical record for frequency in visits and chief complaints." (**See clinical tip, p. 94, on allergies.**)

• The patient claims he or she lost a prescription.

Jones says that the patient may state the prescription was "'washed in my jeans,' or demand what 'works,' and only wants [hydromorphone]." ■

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SOURCE

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CLINICAL TIP

Allergy reported, but no record of it?

If a patient reports an allergy that is not noted on his or her medical record, suspect possible abuse of prescription drugs, says **Carol Jones**, RN, an ED nurse at Geisinger Medical Center in Danville, PA. "A patient may make comments such as, "Don't give me [ketorolac]," but cannot describe the allergic reaction, she adds. ■

Misunderstood physician? Patient may be harmed

If you're taking a verbal order from an emergency physician, remember that there is always a potential for miscommunication, warns **René Borghese**, RN, BAS, unit educator in the ED at Duke University Medical Center. "This is the primary reason we utilize them only when absolutely necessary," she says.

Even with electronic documentation, however, verbal orders are often needed during a cardiopulmonary arrest or trauma situation, says Borghese. "Tension is sometimes high during these scenarios," says Borghese. "Miscommunication could be detrimental to the patient, if the wrong medication or treatment were given."

Repeat orders prior to carrying them out to verify for correctness, advises Borghese. Here are other scenarios that can lead to errors:

• Consultants or resident physicians may not be familiar with the flow of the ED.

"Additional effort on the part of the emergency nurse is sometimes necessary to ensure all orders are appropriate," Borghese says. Rely on a strong clinical knowledge base in order to recognize and question orders that might not be optimal, she adds.

"The emergency nurse must have the fortitude to initiate communication with *all* levels of providers," says Borghese.

• Patients may have similar names and/or diagnoses.

"Verbal interaction, followed by documentation of pertinent events, will ensure the safety of our patients," Borghese says.

• The ED physician may be experiencing numerous interruptions.

"When possible, the nursing and medical staff should have close physical proximity to one another," says Borghese. "This fosters an open communication model." ■

EXECUTIVE SUMMARY

Dangerous miscommunications may occur with ED physicians due to verbal orders, patients with similar names or diagnoses, and constant interruptions. To reduce risks:
• Repeat orders before carrying them out.
• Recognize when orders may be inappropriate.
• Don't hesitate to report concerns.

SOURCE

For more information on improving communication with ED physicians, contact:
• **René Borghese**, RN, BAS, Unit Educator, Emergency Department, Duke University Medical Center.
Phone: (919) 668-4955. E-mail: rene.borghese@duke.edu.

Boarded patients may be overlooked: Make changes

David M. Solomon, RN, BSN, CEN, EMT-P, patient care coordinator in the ED at Catawba Valley Medical Center in Hickory, NC, says that usually, medications for boarded patients have to be ordered from the pharmacy.

"In our ED, this means someone has to walk to the pharmacy and pick those medications up," he says. "The medications then have to be verified with the

EXECUTIVE SUMMARY

Care of boarded ED patients can be improved by working with the pharmacist and placing all patients in a single location. Other recommendations:
• Store commonly used inpatient medications in automated dispensers.
• Have float nurses care for inpatients.
• Use the same schedule and documentation as medical/surgical nurses.

orders and [Medication Administration Records]."

Solomon says that it has been his experience that by the time the ED nurse has evaluated a patient, contacted an admitting physician, received orders, and made the decision to hold the patient, the patient is already behind on his or her regularly scheduled medications.

When a patient is held in the ED, nurses must inform the pharmacy to ensure that the medications will be prepared and delivered, says **Jenny Bosley**, RN, MS, CEN, a clinical nurse specialist in the ED at Thomas Jefferson University Hospital in Philadelphia, PA.

The ED has two full-time pharmacists who can review orders, make recommendations for dosing and administration, and provide staff and patient education, she reports. "They work with the main pharmacy to order and obtain needed medications for the boarded inpatients," says Bosley.

The ED's automated medication dispenser has been set up to include individual labeled bins, adds Bosley. "A bin corresponds with each patient room, and can mimic the medication carts commonly found on an inpatient nursing unit," she says. "This ensures that the medications are secure and kept separated."

The ED pharmacist consistently monitors medication inventory, and makes adjustments, as needed, to specific inventory and/or par levels, says Bosley.

Request help from RNs

Bosley says that critical care pool nurses care for admitted patients in the ED if available. "If there is a nurse available to come to the ED, the pool nurse can care for them just as they would on an inpatient unit," she says. "This, in turn, frees up an ED nurse, who can then help at triage or assist another ED nurse."

When Portland-based Maine Medical Center's ED has more than three boarded patients, inpatients are "corralled" in the ambulatory section of the ED, says **Kathleen L Wurgler**, RN, BSN, an ED nurse. Float nurses care for these patients until they go upstairs, she adds.

"Satellite nursing units are opened up to meet the need of the boarded patients downstairs," says Wurgler. "This allows the flow of the ED to resume." **(See related story, p. 95, on using a Medication Administration Record.)** ■

SOURCE

For more information on boarded ED patients, contact:
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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. ■

CNE ANSWERS

Answers: 21. C; 22. D; 23. B; 24. A

COMING IN FUTURE MONTHS

- Identify neurological deficits in elder patients
- Avoid dangerous mistakes during handoffs of children
- Don't let patients acquire infections in your ED
- Steps to take if patient withholds clinical information

CLINICAL TIP

Mimic med/surg MAR practices

ED nurses at Catawba Valley Medical Center in Hickory, NC, implemented a new process for boarded patients that mimics what is done on the medical/surgical units, says **David M. Solomon**, RN, BSN, CEN, EMT-P, patient care coordinator in the ED.

"This includes the same schedule and documentation used on the med/surg units," he adds. "The ED charge nurses also watch to ensure the medication regimens are followed."

ED nurses use a Medication Administration Record (MAR) just as inpatient nurses do, says Solomon. "This is not something the ED commonly uses," he says. "The ED isn't used to this type of schedule. We normally work on what the patient needs in the moment."

The MAR involves the pharmacy, explains Solomon, and is a medication administration schedule used for patients who are going to be staying in the hospital for more than a few hours.

"The schedule ensures they routinely get the medications they have been prescribed, before and after hospital admission," says Solomon. "The ED doesn't deviate from a patient's normal medication regimen, or one that is created for their hospital stay based on their condition."

When the patient gets admitted, the MAR goes upstairs with the patient, says Solomon. "There is an easy transition after the patient's admission," he says. "The floor nurse only has to continue what we have already started, so it's less work on them." ■

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.

21. Which is true regarding assessment of patients presenting with psychiatric symptoms, according to **Tia Valentine**, RN, CEN?
A. Patients with liver failure will *not* present as confused or lethargic.
B. Elderly patients with pneumonia will *not* present with altered mental status.
C. Acute onset of confusion or weakness may be side effects of psychiatric medications.
D. Altered mental status is *not* caused by urinary tract infection.

22. Which is recommended to prevent catheter-associated urinary tract infections, according to **Katherine Murczek**, RN?
A. Raise the drainage bag over the level of the bladder.
B. Vigorously cleanse the perineal area before indwelling catheter insertion.
C. Change indwelling catheters and drainage bags at routine, fixed intervals rather than according to clinical indications.
D. Use all components of the urinary catheter kit.

23. Which is true regarding caring for ED patients with dog-bite injuries, according to **Leora Wile,** BSN, RN?
A. Early washing of the wound will *not* decrease the risk of rabies.
B. Wounds may need to be injected with lidocaine prior to irrigating for patient comfort.
C. It is not necessary to get patients completely undressed if clothing is not damaged.
D. ED nurses should use shieldlike devices, as these increase the effectiveness of irrigation.

24. Which is recommended to improve care of boarded patients in the ED, according to **David M. Solomon**, RN, BSN, CEN, EMT-P?
A. ED nurses should use the same schedule and documentation as medical surgical units to ensure an easy transition after the patient's admission.
B. ED nurses should not utilize pharmacists to make recommendations for dosing and administration.
C. Automated medication dispensers in the ED should not be set up to mimic medication carts commonly found on an inpatient nursing unit.
D. ED nurses should not utilize a Medication Administration Record.