ED Management®
The monthly update on Emergency Department Management

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IN THIS ISSUE

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Report puts spotlight on inpatient holds: The No. 1 reason for ED overcrowding

You'll need creative strategies to tackle this dangerous problem

Holding admitted patients waiting for an available bed not only hinders your ability to provide quality care, frustrates staff, and hurts your bottom line, but it also is the *single biggest factor* resulting in overcrowded EDs, according to a just-released report from the Washington, DC-based General Accounting Office (GAO).

According to the report, *Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities*, ED delays are closely linked to the inability to transfer patients to inpatient beds, which pulls staff and resources from ED patients.

The practice of holding admitted patients in the ED is dangerous because it hinders the ability to treat severely injured and sick patients, says **George Molzen**, MD, FACEP, current president of the Dallas-based American College of Emergency Physicians.

"It's essential that patient care not be delayed, especially at a time when we have added responsibilities to be prepared to respond to disasters or acts of terrorism," he says. Demonstrate to administrators that the practice of holding inpatients is causing delays in EDs nationwide by showing them the GAO report, Molzen advises. "By doing this, there won't be as much finger pointing at the specific manager," he says. "You can also use the report as ammunition to lobby for changes in holding of inpatients." **(To access the complete report, see source box, p. 63. For strategies on holding of inpatients, see "Speed up orders for inpatients held in ED," *ED***

Executive Summary

A just-released General Accounting Office report identified holding inpatients in the ED as the No. 1 reason for overcrowding.

- Have inpatient nurses care for admitted patients in the ED, including paperwork.
- Use a "bed control" office to get admitted patients discharged or transported more quickly, freeing ED beds.
- Consider adding an admissions nurse to handle inpatient documentation or a second ED charge nurse to track inpatients.

***Management*, March 2003, p. 29, and "Use protocol to send inpatient holds upstairs," *ED Management*, April 2003, p. 43.)**

According to the report, which included a survey of 2,000 EDs and six site visits, at least 75% of inpatients were boarded in the ED for two hours or more in the past year at one-third of the facilities.

Here are strategies that will help you successfully reduce delays caused by inpatient holds:

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• Create a "bed control" office.

Lack of an efficient bed control system is a problem at many EDs, says **Robert W. Stein III**, BSN, MSHA, RN, CEN, CHE, president of LeNurse, a St. Cloud, FL-based consulting firm that provides medical-legal services to health care providers. The process of obtaining a bed assignment may depend upon the day of the week, the time of day, and even the nurse who happens be working a particular shift, he explains.

Inpatient nurses may fail to update computers when a patient is discharged, adds Stein. "This leaves the appearance that the room is still occupied," he says.

At Methodist Children's Hospital in San Antonio, a bed control nurse and nurse administrator work to facilitate placement of admitted ED patients, says **Janice Elliott**, RN, the facility's senior clinical administrator. "We identify areas that are in crisis or moving toward crisis, and try to intervene in the most appropriate way," says Elliott. "We consider ourselves to be a little like air-traffic controllers."

The bed control office monitors bed status and sends pages out to charge nurses and nurse managers to inform them if units are "clear," "on alert," or "at capacity," she explains. "This lets everyone know if they need to look at how many potential dismissals they have and how many patients could be downgraded to the next level of care," says Elliott.

When the ED is in the alert or at capacity stage, steps are taken immediately to get inpatients moved upstairs, says Elliott. "We go and assess which patients can be moved or go home, to free up more beds," she says.

For example, physicians are contacted to determine if patients can be discharged or downgraded from the pediatric intensive care unit to the regular floor so that patients can be moved out of the ED, she explains.

"It is imperative that the person doing bed control have a working knowledge of EDs and how crucial it is for them to move patients," she says. "Without that, you can end up with congestion in the ED that is crippling to staff and patient movement."

• Use inpatient nurses to care for admitted patients being held.

Unlike ED nurses, floor nurses already are familiar with the standards of inpatient care, notes Stein. "They can provide the necessary care without being distracted by an acute myocardial infarction or motor vehicle crash arriving via ambulance," he says.

Since the revenue for these patients already is going to the inpatient units, the cost of inpatient nurses working in the ED can be charged back to the inpatient unit, explains Stein. "This adds a financial incentive to motivate the inpatient nurse managers to help solve the 'ED problem,'" he says.

In addition, inpatient nurses may be more willing to facilitate patient transfers after seeing the conditions in the ED for themselves, he adds.

At Methodist Children's, a staff person designated as a "SWAT" nurse has a dramatic impact on inpatient holds in the ED, says Elliott. This floating nurse assists with incoming admissions and discharges, transports patients to radiology, and cares for inpatients in the ED, she explains.

To free ED nurses, inpatients held in the ED overnight often are moved into an observation area and assigned to the SWAT nurse and a technician who can care for up to four of these patients until the morning when beds become available, says Elliott.

The SWAT nurses are accustomed to taking care of inpatients, but they also are oriented to the ED, says Elliott. "They can transfer the patients over to computer charting, give medications, and do everything just as they would on the floor," she says.

This system results in better continuity of care, because ED nurses unaccustomed to caring for inpatients may miss routine orders such as repeat antibiotics or medications, says Elliott.

• Add a second charge nurse in the ED.

Keeping track of patient flow in a hectic ED is a challenge for even the most seasoned charge nurse, Stein says. "Add tracking inpatients on top of that, and things will get missed," he says.

On occasion, inpatients being held in EDs have gotten "lost" and remained hours to days after an inpatient bed was available, he notes.

To address this problem, consider adding a second charge nurse to each shift, Stein recommends. The "co-charges" can work as a team and communicate with a computerized patient tracking board and walkie-talkie radio contact. One nurse can focus on patients in the ED waiting room and treatment rooms, and the other can track the flow of admissions, he advises.

• Have an admissions nurse handle inpatient documentation.

At Osceola Regional Medical Center in Kissimmee, FL, inpatient nurses were resistant to accept admitted patients from the ED because of the need for an extensive nursing admission history, nursing assessment, and care plan, says Stein, the facility's former patient service leader for emergency services.

"The assessment and computer time to document could take up to an hour for each admission," he says.

The facility's policies required the receiving nurse to complete and document these admission notes before leaving at the end of the shift, he explains.

"This may be difficult to impossible to achieve under the excessively high nurse-to-patient ratios created by the nursing shortage," Stein says. ED nurses are not trained to document these inpatient assessments and lack time to complete them, he explains. To solve the problem, a new "admissions nurse" position was created to complete and document assessments while the patient is in the ED waiting for an inpatient bed to become available, Stein explains.

"By having the admissions nurse complete the required documentation before the patient was transferred, the inpatient nurses were more amenable to immediately filling a bed as soon as it became available," Stein says. ■

Sources/Resources

- **Janice Elliott**, RN, CEN, CFRN, Senior Clinical Administrator, Methodist Children's Hospital, 7700 Floyd Curl Drive, San Antonio, TX 78229. Telephone: (210) 575-7104. Fax: (210) 575-7156. E-mail: Janice.Elliott@MHShealth.com.
- **Robert W. Stein** III, BSN, MSHA, RN, CEN, CHE, LeNurse, 4069 13th St., No. 112, St. Cloud, FL 34769-6701. Telephone: (407) 891-1911 Fax: (407) 891-8639. E-mail: bobstein@lenurse.com. Web: www.lenurse.com.

- The complete March 14, 2003, report *Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities* is available free at the United States General Accounting Office web site (www.gao.gov). Click on "GAO Reports," "Find GAO Reports," and type in "GAO 03-460" without the quotation marks. Also, single printed copies of the report are available at no charge. To order, contact U.S. General Accounting Office, 441 G St. N.W., Room LM, Washington, DC 20548. Telephone: (202) 512-6000. Fax: (202) 512-6061.
- The Joint Commission on Accreditation of Healthcare Organizations is seeking comments on a proposed leadership standard to address ED overcrowding. The proposed standard calls on hospital leaders to implement plans to identify and address situations that result in ED crowding, such as performance improvement activities, coordination with community resources, and tracking the capacity of units that receive ED patients. If approved, the standard would be implemented in January 2004. The deadline for comments is June 2. The draft standard and an online evaluation form can be accessed on the Joint Commission web site (www.jcaho.org). Click on "Accredited Organizations," "Hospitals," "Standards," "Field Reviews," "Emergency Department Overcrowding." For more information, contact Joyce B. Marshall, Division of Research. Telephone: (630) 792-5934. E-mail: jmarshall@jcaho.org.

ED Benchmarking Success

Make these changes to cut delays, diversion hours

Triage protocols and teams yield dramatic results

A sharp decrease in hours on diversion. Decreased length of stay. Greater staff satisfaction.

These three items are on every ED manager's wish list, but they are real-life examples of changes made as a result of one ED's participation in the GE Medical Systems Six Sigma process, reports **Patricia Bunce**, RN, BSN, CEN, director of emergency and critical care services at Good Samaritan Hospital in Dayton, OH.

General Electric (GE) has used a quality improvement process known as "Six Sigma" in manufacturing for years, which consists of a five-phase, problem-solving process called "DMAIC" — define, measure, analyze, improve, and control — that ensures lasting change, says Bunce.

GE has now created a division that helps health care organizations improve, based on the Six Sigma process, she explains. The process eliminates unproductive steps and uses technology for improvement, and it has had a dramatic impact on the ED's operations, she reports.

The GE consultant team was hired for one year. A "Master Black Belt" from GE, a specially trained individual acting as a team leader responsible for teaching the process to staff, was given the position of vice president of strategic improvement at the facility, Bunce says.

An ED supervisor and Bunce were trained as "change facilitators," which includes holding regular problem-solving meetings with ED staff, with subgroups designated to implement solutions. "It has been extremely successful," she says.

The ED's original length of stay averaged 326 minutes from placement in a treatment room to discharge, which decreased to 180 minutes after key changes were made, Bunce explains.

There also has been a dramatic decrease in diversion hours since a "zero reroute commitment" was made in January 2003, Bunce reports. In February 2002, the ED was on reroute status 107 hours, but a year later, diversion hours totaled only six — a decrease of 94%, she adds.

Here are two key changes that were made:

• Triage protocols were implemented for early blood draws, urine specimens, and intravenous (IV) lines.

The ED had a problem with delays in collection of lab specimens, says Bunce. As a result, blood, urine, and IVs now are started routinely at triage for certain chief complaints, she says.

"Instead of a lab tech making his or her way around the ED, we trained our nurses and paramedics to draw blood at the time of the IV start and send it to the lab," she explains.

The laboratory holds the specimen until the actual order is received, she says. "This reduces time from order to collection to zero," Bunce says.

Executive Summary

Significant reductions in delays and diversion hours are reported by an ED that has implemented changes as part of the GE Medical Systems Six Sigma for Healthcare process.

- Triage protocols for blood draws, urine, and intravenous lines are used.
- Nurses are paired with a technician or paramedic and work as a team.
- Technicians are assigned specific tasks, such as triage, electrocardiograms, or performing repeat vital signs.

Nurses and paramedics work together

Urine specimens are collected at triage or as early in the visit as possible for patients who are brought by ambulance, she says. "We are also working on protocols including standing orders for urinalysis, urine pregnancy, and some blood tests," she adds.

• Nurses and paramedics work as a team.

The ED now uses a "team concept" consisting of a nurse and technician or paramedic, says **Mary Porter**, RN, nurse manager of the ED.

"The technician and paramedic roles have changed so that they feel more like a part of the patient care team," Porter says.

Before, technicians and paramedics were frustrated because they didn't know what care the patient needed until told by a nurse, Bunce says. "Now, all members of the team receive report on the patient," she explains.

Previously, the technicians and paramedics assisted all of the nurses simultaneously and often became overwhelmed with all the requests for help, Porter

Sources/Resource

For more information on the GE Medical Systems Six Sigma for Healthcare process, contact:

- **Patricia Bunce,** RN, BSN, CEN, Director of Emergency and Critical Care Services, Good Samaritan Hospital, 2222 Philadelphia Drive, Dayton, OH 45406. Telephone: (937) 278-6251, ext. 1332. E-mail: PBunce@shp-dayton.org.
- **Mary Porter**, RN, Nurse Manager, Emergency Department, Good Samaritan Hospital, 2222 Philadelphia Drive, Dayton, OH 45406. Telephone: (937) 278-6251, ext. 1333. E-mail: MPorter@shp-dayton.org.

- For more information GE's Six Sigma for Healthcare, contact GE Medical Systems, N16 W22419 Watertown Road, EC-05, Waukesha, WI 53186 Telephone: (877) 438-4788. Fax: (262) 544-3384. E-mail: geeducation@med.ge.com. Web: www.gemedicalsystems.com/prod_sol/hcare/sixsigma/index.html.

says. "Nursing staff had to hunt for someone and frequently could not find a tech or paramedic who was available," she explains.

Now, the technicians and paramedics do not float to other teams unless requested by the charge nurse, she explains. "When they do leave the team for other tasks, they communicate this to their team members," Porter says.

Previously, if repeat vital signs needed to be taken, the nurse would have to locate a technician or paramedic to do this, and if one could not be located, the nurse would perform the task, says Porter. "This led to delays in accomplishing the task," she says.

The task now is delegated routinely to technicians and paramedics, who are given specific times for repeat of vital signs based on preset acuity parameters, says Porter.

"This helped to create the personal accountability to accomplish the task and subsequently improved the standard of care," she says.

Technicians also are assigned to specific areas, such as triage or electrocardiograms, says Porter.

They also are assigned to specific patients, Bunce adds. Previously, the technician who brought a patient back to a bed might not be the same technician who cared for the patient during his or her stay in the ED, she explains.

"Now, when a bed is empty, the tech on that team brings the patient back, gets him or her ready to be seen, and that is the same technician who will meet any personal needs and work with the nurse caring for the patient," Bunce says. ■

Do you give poor care to patients in pain?

Use interventions for drug seekers, those in pain

A sickle cell patient is in excruciating pain. A man who comes to your ED frequently always complains of different illnesses to obtain narcotic analgesics. These two patients have completely different needs, but you'll need strategies to improve care for both.

To improve management of chronic pain patients, follow these steps proven to work:

• **Give patients a "narcotic contract."**

A narcotic contract was created for patients who frequently seek pain medications at the ED at Swedish Medical Center in Seattle, says **Judy Street**, RN, manager of emergency services. The contract informs patients that for future ED visits, the ED physician will evaluate whether pain medications are appropriate, says Street. Patients are asked to sign it and are given a copy, she adds.

"The intent is to treat pain that is obviously not being managed by narcotic use, as well as to alert drug seekers that we will not assist in their continuation of abusing narcotics," Street says.

The contract is used at the discretion of the ED physician and nurse, she says. The ED's social workers help to identify patients and explain the use of the contract, adds Street.

A discharge instruction sheet explains the appropriate use of narcotics and lists alternative therapies for management of pain such as heat, ice, and elevation, she says.

• **Have a tracking system.**

At Morristown (NJ) Memorial Hospital's ED, a tracking system called EDIM (Emergency Department Information Manager) developed by Livingston, NJ-based Emergency Medical Associates is used to gauge

Executive Summary

You'll need strategies to improve care of patients who request pain medications frequently.

- Use care plans to ensure that patients with conditions such as sickle cell disease will have medications given immediately.
- Use written agreements to discourage drug-seeking patients.
- Have a system to alert ED staff to a patient's existing pain management plan.

the frequency of visits for pain, says **Mark Mandell**, MD, chairman of the department of emergency medicine. This system allows clinicians to see the patient's complete history and physical, he adds.

"When a patient comes into the ED, it is easy to see how often the patient has been in the ED and why," he says. If something in the patient's history alerts physicians that there could be a problem with narcotic abuse, the patient still will receive the medication, but the patient's name is referred to the ED's care manager, Mandell says.

"Our procedure is that patients who come into the ED usually will get the benefit of the doubt and receive medication," he says.

However, the care manager will review the patient's history, check with the patient's doctors, and draw up a care plan for pain management, he explains. The care plan is placed in a book in the ED, and the patient's chart is tagged with a code so the physician knows to look it up, Mandell points out.

"The costs of the plan consist of having an individual who will call the patient's physician and compose a care plan," he says. "I would guess that this would take no more than one hour per patient, maybe less."

The care plan also gives nurses a chance to educate patients who frequently come to the ED because they are unable to access appropriate follow-up care, says **Richard Klemm**, RN, the ED's care manager. One man kept coming to the ED for pain medicines and antibiotics after surgery and told Klemm that he had to wait a long time for follow-up appointments.

"At that time, I called the facility, made an appointment for him, documented it on the discharge instructions and in his care plan," he says. "We were able to decrease his visits from several each month to one visit every three or four months."

- **Send patients a letter.**

If a patient requests pain medication frequently, a letter is sent reviewing the patient's history and informing him or her that no additional pain medications will be prescribed until further notice, Mandell says. **(See sample pain management letter, at right.)** "It essentially cuts off the patient from narcotics unless we hear from the patient's doctor that it is OK to continue," he says.

This step discourages drug-seeking patients, Mandell explains. "Occasionally, we are able to steer patients with a drug problem to a treatment center," he says.

Some ED physicians tend to develop a following among certain individuals who come in on days when that physician is on duty, notes Mandell. This system avoids that problem, he says.

"We are able to be generous with patients who require pain medication, knowing that we have a strategy to make sure that we do not attract drug seekers to the ED," he says.

The registered letters also reduce the frustration of nurses dealing with drug-seeking patients, Klemm says. If the registered letters sent to a patient are returned to Klemm, he places them in the care plan book located at the nurse's station. Then when the patient returns to the ED, nurses will hand deliver the letter and then document it.

"There is a sense of satisfaction among the staff when this occurs," he says. "The patients realize after

Letter to Narcotic Abusers

Dear John Doe:

Upon review of your medical records, it has been noted that you have made eight visits to Morristown Memorial Hospital's Emergency Department since April 23, 2003, requesting narcotic treatment for headaches, backache, right arm pain, neck pain, and several incidents of burns to the right arm. It also is noted that you requested refills of your narcotic prescriptions.

We will be happy to continue to evaluate and treat your medical problems in the future. You always have the right to come to the Emergency Department for assessment of your condition and stabilizing treatment of any emergency medical conditions that you may have. However, the Emergency Department will not refill your prescriptions or be able to treat you with narcotics for routine management of pain. You must develop a relationship with a primary physician or specialist on the staff at Morristown Memorial Hospital, who will follow you and assist us in your care. To signify to us that you have developed such a relationship, I will need to receive a letter from your primary physician or specialist telling me that he/she is following you and letting me know how he/she wants your pain managed in the Emergency Department. We will keep this letter on file in the department.

Please note that Morristown Memorial Hospital has a pain management clinic. When you establish care with a primary physician, you may be able to arrange care with the clinic to better manage your pain.

Please do not hesitate to call Richard Klemm, RN, Emergency Department Care Manager, at (973) 971-5713, if you need any assistance.

Source: Morristown (NJ) Memorial Hospital.

Sources

For more information on improving care of patients with chronic pain, contact:

- **Richard Klemm**, RN, Emergency Department Care Manager, Morristown Memorial Hospital, Atlantic Health System, 100 Madison Ave., Morristown, NJ 07960. Telephone: (973) 971-5713. Fax: (973) 290-7209. E-mail: Richard.Klemm@ahsys.org.
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the first or second visit that they will no longer be getting the narcotics and may choose not to return."

• Add a "special needs alert" at registration.

This alert helps to identify patients with chronic or episodic pain episodes, Street says.

"The plans for these patients are on a shared drive requiring password access," she adds. For example, a sickle cell patient would be identified at registration as having an existing pain management plan in the ED, so treatment immediately can be started, Street explains.

"We are able to identify patients for whom early intervention will improve outcome," she says. "As we all know, wait times in EDs are not going down." ■

Does your ED supply interpreter services?

Is your ED in compliance with federal regulations for care of non-English-speaking patients and their families? You are required to provide language assistance to patients in your ED, and penalties for failure to comply are severe, including exclusion from participation in Medicare and Medicaid and possible criminal charges.

In addition, standards from the Joint Commission on Accreditation of Healthcare Organizations require that you find effective ways to communicate medical information to patients who don't speak English. The agency also requires you to address how staff interact with patients from different cultures.

Here are effective strategies to comply:

• Provide trained and competent interpreters.

Federal regulations mandate that to receive federal funds, health care organizations must offer and provide language assistance services to patients with limited English proficiency in a timely manner, says **Mary Jo Webb**, RN, MSN, director of emergency nursing at San Francisco General Hospital and Medical Center.[1] **(For information on Emergency Medical Treatment and Labor Act requirements for translators, see "EMTALA Q&A," p. 69.)**

Solutions include hiring bilingual staff members and staff interpreters, enlisting the help of community volunteers, or contracting with a telephone interpreter service, she adds.

Health care providers are banned from requiring patients to use family and friends as interpreters, Webb cautions. "We do not encourage family or friends to interpret because of confidentiality concerns and the risk of misinterpretation," Webb says.

Family or friends may not understand medical terminology, and this can cause problems, she explains. "The wrong question with the wrong answer could affect the treatment plan," she says.

San Francisco General Hospital and Medical Center's ED uses the facility's translation department, which is capable of interpreting 10 languages/24 hours a day, and it also contracts with the Portland, OR-based Pacific Interpreters for telephone translation, Webb says.

The language spoken by the patient is documented on the triage sheet, and translation services are provided from that point on, explains Webb.

• Use a closed-circuit TV with interpreter.

At Genesys Regional Medical Center in Grand Blanc, MI, the ED sees very few non-English-speaking patients, says **Jackie Sage**, RN, former ED nurse manager.

"This puts us in a minor crisis when we do have a need for interpreters," she says. Although Genesee County provides the ED with a list of local translators to access, there is often a delay in their arrival, and the cost is $35 per hour, she adds.

Executive Summary

To comply with federal guidelines, your ED must provide language assistance to non-English-speaking patients.

- Don't use family members as interpreters.
- Use a closed-circuit TV with a live interpreter or use the services of a telephone translation service.
- Offer incentives for multilingual staff, and provide tuition reimbursement for language classes.

To address these problems of quick access and cost, a closed-circuit TV is brought into the patient's room for videoconferencing, a service provided by Flint, MI-based Communication Access Center, which costs about $20 per contact, she reports.

"We place it at the end of the bed, and we can have three-way conversations with a live interpreter," Sage says.

The patient, triage nurse, primary nurse, physician, and social worker can participate in the communication, says Sage. "This process has worked great for us so far," she says. "The downside is that the interpreters are not available 24 hours a day at this time, but we are progressing to that coverage."

• Hire bilingual staff.

Webb hires multilingual staff whenever possible. "We have nurses, physicians, and ancillary staff who are multilingual," she says. Approximately 40% of the ED staff speak a foreign language, mostly Spanish, says Webb. "It is not a criteria for hiring, but we prefer bilingual staff," she says.

• Give staff incentives for multilingual status.

Staff members who are multilingual frequently go to other areas of the hospital to help interpret if needed, Webb explains. "Our staff receive interpreter pay if they are credentialed," she says.

ED staff can take a language exam given through the facility's human resource department, she explains. "It does not cost the employees anything, but if they want to be paid for interpreting, they have to pass the test," Webb explains. "If they pass, they are credentialed that they are qualified to interpret, and get an additional $25 per week," she explains.

Several ED nurses receive tuition reimbursement for taking adult education Spanish courses, Webb says. "The staff realize the significance of this, since a large part of our population speaks Spanish," she says.

Consider reimbursing staff for language classes, Webb recommends. "Our staff can get reimbursement through their educational fund if they opt to use the money for that purpose," she says.

• Give patients written materials in their native language.

Federal guidelines recommend that you should offer written materials for each group of non-English-speaking patients constituting 5% of your ED's patient volume.[1]

All forms and signs in San Francisco General's ED are printed in four languages because of the diverse patient population, says Webb. Forms are sent out to the San Francisco Department of Public Health to be translated into Spanish, Russian, and Chinese, she says.

• Give staff diversity training.

Cultural and diversity training are given to all ED

Source/Resources

For more information on care of non-English-speaking patients, contact:

- **Mary Jo Webb**, RN, MSN, Director, Emergency Nursing, San Francisco General Hospital and Medical Center, 1001 Potrero Ave., San Francisco, CA 94110. Telephone: (415) 206-4097. Fax: (415) 206-5818. E-mail: Mary.Jo.Webb@sfdph.org.

For resources on non-English-speaking patients, contact:

- **The Office for Civil Rights** of the Department of Health and Human Services document titled *Policy Guidance on the Title VI Prohibition Against National Origin Discrimination as It Affects Persons With Limited English Proficiency* is available at no charge at www.hhs.gov/ocr/lep.
- **The Care Notes System** is a patient education tool written at the sixth- to eighth-grade reading level, with 3,000 titles available in English and Spanish. For more information, contact Micromedex, 6200 S. Syracuse Way, Suite 300, Greenwood Village, CO 80111-4740. Telephone: (800) 525-9083 or (303) 486-6444. Fax: (303) 486-6464. E-mail: info@mdx.com. Web: www.micromedex.com/products/healthcare. Click on "Patient Education," and "Care Notes System."
- **Communication Access Center** provides interpreters on site and via videoconferencing. For more information, contact Communication Access Center, 1631 Miller Road, Flint, MI 48503. Telephone: (810) 239-3112. Fax: (810) 239-1606. E-mail: info@cacdhh.org. Web: www.cacdhh.org.
- **Pacific Interpreters** provides telephone translation services in more than 130 languages. A per-minute rate is charged, based on volume and other factors. For more information, contact Pacific Interpreters, 520 S. W. Yamhill, Suite 320, Portland, OR 97204. Telephone: (800) 311-1232. Fax: (503) 445-5502. E-mail: sales@pacificinterpreters.com. Web: www.pacificinterpreters.com.
- **Medical Spanish for the Emergency Room**, a web site that was developed by Matthew Kopf, MS, and Julie McGowan, PhD, from the Burlington-based Vermont Initiative for Rural Health Information and Telemedicine. It assists medical professionals with patient history and physical examination if translation resources are unavailable or delayed. Web: www.vtmednet.org/medspanish.
- **Language Assistance** provides videoconferencing services with medically trained and certified interpreters for Spanish-speaking and hearing impaired patients. For more information, contact Language Assistance, 7227 Fannin St., Suite 103, Houston, TX 77030. Telephone: (888) 466-8255 or (713) 790-1295. Fax: (713) 790-1253. E-mail: info@languageassistance.com. Web: www.languageassistance.com.

staff by the clinical educator and clinical nurse specialist, with frequent classes offered, reports Webb.

"We stress cultural differences and beliefs that may affect the patient's care," she says. The health department supplies all the training materials, she says.

In addition, the county health department provides cultural diversity training several times a year, says Webb. "We send staff to be trainers, and they, in turn, train staff in the department," she says.

Additional diversity training is provided during the ED's annual competency day, Webb says. The clinical nurse specialist prepares the materials from a variety of sources, she says.

"We also utilize our equal employment opportunity department to provide individual training if needed," she says.

Reference

1. 67 *Fed Reg*. 41455 (June 18, 2002). ■

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 would like answered, contact Joy Dickinson, Senior Managing Editor, ED Management, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: joy.dickinson @ahpcub.com.]

Question: When performing a transfer, is it necessary to have an interpreter along for the transfer of a non-English-speaking patient, assuming that an interpreter was available for performing the medical screening examination?

Answer: If it is medically necessary to have verbal communications with the patient, for example, to evaluate neurological status or pain level, then it would be appropriate to send an interpreter, according to **John Lipson**, MD, MBA, principal of Columbus, IN-based Medical Staff Support Services, which assists medical staff leaders and administrators with EMTALA compliance. If the patient's medical condition does not require verbal communications — for example, the patient had a dense stroke or a simple ankle fracture — then an interpreter would not be necessary, Lipson says.

He notes that the transferring physician is responsible to make sure that the patient is transferred in an appropriate medical environment.

Although EMTALA doesn't directly address interpreters for patients with limited English proficiency, other federal regulations do, notes **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

He points to the Civil Rights Act of 1964, which requires hospitals that receive federal funds to provide non-English-speaking patients with oral and written language assistance. "EMTALA is silent on the issue, but the law is clear that translators must be available in the ED," he says.

In addition, Title VI prohibits discrimination against people based upon their nation of origin, Lawrence explains. "This is the reason hospitals have signage in their EDs advising patients of the availability of translators," he says.

The federal government has made it plain that it will seriously consider anything that discourages a patient from receiving his or her medical screening examination to be an EMTALA violation, he adds. "That would most certainly include a lack of ability to timely understand what the patient's chief complaint or history is," says Lawrence.

In some instances, federal authorities have indicated that a family member or nontrained interpreter is not sufficient to provide the degree of assistance required, he notes.

Still, it is unlikely that the lack of a translator during a transfer would constitute an EMTALA violation, Lawrence says. By the time a transfer takes place, medical personnel have a fairly good understanding of the patient's condition and stabilizing treatment has begun or has been accomplished, he explains.

"Also, practicality plays a necessary role," adds Lawrence. "For the less-common languages, many hospitals use a commercial telephone-based service. This would be difficult to accomplish in an ambulance

Sources

For more information, contact:

- **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.
- **John D. Lipson**, MD, MBA, Medical Staff Support Services, 6043 Chinkapin Drive, Columbus, IN 47201. Telephone: (812) 342-2658. E-mail: lipsonj@medstaff.net. Web: www.medstaff.net.

setting unless cell phones were used." The receiving facility must be made aware of the patient's language needs, and any changes in the patient's condition during transport probably would not require detailed translation, he says.

"Of course, a translator would be a nice touch and greatly appreciated by the patient," Lawrence adds. ■

JOURNAL REVIEW

Schmidt CE, Bottoni T. **Improving medication safety and patient care in the emergency department**. *J Emerg Nurs* 2003; 29:12-16.

Only half of ED staff would report a near-miss drug error if the patient was not harmed, according to this study from the Naval Hospital Jacksonville (FL).

The researchers surveyed 58 ED staff to identify obstacles to reporting medication errors and assessed the contents of the ED's automated medication dispensing machines to assess medications that looked or sounded alike.

Here were their key findings:

• About half of ED staff (51%) believed there would be repercussions for reporting a medication error.

• Almost a quarter of the 278 medications found in the automated medication dispenser were similar in appearance or name, or existed in multidose formulations.

• Eight medications that looked similar were located in the same drawer.

As a result of the findings, the following actions were taken:

• Ten drugs in multiple-dose formulations were found to be unnecessary and were removed, and 10 medications with similar names or packaging were moved so they were separate from the look-alike or sound-alike drugs.

• During the three-month period of the study, six near misses were reported anonymously via a lockbox. Each of the six cases was discussed with staff members and used as a teaching opportunity.

• Since less experienced ED nurses were anxious about manual preparation of vasoactive medications, these are now stat-prepared on demand by critical care pharmacists and immediately transported to the ED.

• Classes were scheduled frequently to review safe and proper medication administration.

"We hope this endeavor will continue to promote a climate for the recognition and reporting of potential and actual medication errors," the researchers concluded. ■

Save 20 overtime hours with videotaped meetings

Every month, up to 20 hours of overtime are saved in the ED at Paradise Valley Hospital in National City, CA, by videotaping staff meetings and inservices.

Because staff can watch the videotaped meetings at their convenience, this prevents management from having to pay overtime, explains **Stephanie J. Baker**, RN, BSN, CEN, MBA/HCM, director of emergency services at Paradise Valley Hospital.

It also provides staff who are working, on vacation, or unable to attend with an alternative method of receiving mandatory or critical information, Baker points out.

"Many times staff can watch the tape in the early morning hours," she adds.

All staff are required to watch the tape by the end of a two-week period and sign an inservice record that indicates they are responsible for the information provided, Baker says.

"This method has improved staff compliance with mandatory meetings and inservices and reduced department overtime costs," she says.

An ED technician sets up a video camera on a tripod before the meeting, she says. The current month's tapes are catalogued and kept in the lounge where staff can view them, and other inservice tapes are kept in the educator's office and can be checked out as needed, she says.

More than $500 a month saved

If the meetings were not videotaped, the ED would have to pay about 10 regular hours at $30 per hour and five to 10 double-time night shift hours at $45 per hour, estimates Baker.

"This equates to around $500 to $750 saved per month," she says.

Source

For more information, contact:

- **Stephanie Baker**, RN, BSN, CEN, MBA/HCM, Director of Emergency Services, Paradise Valley Hospital, National City, CA 91950. Telephone: (619) 470-4386. E-mail: StephanieRNI@cox.net.

Staff are expected to attend at least 18 of the 24 annual staff meetings in person, but they are allowed to watch six taped meetings annually to accommodate vacations and scheduling needs, Baker says.

Staff participation in meetings and inservices is a factor for annual evaluation and clinical ladder requirements, she explains.

"We also rotate the times of the staff meetings and inservices each month to better accommodate night and swing-shift staff, and we always try and have the meetings catered by a drug rep to entice them with food," says Baker.

[Do you have a cost-cutting tip to share with ED Management *readers? If so, please contact Joy Dickinson, Senior Managing Editor,* ED Management*, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: joy.dickinson@ahcpub.com.]* ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions.

Participants should select what they believe to be the correct answers, then refer to the answer key **(see below)** to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the September issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

Answer Key: 13. A; 14. B; 15. B; 16. D; 17. C; 18. D

CE/CME *questions*

13. Which is recommended to reduce delays caused by holding inpatients in the ED, according to Robert W. Stein, president of LeNurse?
    A. Having inpatient nurses do paperwork in the ED for patients waiting for an available bed
    B. Having ED nurses do all admission paperwork for inpatients being held
    C. Involving only ED nurses in facilitating patient admissions
    D. Having only a single charge nurse even when the ED is overcrowded

14. Which is recommended for use of technicians in the ED, according to Patricia Bunce, director of emergency and critical care services at Good Samaritan Hospital?
    A. Having only nurses receive report on a patient
    B. Having technicians assigned to specific tasks
    C. Having technicians assist all of the ED nurses simultaneously
    D. Having several technicians assigned to each patient

15. Which is recommended to improve care of non-English-speaking patients, according to Mary Jo Webb, director of emergency nursing at San Francisco General Hospital?
    A. Using family members to translate the patient's history
    B. Giving incentives to multilingual staff
    C. Asking friends to translate, if the patient agrees
    D. Providing translators only if requested

16. To comply with EMTALA, which is required for a transfer of a non-English-speaking patient, according to Jonathan D. Lawrence, an ED physician and medical staff risk management liaison at St. Mary Medical Center?
    A. An interpreter is not necessary for any patient.
    B. An interpreter is required even if the patient's medical condition does not require verbal communications.
    C. Family members should be asked to act as translators.
    D. Translators must be provided if there is a lack of understanding as to what the patient's chief complaint or history is.

COMING IN FUTURE MONTHS

- Increase reimbursement for admitted patients held in the ED
- Cut costs with novel documentation strategies
- Screening guidelines speed care of psychiatric patients
- Effective ways to improve security at your ED

17. Which is recommended for chronic pain patients, according to Mark Mandell, MD, chairman of the department of emergency medicine at Morristown Memorial Hospital?
    A. Refuse to give narcotics to any patient who requests them frequently.
    B. Inform staff that a patient is a drug seeker and should not be given narcotics.
    C. Develop a care plan if narcotic abuse is suspected.
    D. Avoid giving narcotics to any patient who presents with a pain-related complaint more than three times per month.

18. Which of the following is true regarding medication safety, according to a study published in the *Journal of Emergency Nursing*?
    A. The majority of ED staff would report a near miss if the patient was not harmed.
    B. No staff said they would report a near miss involving a medication error.
    C. It doesn't matter if look-alike drugs are stored next to one another, as long as they are kept in automated medication dispensers.
    D. Staff should be encouraged to report near misses anonymously using a lockbox.

CE/CME objectives

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

- Discuss and apply new information about various approaches to ED management. (See "*Report puts spotlight on inpatient holds: The No. 1 reason for ED overcrowding*" in this issue.)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See "*Does your ED supply interpreter services?*" and "*EMTALA Q&A*.")
- Share acquired knowledge of these developments and advances with employees. (See "*Make these changes to cut delays, diversion hours*.")
- Implement managerial procedures suggested by your peers in the publication. (See "*Do you give poor care to patients in pain?*" and "*Journal Review.*") ■