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ED Management®

The monthly update on Emergency Department Management

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Inside

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ED managers react to threat against hospitals: Here are security strategies

Solutions range from ID badges to revamped lockdown procedures

When the Federal Bureau of Investigation disseminated a statement to medical centers in four cities warning of a potential terrorist attack in mid-December, emergency department (ED) managers reacted decisively to implement effective security measures. Those measures are being examined by EDs around the country that want to ensure their facilities are fully protected.

"Although the current threat is probably not credible and hospitals have, thus far, been unusual targets for terrorists, I'm certain that there are individuals who would seek to advance their cause by attacking a health care facility," says **Brent R. King**, MD, FACEP, FAAEM, FAAP, chief of emergency medicine at Memorial Hermann Hospital in Houston. "That being the case, we should always be prepared."

The potential threat was reported to hospitals in Chicago, Houston, Washington, DC, and San Francisco. The challenge is to keep EDs accessible to patients while increasing security measures to prevent possible terrorism, King says.

"The very nature of emergency medicine means that we work in a relatively open environment," he says. "We want people to have ready access to our EDs in their time of need."

ED managers were quick to share the news with staff. **Michael F. Boyle**, MD, FACEP, medical director of emergency services at Memorial Hermann Southwest Hospital in Houston, reports that immediately after he was informed of the threat, he sent an e-mail to alert his colleagues.

"The EDs appreciate the warning, because it serves to help us maintain vigilance," says **James G. Adams**, MD, chief of the division of emergency medicine at Northwestern University Medical School in Chicago.

Executive Summary

A recent terrorist threat against hospitals has put emergency departments on heightened alert.

- Lockdown procedures are being practiced.
- Identification badges are worn by staff and visitors.
- Tabletop exercises using bomb threat scenarios are being held.

Boyle says staff will be more likely to report suspicious activity due to the threat.

"It's a good thing for us to be tested in this way," says **Timothy Seay**, MD, FACEP, regional medical director for Greater Houston Emergency Physicians. "There is no downside to having this information."

Here are some steps taken to increase security at the EDs in the threatened cities:

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- **The number of security officers is being increased.**

The ED is a difficult security environment, Seay says. "Traditionally, [the ED] is the thoroughfare into the rest of the hospital after visitor hours," he says.

Northwest Community Healthcare in Arlington Heights, IL, increased the number of uniformed officers in response to the threat, and the local police were asked to increase their mobile surveillance, explains **Arlene Stucki**, chairwoman of emergency management.

In addition, some employees, such as nonclinical directors, have been cross-trained to function in security roles when needed, she says. These individuals wear identification vests, monitor exits, screen visitors, and have radio access to trained security guards, she says.

"We use them in any event that exceeds the capacity of our security staff, which is three to four people on a normal day," she says.

- **EDs are practicing lockdown procedures.**

Stucki's facility has practiced its lockdown procedures, which would be used whenever the ability to

Match your security response to the current threat alert

At Northwest Community Healthcare in Arlington Heights, IL, the disaster plan addresses the color-code alert system from the Washington, DC-based Office of Homeland Security. Here is the facility's minimal response to each threat level:

Green: **Low risk of attack.** A continual state of awareness is maintained.

Blue: **General risk of attack.** Any upgrade in status is checked with the village command center during business hours, or with 911 off-shift.

Yellow: **Significant risk of attack.** Continue above procedures. In addition, increased security restrictions are considered.

Orange: **High risk of attack.** Continue above procedures. In addition, the Incident Command Center will be implemented to direct operations.

Red: **Severe risk of attack.** Continue above procedures. In addition, will consider moving to lockdown status. ■

continue operations is threatened due to contamination or security.

In addition, policies were developed for employee housing, child care, and pet care in the event of a lockdown. **(See Emergency Preparedness Tiered Response, inserted in this issue.)** The facility administrators considered going to lockdown status in response to the recent threat, she adds.

"We have policies and procedures in place for a lockdown status if needed, but did not see that as appropriate to this threat," Stucki says. "We have chosen to remain an open facility at this point."

Policy allows for traffic, parking restrictions

The facility's lockdown policy allows for rapid expansion of the security force if needed, Stucki notes. During lockdown, access to the ED, traffic, and parking are all controlled, she says.

"We can control who enters and who exits the facility, and where," she says.

If a mass casualty event occurred and the ED needed to decontaminate patients or use a secondary ED site, security would direct and restrict traffic appropriately, Stucki explains.

Security staff also are needed to support clinical triage decisions, Stucki says. "People who are panicky, but not clinically ill, may resist triage decisions that will place them in a holding area," she says. "So it's definitely got to be a combined effort."

- **Revamped disaster plans are being used.**

Most ED managers said they drew heavily upon recently revamped disaster plans to address the current threat.

"Every aspect of bioterrorism and disaster management was hashed out in a detailed way based on new threats, but not in response to this particular threat," Seay explains. "We are already well equipped to handle it."

He points out that since Sept. 11, 2001, the level of preparedness has increased dramatically.

"We were behind, as an industry, in recognizing this problem," Seay says. "Now everybody has access to external decontamination showers, and there is a central supply system that has bioprotective clothing, so all of those items are stored and available."

Boyle reports that the ED will be actively conducting drills with new bioterrorism equipment and decontamination supplies.

"We have a fully stocked bioterrorism pharmacy, along with a central system stockpile," he reports.

When Stucki met with others at her facility to discuss their response to the threat, the facility's revised disaster plan was a cornerstone of their planning.

"We mainly relied upon the changes we have made prior to this announcement, to decide our response," Stucki continues.

She explains that the plan now includes specific responses to the Washington, DC-based Office of Homeland Security's color-code system for terrorist threats. **(See chart listing the facility's responses to each color code, p. 2.)**

For example, when the code changed to "orange" status the week of 9/11/2001, campus security was increased and the Incident Command Center was activated, Stucki says.

"When the FBI threat came forward, we did the same, even though the color code was not elevated, because the threat was leveled specifically at hospitals," she adds.

- **Tabletop exercises are being conducted for these scenarios.**

King recommends conducting tabletop exercises, which involve the gathering of key players to talk through a response to a given scenario, to address possible scenarios based on the threat.

Sources

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What would your facility do? Review this threat scenario

Below is a scenario used for a tabletop evacuation drill at Northwest Community Healthcare in Arlington Heights, IL:

Susie, one of the telemetry technicians for 3-North, alerts security that she is frightened by threats from her ex-husband. She gives security a photograph, and she asks that if anyone calls to speak with her that no information be given. She asks that if this person is sighted on campus, that he not be given information that she is working. The police department is alerted to the threat. Her ex-husband, Wayne, has been advised by her lawyer that he is not to attempt to contact her at any time.

9 a.m.

Wayne enters the building at the visitors' entrance, and walks to elevator "A." There is nothing unusual about his manner. He is carrying a brown shopping bag. He takes the elevator to 3-North, turns left, and heads down the hall toward the nurses' station. He stops there, and he asks if he can speak to the director of the unit. The unit secretary asks if he has an appointment, and he replies that hoped that he could leave a thank-you gift because the nurses recently took such good care of his mother. The secretary replies that she will check if the director is in, but she thinks she is at a meeting. While she is calling, Wayne casually looks about, and notes that Susie is not in the telemetry room. He places the shopping bag just inside the door, unnoticed by the tech at the monitors. He says nothing to the secretary, and he walks back down the hall to the stairwell, where he leaves his jacket, cap, and a pair of glasses; removes rubber gloves; and runs down the stairs. When the secretary looks up, he is gone.

9:15 a.m.

Susie returns from a break and enters the Telemetry room. She notices a shopping bag sitting on the floor in the doorway and asks her co-worker if the bag is hers. The co-worker says "no." They look in the bag, see a wrapped, unlabeled package in the bag, and they both suddenly become frightened. Susie's co-worker calls "911" and "3333," an emergency line that overrides any other calls and results in the operator immediately calling 911. She tells the operator that there is a suspicious package in the room. Both women start to leave the room, but there is a sudden loud explosion in the doorway.

Instantly there is fire. The alarm system sounds, and a "Code Red" is announced over the public address system. The hall and nurses' station are filled with debris, and several patients and staff members are on the floor of the hallway and in the station. There is heavy smoke. It is difficult to breathe. The sprinkler system floods the area. Staff members begin moving patients from nearby rooms beyond the fire doors.

Security and facility support people arrive with extinguishers, but they are quickly driven back behind the fire doors. The nursing supervisor arrives and assists with moving people out of the immediate area. The explosion was heard in administration.

9:22 a.m.

Arlington Heights Fire Department arrives and immediately calls for additional support. Police are on the scene as well.

9:30 a.m.

The fire chief orders horizontal evacuation of 3-North as quickly as possible. At this point, the fire department will command the use of elevators. Firefighters enter the stricken area to extinguish the fire.

9:40 a.m.

2-North reports water running through the ceiling in the west hall. 4-North reports heavy smoke and damage with patient injury in room 455. Incident Command in collaboration with the fire chief orders horizontal evacuation of 2-North and a vertical evacuation of 4-North. ■

"As it currently stands, the greatest risk to hospitals and to their personnel is a contaminated environment that might harm staff and other patients and might close the hospital," he says.

He emphasizes the need for advance planning to manage a smallpox outbreak, or contamination from a chemical, radioactive, or biological agent inadvertently brought into the facility by a victim.

- **Identification (ID) badges are being used.**

Boyle says that his facility is about to implement a new ID card system to increase security.

David K. Zich, MD, assistant professor for the department of emergency medicine at Northwestern Memorial Hospital in Chicago, says his ED uses prominently displayed ID badges for all employees, and it limits access to patient care areas by the general public.

"All visitors to the ED are required to wear visitor

badges after checking in with the security desks," he says.

- **Bomb threats are being addressed.**

Stucki reports that an updated bomb threat policy was presented at a monthly information meeting that is open to all employees. **(See policy for bomb threats/bomb on site, inserted in this issue.)**

"We have retrained our hospital staff in the correct response to bomb threats or bomb presence in the facility," she says. She says that 1,400 employees participated in an inservicing that included training in communication in the event of a bomb.

Scenario puts all staff through their paces

An extensive tabletop exercise recently was held using the scenario of a bomb threat, with fire and police department personnel participating, she says. **(See tabletop evacuation drill scenario, p. 4.)**

Hold drills with scenarios that resemble actual events, advises Stucki. "I wrote the exercise, and submitted it to our fire and police departments to be sure they agreed that it was realistic as to time sequences and actual outcomes of the incident," she says.

By doing this drill, ED staff learned about the correct interface with emergency agency providers and how far staff should go in emergency rescue and treatment, Stucki says.

"We also talked through the utility failures that would result from this scenario, and the actual evacuation of patients, both horizontally and vertically," she says. ■

Do you know who will be vaccinated at your ED?

It's time to make decisions about smallpox

As the reality of smallpox vaccine administration grows nearer, the main question you need to answer is: Who will be offered the vaccine?

Phillip L. Coule, MD, director of emergency medical services and emergency care center at the Augusta-based Medical College of Georgia, says, "Not only does our state have a plan for how the vaccine will be rolled out, but our hospital has been working for some time on who we're going to offer the vaccine to."

Emergency department (ED) managers at the Medical College of Georgia recently participated in a conference call regarding pre-event smallpox immunizations, with only an hour's advance notice.

Executive Summary

The administration of the smallpox vaccine is imminent, so emergency department managers are making difficult decisions about which individuals should be vaccinated.

- If all attending physicians are vaccinated, these individuals can care for patients with suspected smallpox.
- Consider offering vaccine first to staff who have been immunized previously.
- Survey staff to find out which individuals have contraindications for the vaccine.

"We were told there was a definite decision made for how and when Georgia would roll out the vaccine," Coule reports. At press time, the first phase of that state's smallpox vaccination was to begin on or before Dec. 15.

Although vaccine programs also will be implemented shortly in other states, Georgia is somewhat "ahead of the game" due to excellent lines of communication with the public health department, which arranged the conference call, Coule notes.

Program to start in Atlanta

The vaccine program is slated to begin with the trauma centers that are in the Atlanta metropolitan area and then branch out to the other trauma centers in the state, Coule says.

Trauma centers were chosen to receive the vaccine first, because they usually are located in larger metropolitan areas and have effective relationships with the state public health department, he explains.

"There is a well-worn path of communication that is very easy to activate for this purpose," he says. "For example, the entire network of trauma centers were all asked to participate in a conference call within one hour, and I believe we had 100% attendance."

Here are some actions being taken:

- **The vaccine will be offered to all the ED attending physicians.**

The plan at the Medical College of Georgia is to have a group of immunized physicians and nurses to care for any suspected patient, to minimize the exposure to staff who haven't been immunized, Coule explains.

"We occasionally will get a patient with an atypical rash that looks like it could be smallpox," he says.

In this scenario, the nurse or physician would immediately leave the room, place the patient in isolation, and have an immunized attending physician go in and take care of the patient, in case it turns out to be an actual case, he says.

Sources

For more information on the smallpox vaccination plans, contact:

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Vaccinating all attending physicians is the only way the smallpox vaccine program outlined by the Centers for Disease Control and Prevention could work in the ED, says Coule. "Otherwise, the person who is ultimately responsible for the patient is not one of those people going into the room of a suspected case," he says. "A case could come in at any time of the day or night on any shift."

- **Not all ED staff will be offered the vaccine.**

Other ED staff would not be offered the vaccine at this stage, says Coule. "We know that we will not have enough vaccine available to us, at this stage, to offer it to anybody who wants it," he says.

- **Staff are being briefed and surveyed.**

At Inova Health System in Falls Church, VA, a memo is being distributed to staff outlining the relevant issues, along with a one-page survey for all staff to review and complete, says **Dan Hanfling**, MD, FACEP, director of emergency management and disaster medicine. **(See Memorandum and Smallpox Vaccine Screening Survey, enclosed in this issue.)**

"The purpose of the survey will be to get staff thinking about possible contraindications to smallpox vaccine, and whether they would be eligible, or interested, to receive the vaccine," he says.

Hanfling's facility will mirror the strategy used by the Jerusalem-based Israeli Ministry of Health by giving the vaccine preferentially to health care providers who have been immunized previously against smallpox. About 15,000 have received the vaccine with no serious side effects reported.

"Needless to say, we are doing this in close consultation with our local public health departments, as the logistics for vaccine administration is likely to rest with them," he says.

Hanfling says he's concerned that the liability issues of the vaccine have not been completely resolved.

He notes that vaccine makers and those who administer the vaccine will be covered by the federal government.

"But those who receive the vaccine on a voluntary basis are still not covered in the event of any adverse reaction," he says. ■

ED Benchmarking Success

Critical-care transport team improves care

When a 2-week-old infant was rushed to the ED at Loma Linda (CA) University Medical Center with injuries from a motor vehicle accident, the facility's critical-care transport nurse noted that the infant was only minimally responsive to stimuli, even needle sticks.

As a result of the nurse's suggestion, in collaboration with the resident and attending physician, a decision was made to obtain a head computerized tomography (CT) scan immediately, instead of waiting until the morning, recalls **Sharon Pearson**, RN, the facility's critical-care transport manager.

"The CT did show blood, and this probably would not have shown up on an ultrasound," Pearson says. "There could have been a negative outcome if the CT had not been obtained in such a timely manner."

Transport team fills a vital role

That scenario illustrates the important role that a critical-care transport team plays in the facility's ED, she says. The team transports critically ill, monitored, and sedated patients for appropriate diagnostic procedures

Executive Summary

A critical-care transport team can prevent adverse outcomes, improve patient flow, and reduce delays.

- The team carries equipment and medications that can save a patient's life.
- Emergency department (ED) nurses can remain in the department, instead of having to transport patients for diagnostic tests.
- Transport nurses assist with resuscitations of trauma patients in the ED.

and provides 24-hour coverage with one to eight nurses.

Here are several benefits of the critical care transport team:

- **Patient flow is improved.**

Nurses don't have to cover for a colleague while he or she transports a patient, says **Jennifer Dearman**, RN, nurse manager for emergency services. "Since the ED can maintain our own staff, patients can be seen more quickly," she says.

Transporting patients for tests can take a nurse out of the ED for several hours, because of the need to bring the patient to several diagnostic areas, Pearson says. For example, a trauma patient first will be taken for CT scans of the head, abdomen, and pelvis.

"We have recently started doing CT scans of the c-spine from the base of the skull to the pedicle of T1 or T2," Pearson says. "If the chest X-ray is at all suspicious, we will also get a chest CT."

In addition, the patient will be taken for magnetic resonance imaging if there is any question of a spinal-cord injury, she says.

"When all the primary studies are completed, we will get the completed spine films and transfer the patient to the ICU [intensive care unit]," Pearson points out.

- **Continuity of care is improved.**

The team is activated to the ED to assist during all traumas.

"All the while, they are learning about the patient that they will accompany to CT," says Dearman. "This is good for continuity of patient care."

Transport nurses pitch in with procedures such as putting in Foley catheters, nasogastric tubes, and intravenous lines. "They are present while the patient is being worked up, so they are aware of any problems identified during the course in the ED," Dearman says.

They also are involved in the medication and/or sedation of the patient while in the ED, which is helpful during transport, she adds.

"They would also be able to give a much more comprehensive report to the inpatient unit receiving the patient, because they have been a part of the treatment from the beginning," Dearman says.

- **Adverse outcomes are avoided.**

The team is made up of highly experienced critical care nurses, with a minimum of three years of ICU or ED experience required, says Dearman.

"Their level of assessment skills, clinical judgment, and critical thinking helps prevent adverse outcomes," she says.

If a patient's condition deteriorates during transport, the team is ready to handle this change and has all the equipment and supplies ready at a moment's notice, Pearson says.

Sources

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"Our advantage is our training and experience is in the transport environment," she points out. "We know all the potential things that can occur, we know who to delegate things to and how to get the necessary help if we need it for a safe transport without negative outcomes."

She recalls that after a 20-year-old man was intubated, sedated, and given a paralytic, the head CT scan showed an epidural bleed with shift. Although the patient's pupils had been equal and reactive, the transport nurse noticed that now one pupil was dilating and only sluggishly reactive.

"The neurosurgeon ordered mannitol and 3% normal saline, which we had with us, so we were able to administer this immediately," says Pearson.

- **Costs are saved.**

ED managers from other facilities have contacted Pearson and expressed a desire to implement a critical-care transport team, but they face a specific obstacle.

"The roadblock has always been that administration wants to see a revenue producer," she says. "You can't really demonstrate a revenue, but you can show a cost savings."

Reducing liability risks

For example, Pearson says that liability risks are significantly lower because of the team's expertise in the transport environment. "Avoiding even one potential lawsuit more than pays for our team," she says.

Also, the transport nurses are cross-trained to help out in the ED and other departments, she says. "So, we get maximum productivity out of them," she says.

The team helps out with inpatients being held waiting for beds, Pearson says.

"If we know the ED is getting hit really hard, we will go with the patient to wait until a bed is staffed for us," she says. ■

Could your ED meet a 15-minute service pledge?

Executive Summary

Patients dissatisfied with long waits is one of the most pressing problems that emergency department (ED) managers must address, and there is a trend of EDs offering service guarantees to patients to obtain higher satisfaction scores.

- At participating EDs, patients are offered letters of apology, movie passes, or a free visit if the guarantee isn't met.
- Census increased dramatically after the guarantee programs were implemented.
- To ensure the guarantees are met, additional nursing staff or ED beds may need to be added.

Imagine promising that every patient who walks through the door of your emergency department (ED) will be seen in 15 minutes.

Does this sound like an invitation for a public relations nightmare? You may be surprised to learn that an increasing number of EDs are offering patients similar service guarantees.

At Northern Nevada Medical Center in Sparks, ED patients are guaranteed they will be seen within 15 minutes or the visit is free. The guarantee is posted in the ED and advertised via newspapers, radio stations, notices in telephone directories, and billboards.

If the guarantee is not met, the patient complains to the nurse, who reports it to the nurse manager, who then instructs the business services manager not to bill the patient for the ED visit, says **Jean Lyon**, PhD, RN, chief nurse executive at Northern Nevada Medical Center in Sparks, NV.

"With a designated triage nurse, the only way the guarantee is not met is if several patients arrive in the ED at the same time, and can't all be triaged within 15 minutes," she says. "This does not happen very often."

ED patients at Oakwood Hospital Medical Center in Dearborn, MI, are guaranteed that they will be seen by an ED physician and care will begin within 30 minutes of arrival.

"If we do not meet this, the patient receives a letter of apology signed by me and the ED medical director, along with two movie passes," says **Corinne G. Victor**, RN, CEN, administrator for emergency services.

Each patient's arrival time is entered into the computer by the greeter at the front desk, and if the 30 minute guarantee isn't met, the staff will inform the patient, Victor explains.

If for some reason this delay is overlooked by the staff, it will be caught when the charts are reviewed by

These changes were made after ED volume rose 45%

Here is the service guarantee offered by the emergency department (ED) at Dearborn, MI-based Oakwood Hospital Medical Center:

> "Wait on the phone; wait in line; wait to download; wait for the mail; wait for the tax refund. Don't wait to see a doctor. When you set foot in an Oakwood Emergency Room, we'll make sure you see a doctor in 30 minutes or less. Every location, every time. In fact, if you're not seen in 30 minutes or less, we'll give you two free Star Theatres movie tickets and a letter of apology. The 30-minute guarantee — another medical breakthrough from Oakwood."

Here are process changes made after patient census increased dramatically in the ED:

✔ A dedicated observation unit managed by the ED was opened with 16 beds.

✔ A pre-admission form is filled out by the ED physician as soon as the patient is evaluated to expedite the admission and bed assignment process.

✔ A holding area was created for spare beds for the nursing units to access.

✔ Unreported available beds are monitored by an employee stationed at the discharge entrance who enters the information in the computer as a patient is discharged. Thus, staff in the bed control center, which controls all beds assigned in the hospital, knows that they can assign that bed to be cleaned.

✔ "No excuse" policy is enforced for the discharge time of 11 a.m., which impacts the ED by facilitating an expeditious discharge, so that the bed can be cleaned and assigned to another ED patient. The patient and family are supplied with transportation by ambulance, van, or taxicab, and a companion of the patient is sent home with the patient if he or she lives alone. ■

Sources

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- **Corinne G. Victor**, RN, CEN, Administrator, Emergency Services, Oakwood Hospital Medical Center, 18101 Oakwood Blvd, Campus, Dearborn, MI 48101. Telephone: (313) 593-7454. Fax: (313) 593-8858. E-mail: VICTORC@oakwood.org.

the ED billing department, she says. "If we missed the guarantee, those charts are copied and given to the ED clinical manager," says Victor. "She will call the patient, and send out the tickets and letter of apology at that time."

The guarantee is in place for all five EDs in the Oakwood Healthcare System and is heavily advertised, with a prominent sign posted in the ED's waiting rooms, says Victor. "We have also done postcard mailings to our market share, which could be as many as 150,000 for one ED at a given time," she says.

ED managers report that the service guarantees have succeeded in their goal: to set their department apart from competitors. "Our 15-minute guarantee has become Northern Nevada Medical Center's brand in the market," says Lyon.

Here is what EDs offering service guarantees have experienced:

- **Not many patients were dissatisfied.**

As an ED manager, you probably have visions of a long line of patients complaining that you have failed to meet the guarantee, but actual results reveal a very different outcome.

Victor reports that from the start of the program in July 2000 through September 2002, all five EDs in the Oakwood Healthcare System have collectively given out movie tickets to only 638 patients out of 361,234. "Star Theatres gave us the first 200 tickets at no cost, which was wonderful," says Victor. "We have had to pay for 438 tickets at $6 each, for a total of $2,628."

Likewise, Lyon reports that the ED has written off just a single visit over a two-month period. "The average is five or six a year, in a volume of 1,750 to 1,850 visits a month," she adds.

- **Patient satisfaction has increased.**

Lyon attributes high patient satisfaction in large part to the guarantee program. "Letters, telephone calls, and patient and family comments show that many people come to our ED not because it is closest, but because they have heard from friends and neighbors that they will receive fast, high-quality treatment," she says.

Victor reports, "It had an incredible impact on our patient satisfaction." In fact, patient satisfaction scores rose from 70% to 96% after the service guarantee program was implemented, she says.

- **Most staff responded positively.**

The majority of ED staff were enthusiastic about the guarantee, but not everyone, Victor says.

"In the beginning of the guarantee, we lost some staff," she acknowledges. "These were folks who for one reason or another, just couldn't change their way of thinking."

Overall, the guarantee program resulted in greater staff satisfaction, she says. "The staff are happier because patients aren't always upset with the wait," she explains.

- **Census increased significantly.**

Lyon says that the ED's volume has increased steadily over the past five years, which made it harder to meet the 15-minute guarantee. As a result, she says that additional nurses were hired, including a designated triage nurse. "This change in the staffing pattern ensures that the guarantee is achieved," she says.

In addition, an ED expansion is under way that will increase the number of beds from eight to 18.

"If the volume continues to increase, we will add more ED nursing staff to make sure we meet the guarantee," she says.

Because of the program, the ED's volume has outgrown its capacity, Victor says.

"Be careful what you ask for! We have experienced a 45% increase in volume since 1999," she reports. "We wanted an increase in market share, but this was phenomenal." **(See list of changes made in the ED to address increased census, p. 8.)** ■

EMTALA Q & A

[Editor's Note: This column is part of an ongoing series that will address reader questions about the Emergency Medical Treatment and Labor Act (EMTALA). If you have a question you'd like answered, contact Staci Kusterbeck, Editor, ED Management, *280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciKusterbeck@aol.com.]*

Question: I work in a rural emergency department (ED) that increasingly has been treating patients without seeing an ED physician. Patients are being sent

from clinics to get intravenous therapy, palliative medications, and lab tests at a scheduled time. The ED is being utilized as an outpatient department, and no medical screening examination (MSE) is given. Is this a violation of EMTALA?

Answer: The statute states that everyone who "comes to the hospital for examination or treatment" needs an MSE, says **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

However, Lawrence notes that recent regulations specify that patients coming to the *hospital* for regularly scheduled appointments do not need the screening exam.

"The problem in this scenario is that they are coming to the *ED* for their regularly scheduled treatment," he explains.

Have the medical staff amend the rules on who may perform a screening exam to allow for nurse screening on these patients, he suggests.

As long as all patients in the same or similar circumstances are treated the same way, EMTALA screening regulations will have been met, he explains.

Under EMTALA, any unscheduled patient is deemed to have an emergency medical condition and therefore requires an MSE, according to **John D. Lipson**, MD, MBA, principal of Columbus, IN-based Medical Staff Support Services, which assists medical staff leaders and administrators with EMTALA compliance.

In the above scenario, the ED is being used to give scheduled treatment that normally would be done in another outpatient setting in other hospitals, Lipson says.

Address these issues

Therefore, there are two questions you need to address to understand how to handle the individual patient, he says.

"First, is the patient truly a scheduled visit?" he asks. For instance, an asymptomatic patient getting a series of rabies shots is a scheduled patient, as is a patient who routinely receives a monthly blood transfusion for chronic anemia.

However, a patient sent from a doctor's office to receive a narcotic injection for pain is an unscheduled patient, and therefore requires an MSE by the ED physician before the injection is given, Lipson says.

Likewise, a patient sent from a nursing home with fever to receive IV antibiotics is an emergency patient and therefore requires an MSE, he says.

All patients must be registered, and the registration book should clearly indicate the patient is being seen for a scheduled appointment, he adds.

Lipson says that the second question to answer is: Does the scheduled patient have signs or symptoms that, to a layperson, might indicate the possibility of an emergency medical condition?

Have a nurse screen the patients and take a simple history and a set of vital signs, Lawrence suggests. "If either revealed a change in condition from that for which the patient was sent to the ED, then a more extensive physician screen would be indicated."

Hospital policy must indicate that if the ED nurse, in doing the nursing assessment, finds a condition such as pain, fever, abnormal vital signs or new patient complaints, an MSE will be performed by a physician, Lipson advises.

"If the ED is being used for chemotherapy, patients who have a change in condition, fever, pain, nausea, or out-of-bounds laboratory studies also should be evaluated by a physician and receive an MSE," he says.

Although these patients have not made the traditional request for examination and treatment of a medical condition by a qualified medical person, they *are* coming to the ED with the request for treatment, points out **Denise Casaubon**, RN, owner and president of DNR Consultants, a Fountain Hills, AZ-based company specializing in health care corporate compliance.

What should be considered is the nature of the procedures being performed, Casaubon says, and she recommends that protocols define the necessary terms (such as what constitutes an outpatient) and address what to do in the event of an adverse outcome.

"If issues such as these are not clearly addressed, the hospital is exposing itself to increased liability," she says. ■

Sources

For more information about the Emergency Medical Treatment and Labor Act, contact:

- **Denise Casaubon**, RN, DNR Consultants, 16217 Balsam Drive, Fountain Hills, AZ 85268. Telephone: (480) 816-6695. Fax: (480) 836-8185. E-mail: Dcasaubon@msn.com.
- **Jonathan D. Lawrence**, MD, JD, FACEP, Emergency Department, St. Mary Medical Center, 1050 Linden Ave., Long Beach, CA 30813. Telephone: (562) 491-9090. E-mail: jdl28@cornell.edu.
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JOURNAL REVIEW

French ED, Sole ML, Byers JF. **A comparison of nurses' needs/concerns and hospital disaster plans following Florida's Hurricane Floyd**. *J Emerg Nurs* 2002; 28:111-117.

Emergency department (ED) nurses are concerned primarily about family safety, pet care, and personal safety while at work during disasters, says this study from University of Central Florida School of Nursing in Orlando. The researchers surveyed four focus groups of 30 ED nurses and reviewed each hospital's disaster protocol to determine nurses' concerns and needs during a natural disaster.

Those nurses said they would like disaster plans changed to address work assignments, financial compensation, flexibility for extenuating circumstances, pet care, shelter for family members, and basic needs. They also said that managers were not "in the trenches" with staff and didn't provide good leadership. In reviewing the disaster plans, researchers found the following:

- Policies for all four hospitals failed to address how basic provisions would be handled, such as food, water, blankets, pillows, and beds.
- Employees' families were directed to public shelters instead of hospital campuses.
- Pet care was addressed in only one policy, and it only gave recommendations for local animal shelters.

The researchers concluded that the nurses' concerns were valid and that written policies for disaster response were "woefully inadequate" to address staff needs during a major hurricane. "Much work needs to be done to prepare for future disasters," they said.

The researchers recommend the following:

- Designate sleep and shower areas on a priority basis to those providing direct patient care.
- Develop volunteer hotline number for available health care providers to call in to help during disasters.
- Ask for volunteers from existing staff to participate in hurricane response.
- Provide incentives such as increased pay allowances, guaranteed paid time off after the disaster, family shelter areas, and food and drink. ■

CE/CME *questions*

Save your monthly issues with the CE/CME questions to take the semester tests in June and December issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

19. Which of the following is recommended for security in response to terrorist threats against hospitals, according to Arlene Stucki, chairwoman of emergency management at Northwest Community Healthcare?
    A. going to lockdown status when any threat against hospitals is announced
    B. use of security to assist nurses at triage in case of a mass-casualty event
    C. use of tabletop exercises instead of actual drills
    D. implementing a no-visitor policy in the ED

20. Which of the following is recommended for administration of smallpox vaccine to ED staff, according to Phillip L. Coule, MD, director of emergency medical services and emergency care center at the Augusta-based Medical College of Georgia?
    A. All staff should be offered the vaccine simultaneously.
    B. A group of vaccinated nurses and physicians should care for suspected cases of smallpox.
    C. Avoid asking staff about previous immunizations until vaccine supplies are received.
    D. Address contraindications only if an individual is designated to be vaccinated.

21. Which of the following is a result of service guarantees offered by EDs?
    A Significant number of patients complained that the guarantee was not met.
    B. ED staff were very unhappy with the program.
    C. Patient census decreased somewhat.
    D. Patient census increased significantly.

22. Which of the following is a benefit of a critical-care transport team, according to Sharon Pearson, RN, critical care transport manager at Loma Linda University Medical Center?
    A. decrease in patients who leave without being seen
    B. increase in ED revenues
    C. lower liability risks
    D. Fewer EMTALA violations

COMING IN FUTURE MONTHS

■ Update on Joint Commission patient safety standards

■ How to avoid HIPAA violations

■ Use wireless pagers to communicate with staff

■ Comply with regulations for non-English-speaking patients

23. Which of the following is required by EMTALA for patients sent to the ED for outpatient services?
    A. No medical screening examination is required.
    B. The ED physician must examine every patient before treatment is given.
    C. The practice is a violation of EMTALA.
    D. Any unscheduled patient must receive a medical screening examination.

24. Which of the following is true regarding nursing needs during a disaster, according to a study published in *Journal of Emergency Nursing*?
    A. Basic needs of nurses were met.
    B. Employee families were provided with shelter on hospital campuses.
    C. Hospitals failed to address access to basic provisions.
    D. Pet care was addressed adequately.

CE/CME objectives

For more information on the CE/CME program, contact the customer service department at (800) 688-2421. E-mail: customerservice@ahcpub.com.

1. List one effective way to increase security in response to terrorist threats. (See "*ED managers react to threat against hospitals: Here are security strategies," in this issue.)*
2. Name one effective strategy to use for administration of smallpox vaccine to ED staff (See *"Do you know who will be vaccinated at your ED?")*
3. Name one benefit of a critical-care transport team in the ED. (See "*Critical-care transport team improves care")*
4. Identify one result of a service guarantee program in the ED. (See "*Could your ED meet a 15-minute service pledge?")*
5. Cite one way to comply with the Emergency Medical Treatment and Labor Act (EMTALA) when patients are sent to the ED for outpatient services. (*See "EMTALA Q&A*.")
6. Identify one finding of a study on nursing needs during disasters. (See "*Journal Review*.") ■

Northwest Community Hospital Administrative Policy

Bomb Threats — Bomb on Site

PURPOSE

To mitigate the implications of a bomb threat.
To collaborate with law enforcement in their investigation.
To prevent injury to patients, visitors, and employees in the presence of a bomb.

POLICY

Northwest Community Healthcare will work to protect its internal and external customers from any threat of/exposure to explosive devices. Further, we rely on the expertise of the local police department for direction in the management of such an event and will collaborate fully with their direction. The local fire department will stand by in case of need for rescue and recovery. Management of such an event will be done in accordance with Hospital Emergency Incident Command System (HEICS).

PROCEDURE FOR BOMB THREAT

1. An employee receiving a bomb threat will call "911" and clearly report the threat of or the presence of a bomb.
2. The second call should be to Security via #3333.
3. The employee will complete the "Bomb Threat Checklist" to the best of their ability.
4. The operator will call Security by two-way radio. Security will proceed to the site of the call.
5. The administrator on call and the administrative consultant will be notified by Security.
6. The decision to alert staff by overhead page will be made by administration. A "Code Green Alert," followed by the area involved, is an option for the overhead page. (As of 1/1/03, "Code Gray" will be an option page indicating that there is a security Incident.)
7. If this is a threat:
   - Security department-specific procedures on bomb search will be implemented.
   - The designated manpower pool from facility support, is called by Security by radio for a briefing at the security desk.
   - The manpower pool is briefed on the bomb search procedure.
   - Two- or three-person teams are set up to search the hospital.
   - Area of search will be dictated by location given by caller.
   - All surrounding areas of the entire floor level are searched, and the floor levels below and above the reported area are searched.
   - If a suspicious parcel is located, move everyone away from the parcel, secure the perimeter of the area, and wait for the police department to arrive.
   - If no location is designated, the search will be conducted according to the judgment of the chief security officer/ administration.
   - Command will be assumed by the police department upon their arrival.
   - Recipient of threat will immediately fill out the bomb threat telephone call profile form.
   - Law enforcement officials will give direction regarding continued search, evacuation, or discontinuing the search.

PROCEDURE FOR KNOWN BOMB PRESENCE

1. The employee noting the presence of a suspicious device will make every effort to notify “911” and Security personally, or through a colleague.
2. Remain calm.
3. Move carefully but intentionally away from the bomb.
4. Move others carefully and intentionally away from the bomb.
5. Do not touch the device.
6. Take care to not bump furniture, or to disturb the device.
7. Gently close the door if possible.
8. Do not use a two-way radio or a wireless phone in the vicinity of a potentially explosive device.
9. Move everyone a good distance from the device. If possible, move beyond a fire door.
10. Follow direction of Security/police department officers for safety.
11. If faced with an intruder with a bomb, employee will exercise best judgment.
12. If threatened by an imminent blast, immediately drop prone and face away from the expected detonation.

RECOVERY

1. Either a bomb threat or presence may escalate to a “Code Green” evacuation incident at the discretion of administration.
2. Police officers will determine risk of the suspicious device and its proper disposal.
3. Thought must be given to keeping employees and visitors from uninvolved departments from entering the area of risk.
4. Marketing should be notified of the event when reasonable to do so.
5. Consider what information should be shared with employees and customers.
6. A Critical Incident Stress Debriefing will be provided by Chaplaincy Services.

Source: Northwest Community Hospital, Arlington Heights, IL.

Northwest Community Hospital Administrative Policy

Emergency Preparedness Tiered Response Protocol — Code Yellow: Level Four

Effective Date: 2/12/02

PURPOSE: The purpose of this policy is to provide direction for implementing the highest level of campus security while appropriately allocating resources to accommodate critical needs, in the face of an overwhelming catastrophic event. Criteria for this level of response may include, but are not limited to the following:

- The magnitude of the event is such that the implementation of Code Yellow: Level Three Emergency Management Plan requires the highest level of support.
- Northwest Community Hospital must be solely reliant upon its own immediate resources to continue critical operations in the event that community agencies are overwhelmed and unavailable.
- Emergency response to the event threatens the well-being of patients and employees in the hospital, unless specific measures are taken.
- It is recognized that the hospital may be able to provide some, but not all critical services.
- State and federal resources may be forthcoming, but are not immediately available.

POLICY: In the face of overwhelming disaster in our community, the policy of Northwest Community Healthcare will be to do the most good for the most people. Northwest Community Healthcare is committed to preserving the lives of its employees and patients, and to continuing critical services to the community if possible.

OBJECTIVES:

A. The hospital is committed to the protection of its employees.
B. The hospital is committed to protect its current patient population.
C. The hospital must remain functional.
D. The hospital must continue to provide emergency service to those who come for medical screening and treatment.
E. The hospital will intervene and use all available resources to mitigate the effect of overwhelming disaster.

PROCEDURE: The following described actions may occur simultaneously:

1. **Authorize overhead page "Code Yellow: Level Four" X3**

2. **Set up Incident Command with key employees in the following role:**
   A. Public information officer.
   B. A Liaison with outside agencies: Mutual aid hospitals, fire, health departments at all appropriate levels, and law enforcement, as applicable.
   C. Safety and security officer: concerned with campus security as well as employee well-being.
   D. Define other key decision makers according to current phase of Hospital Emergency Incident Command Protocol (HEICS).

3. **Secure the Campus:**
   A. Security will maintain pre-planned, mapped routing of traffic and parking, on and off campus. Security vehicles will be deployed to block determined routes of entry/exit.
   B. Initiate complete lock down until further information is available.
      (1) Auxiliary security personnel deployed to man major entry and exit points.
      (2) As with Code Yellow one, two, and three, no employees may leave without permission of management. (Administrative Policies #45, 45a)

(3) In the event of a chemical terrorist attack, determine that the outside environment is safe. The hazardous materials experts in the fire department will have this information.
(4) In collaboration with Security, determine entry/exit points that can be highly secure, yet allow for emergency routing of patients, physicians, employees, and supplies during lockdown.
(5) Incident command will determine which populations of employees, visitors, and patients should be restricted entry and/or exit.
(6) Communicate to those restricted populations via overhead page that they should remain in the building or where safe exit information is available.
(7) Staff are responsible to be informed about emergency management practice.

4. Create alternate sites for services:

A. If appropriate, route victims of event away from the emergency department.
B. Create outside triage with a medical team.
(1) Consider weather conditions.
(2) If needed, mass decontamination of victims will be done per procedure.
(3) After decontamination, consider day surgery center, or the 901 Building, as a treatment site.
C. If appropriate, convert current emergency department annex and/or pediatric emergency department to accommodate acute patients along with the main emergency department room. Alternate sites for acute care may include surgical preparation area, endoscopy, or recovery room.
D. The following facilities have agreed to absorb skilled level patients during an emergency, according to their ability to do so:
(1) Lutheran Home at 800 W. Oakton St., Arlington Heights.
(2) Marriott-Church Creek at 1200 W. Central Road, Arlington Heights.
(3) Manor Care at 715 W. Central Road, Arlington Heights.

5. Determine whether critical services must be shut down or restricted in use.

- Communication systems: Determine whether alternate messaging system can be employed, whether calls can be managed by a team of responders, or whether in the judgment of the director of the department, more extreme shutdown should be considered.
- Determine utility status, including information management systems.
- Outpatient services, including endoscopy and day surgery center.
- Surgical services
- Inpatient services
- Wellness center
- 901 Building
- Nutrition and food services
- Supply delivery/mail
- Business center
- Treatment centers

6. Procure additional medical staff as needed.

7. Use pre-scripted communication with media until accurate information is available.

8. Open the employee relief center if needed.

9. Direct recovery.

A. Incident command center will direct recovery, perhaps with changing decision makers until recovery is complete.
B. All directors must assess functionality of their department and report to incident command center.
C. Chaplaincy services will continue critical incident stress debriefing as needed.
D. Incident command center will direct all communication with the public in collaboration with community resources.
E. Incident command center will direct all communication with the public in collaboration with community resources.

Source: Northwest Community Hospital, Arlington Heights, IL.

MEMORANDUM

To: Inova Health System Disaster Preparedness Task Force

From: Dan Hanfling, MD, Director,
Emergency Management and Disaster Preparedness

Re: Health Care Work Force Pre-Event Smallpox Vaccination Strategy

Date: Nov. 21, 2002

Based on current information available from the recently convened Advisory Committee on Immunization Practices (ACIP) meeting held in Atlanta on Oct. 15-16, 2002, the following recommendations are likely to be approved by the White House regarding the distribution of smallpox vaccine for health care workers. Current information from the Virginia Department of Health, Deputy Commissioner for Emergency Preparedness suggests that the initiation of smallpox vaccine on a voluntary basis will commence mid-December 2002.

The vaccine will be released to approximately 500,000 health care workers (clinical and nonclinical), strictly on a voluntary basis, who may be most likely to be involved in the initial care of potential smallpox infected patients across the United States. This includes not only physician, nurse, tech, and specialty care staff, but also clerical support, housekeeping, engineering, and safety and security personnel.

The most complete nationwide vaccine safety data (1968) recently were reported by Breman and Henderson in *The New England Journal of Medicine*, April 25, 2002. This nationwide survey found that nine vaccinees died out of 14 million who received the vaccine in 1968. Other rare, but severe, adverse reactions to the vaccine included:

- **encephalitis:** 16 people/14 million (all 16 were first-time vaccinees).
- **progressive vaccinia:** 11 people/14 million.
- **eczema vaccinatum:** 66 people/14 million AND in another 60 persons with a history of eczema who were contacts of vaccinees.
- **generalized vaccinia:** 141 vaccinees/14 million AND in 2 contact cases.

The Centers for Disease Control and Prevention will establish a monitoring system to assess the vaccination program and assist with response to any possible side effects of the vaccine. Each hospital worker who receives the vaccine will be issued a personal identification number at the time of vaccination. Local and national experts in the fields of infectious disease, dermatology, allergy, and neurology will be identified to assist in this process. In the mid-Atlantic region, this will include specialists from Johns Hopkins University and the University of Maryland.

The following EXCLUSION criteria apply to smallpox vaccine receipt, and staff with any of these conditions should **NOT** receive smallpox vaccination:

- pregnancy;
- immunocompromised: steroids, transplants, cancer, HIV/AIDS;
- history of eczema (even if years ago and no longer active);
- active skin lesions including atopic dermatitis;
- household members with any of the above listed criteria;
- allergy to tetracycline, polymyxin, neomycin, streptomycin (contained in vaccine).

Recent scientific literature also suggests that those who have been previously vaccinated with the smallpox vaccine are less likely to exhibit the expected side effects of the current vaccine. Moreover, those who have been inoculated more than once are at even lower risk of incurring the vaccine side effects and are less likely to shed live virus from the inoculation site.

INOVA Health System Smallpox Vaccine Screening Survey

Based on the data, it is suggested that volunteers who agree to receive smallpox vaccination should have been previously immunized so as to minimize the likelihood of adverse reactions. Inova Health System has been asked to determine who may be eligible to receive smallpox vaccine.

Please carefully review the following questions. They are designed to help you establish whether you have any contraindications to receiving the smallpox vaccine.

Age:_____

Department/facility_____/_____

Previous smallpox vaccine? Yes ☐ No ☐

If yes, number of vaccinations _____

CONTRAINDICATIONS TO SMALLPOX VACCINATION:

Immune system problems
(HIV/AIDS, cancer, leukemia,organ transplant) Yes ☐ No ☐

Currently taking medications that may weaken the immune system
(steroids, chemotherapy, organ transplant medications)? Yes ☐ No ☐

Eczema or atopic dermatitis (or past history of these conditions)? Yes ☐ No ☐

Pregnant? Yes ☐ No ☐

Household contacts (with described medical conditions)? Yes ☐ No ☐

Infants at home younger than 1 year? Yes ☐ No ☐

Would you be willing, on a voluntary basis, to receive smallpox vaccination offered by the federal government as a part of the pre-event smallpox preparatory planning efforts? Yes ☐ No ☐

Source: Inova Health System, Falls Church, VA.