ED Management®
The monthly update on Emergency Department Management

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IN THIS ISSUE

Enclosed in this issue:

- 'Mr. Strong' procedure for ED security
- Policy for initial management of potential suicidal/homicidal or potentially violent patients
- 2003 *EDM* Salary Survey

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Are you losing nurses due to violence in your ED? You should take action now!

Emergency nurses at high risk for assaults, study says

If you're having trouble retaining and recruiting ED nurses, it may be time to closely examine your violence prevention strategies. The University of Alberta (Canada) Faculty of Nursing surveyed more than 9,000 nurses. The survey revealed that 22% of ED nurses reported being assaulted during the previous five shifts, and 62% reported emotional abuse.[1] Both percentages are higher than those reported by psychiatric and medical-surgical nurses.

The report found that nurses who reported emotional abuse and at least one other form of violence had the lowest job satisfaction, while nurses who reported no violence were most satisfied.

This study clearly shows that the nursing shortage is a powerful motivator to immediately address the problem of violence and abuse in your ED, says **Kayleen L. Paul**, RN, BS, CEN, director of emergency services at McKay-Dee Hospital Center, a 300-bed facility based in Ogden, UT. "We strongly believe that a violence-free workplace will help us retain our experienced and valuable ED nurses," Paul says.

Confront this problem in your ED, urges **Rosemary Kucewicz**, RN, BSN, ED manager at Northwest Community Hospital in Arlington Heights, IL. "For many years, we accepted aggression as part of our environment and never did anything to prevent or control it," she says. "Every ED manager has to come up with strategies to prevent violence."

As an ED manager, implement a "zero-tolerance" policy for abuse and violence, says **Sherlene Stepp**, RN, clinical nurse supervisor for the ED at University of

Executive Summary

To address the higher risks of violence to ED staff, you'll need to implement strategies for prevention and security response.

- Instead of waiting for an assault to occur, have security respond to *potentially* violent patients.
- Include abuse by co-workers in your violence prevention policies.
- Consider using a security dog as a deterrent.

California-Irvine Medical Center in Orange.

"No staff member should be threatened or harassed," she emphasizes. "We need to let the public know we will not tolerate violence in the ED."

To prevent violence in your ED, use these strategies that work:

• **Develop specific policies to address violence.**

The ED at Northwest Community has detailed policies and procedures for violence prevention, and staff members are regularly inserviced on these, reports Kucewicz.

Your policies must address violence in the workplace, management of psychiatric patients, and security policies, she says.

The ED's policy outlines a "show of force" procedure by security known as "Mr. Strong," says Kucewicz.

"In this policy, you do not wait until the patient does something," she points out. "At the first sign of a potentially violent situation, you page security staff for a show of force." **(See policy for initial management of potentially violent patients and "Mr. Strong" procedure, inserted in this issue.)**

Often, security stands by as the nurse de-escalates the situation verbally, but the show of force prevents a violent outburst, says Kucewicz.

A "no tolerance" procedure was implemented at Covenant HealthCare in Saqinaw, MI, reports **Marc Augsburger**, RN, BSN, BC, manager of the emergency care center.

"If any threatening remarks are made toward our staff, security is immediately notified and responds," he says. "They stand guard at the doorway until a clinical decision can be made concerning the patient."

If any visitor is heard or visualized making threatening comments, security is notified to respond to the ED immediately, says Augsburger. "The visitor is politely asked to leave the property," he says. "If the visitor does not willingly leave, they are escorted out by security."

'No tolerance' policy includes staff

The Canadian study reported that a significant number of incidents were from co-workers. The ED's "no tolerance" policy also is in effect for co-worker abuse, notes Augsburger.

"The co-worker is escorted out, and a thorough investigation of the account is conducted and documented," he says. "Termination is a real possibility."

To notify security, staff can call the five-digit emergency security number or use one of several push buttons throughout the ED that alert the security office, he explains. "These are mostly mounted under desktops within easy reach of staff members," says Augsburger.

The push buttons are not visible, so they can be hit without the patient knowing it, he adds. "The actual button also is protected so that there is little chance of a false alarm," Augsburger says.

If staff members observe a patient or co-worker being threatening, they use the push button or verbally call for help, and security is immediately notified, he says. "Depending on the situation, the observer may

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assist in a de-escalation," Augsburger says.

• Limit the number of people in the department.

"We now allow only one visitor at the bedside, unless the patient is a child," says Stepp.

The ED also has locked-door access, she adds. "This means that anyone who wants to enter has to first check with our greeter, who calls the ED to receive clearance for him or her to enter," she explains.

• Address high-risk patients.

The ED has a very high psychiatric population, notes Stepp. "Most of our violence does occur with this population of patients," she says.

Two beds are designated for psychiatric patients in a secluded area of the ED, says Stepp. "This is helpful because it takes [most] disruptive patients out of the main ED, and it also decreases stimuli that may escalate the patient," she says.

• Assess potential for violence.

A level system was implemented so that ED staff could convey the degree of risk posed by a patient, says Stepp.

"To communicate the potential for violence was very difficult, so we developed a system so everyone would be on the same page," she says. The levels are as follows:

— **Level 1: No risk.** No direct security observation needed.
— **Level 2: Moderate risk.** Observation by security and frequent reassessment by the medical staff.
— **Level 3: High risk.** Constant observation by security and constant assessment by medical staff.

The ED nurse decides the patient's level based on his or her behavior, and security is notified, she explains. "The level number is placed on the patient tracking board so the entire staff will know which patient to watch for," she says. With this system, security and ED staff are aware of a patient's potential for violence, says Stepp.

• Invest in a security dog.

When a disturbing trend was noticed of an increase in assaults on staff and patients coming in with weapons, ED staff knew something had to be done, says Paul. A committee was convened, and drastic measures such as metal detectors and armed security guards were considered, she says.

However, patient satisfaction was at issue, she notes. "We are not a large inner-city ED, and we knew that many of our patients would not expect or accept a 'lock-down' atmosphere," Paul says.

Instead, a security dog was purchased at a cost of $5,000 from a kennel that raises police dogs in Germany. "Any hospital considering a dog program would be best advised to have a close working relationship with their local police agency, so training can occur," she says. "We used their contacts with kennels and their selection and testing criteria to choose the dog."

The hospital's security officer agreed to become the "canine officer" and patrols the ED during night hours with the dog, she explains.

"I have seen patients refuse to respond to armed police officers, but when faced with a growling dog, they immediately back down."

When the first dog was retired, a second dog was purchased from a kennel in the United States, says Paul.

"We have had none of the problems we were worried about, such as infection control issues or the dog behaving inappropriately," she reports.

The dog is occasionally brought in when staff members feel threatened by a patient and is an excellent deterrent to violence, says Paul.

"I have seen patients refuse to respond to armed police officers, but when faced with a growling dog, they immediately back down," she says.

Reference

1. Hesketh KL, Duncan SM, Estabrooks CA, et al. Workplace violence in Alberta and British Columbia hospitals. *Health Policy* 2003; 63:311-321. ■

New screening guidelines cut hours off delays

If a chronic schizophrenic with recurrent hallucinations or a suicidal college student comes to your ED, what comes to mind as the most immediate need? Is it an immediate mental health consultation or a time-consuming assortment of expensive diagnostic tests?

Unfortunately, the most urgent needs of psychiatric patients often are pushed aside in the ED until a wide range of testing is completed for medical clearance, says **Mark Pearlmutter**, MD, chief of Caritas Emergency Medical Group in Boston.

Before a psychiatric assessment can occur, ED physicians are asked if the patient has been "medically cleared," he says.

"They will be asked, 'Did the patient have a toxicology screen? Are the blood tests back? Did you get an alcohol level?'" he says. "As a knee-jerk reaction, many EDs will now automatically perform a predefined battery of ancillary tests for any patient with a psychiatric complaint."

This is detrimental to patient care and patient flow, Pearlmutter argues. "There is no other patient we treat in the ED with whom our hands are tied and we are required to order what we think are totally unnecessary lab tests to get another process to occur," he says. "We frequently find ourselves at the mercy of a receiving psychiatric facility or managed care entity demanding nonsensical lab and imaging studies."

Recently, a patient in a mental health crisis was examined and found to have previously received a prophylactic medication for exposure to tuberculosis, recalls Pearlmutter.

"The patient had no symptoms, but the receiving facility demanded that we do a CT scan of the patient's chest," he points out. "No one in their right mind would feel this was necessary. It cost us $700, which we swallowed."

Incidents such as these prompted Pearlmutter to assemble a work group to assist in developing screening guidelines to identify patients who don't require toxicology screens, medical testing, or imaging studies.

"As the message spreads, receiving facilities know they can no longer hold us at ransom for unnecessary blood or imaging studies," he says. "There is now a position statement that we can speak to."

Having clear guidelines for medical clearance will improve turnaround times and help psychiatric patients receive the care they need, according to **Robert B. Takla**, MD, FACEP, medical director of emergency services at St. John NorthEast Community Hospital in Detroit, where screening guidelines are being developed.

"This is an area that is just often left alone, but we need to address it and improve on the care we deliver," he says.

Consider the following significant benefits of screening guidelines for psychiatric patients in the ED:

• Patients receive care quicker.

If screening guidelines are used, patients receive psychiatric work-ups — which is the reason they came to the ED — hours earlier, Pearlmutter says.

"Asking patients in a mental health crisis to wait for hours while we ask them superfluous and unnecessary medical questions, poke them with needles, and perform X-rays and urine tests is sending a terrible message," he says.

A patient's condition may worsen during the long wait, he explains. "The patient may have presented with anxiety or depression, but after hours of waiting, the patient may become more agitated or even suicidal and require inpatient admission," says Pearlmutter.

• A consistent definition of medical clearance can be used.

ED physicians have a much different perspective of what is emergently necessary to "medically clear" a patient than psychiatrists do, says Takla. "We need to work together to establish comfort levels and optimize treatment for the patient's needs," he says.

While psychiatric patients may have medical conditions that will require treatment, the patient still might be considered medically stable for psychiatric intervention, says Takla.

He gives the example of a patient who is chronically hypertensive and asymptomatic. "That patient will not require any emergent intervention," he says. "In fact, a rapid reduction of the blood pressure is potentially far more deleterious than not treating it."

The facility's emergency medicine and psychiatry departments are developing guidelines so that a consistent definition of medical clearance can be used, says Takla.

"The goal is to treat the patient and not follow a

Executive Summary

Screening guidelines for psychiatric patients can eliminate hours of delays due to costly, time-consuming diagnostic testing.

- If patients don't have to undergo extensive testing, they can be treated without delay.
- By eliminating routine diagnostic testing, $300 per patient can be saved.
- If care is delayed, a patient's condition may worsen and necessitate inpatient admission.

Sources

For more information on screening guidelines for medical clearance of psychiatric patients in the ED, contact:

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- **Robert B. Takla**, MD, FACEP, Medical Director of Emergency Services, St. John NorthEast Community Hospital, 4777 E. Outer Drive, Detroit, MI 48234-3281. Telephone: (313) 369-5689. Fax: (313) 369-5582. E-mail: rtakla@comcast.net.

habitual pattern of ordering studies that may not be necessary," says Takla.

• Fewer ED resources are used.

Patients with psychiatric complaints require significant resources while waiting in the ED to be medically cleared, says Pearlmutter.

"These patients require a lot of nursing care, a fair amount of physician involvement, and almost all require some type of one-to-one care," he says. "All of the extra time the patient sits in the ED — these resources could be going to other patients."

• Costs are saved.

About one-third of psychiatric patients at his ED meet the low-risk criteria, which eliminates the need for testing, says Pearlmutter. Even for patients who don't meet the definition of low medical risk, routine testing is not necessarily recommended, he adds. Instead, selective use of ancillary testing should be based on the patient's clinical presentation and physical findings, he says.

"If you look at the costs associated with medical clearance, including a chemistry panel, a complete blood count, toxicology screen, and various drug levels, it is easily $300 per patient," Pearlmutter says. "If you multiply that figure by the number of patients, you are talking about saving millions every year." ■

Include your community in disaster planning

You may have an effective, well-rehearsed disaster plan, but have you included the community in your planning? A report from the Joint Commission on Accreditation of Healthcare Organizations makes it clear that surveyors will be looking for evidence that you have done so.

"All EDs need to look at the relationship they have with the local and regional emergency management teams," emphasizes **Patricia Gabriel**, RN, BSN, CEN, ED nurse manager at Overlook Hospital in Summit, NJ.

Joint Commission surveyors are looking at this inclusion, says Gabriel. "The key is multiagency cooperation," she emphasizes.

To comply with the report's recommendations, you must do the following:

• Involve the community in your drills.

"Invite anyone you can think of to your disaster drills," advises Gabriel. This includes local police, fire, emergency medical services, local health officers, and representatives from airports or industrial facilities, she says.

"While they are watching the drill, you have the opportunity to learn from their experiences and point of view," she says. "This has been particularly successful for us."

In one drill, local police realized that they needed a secondary command site to be developed, Gabriel says.

"At another drill, we learned that the radios we were going to use with our sectors were conflicting with a neighboring county EMS [emergency medical services] frequency, and since they have a number of 'repeaters' to carry the signal, our communications couldn't be heard," she reports. To correct the problem, the radios were reprogrammed to a different frequency, says Gabriel.

• Involve all staff with community preparedness.

This is an excellent opportunity to develop future leaders and involve staff in disaster planning, says Gabriel.

"Most agencies are not picky about the title of the representative; they are just happy to have the hospital represented," she notes. "As long as the ground rules are set — such as a staff nurse can't make an agreement or policy decision for an institution — it is a great way to reward someone with expertise."

At least once a year at Overlook Hospital, a disaster drill is held at 6 a.m. to include nurses on off-shifts, she says. "The night staff love it because they are included, the day shift is happy to not have it, and the town agencies usually can send someone to participate or watch," Gabriel says.

• Assess communication between your ED and community resources.

You need to assess field communication that will be in place for any disaster, says Gabriel. "All shifts need to be able to respond quickly *on their own* without waiting for managers to direct them," she says.

Conduct drills with simulated patients that move

Source/Resource

For more information on the Joint Commission on Accreditation of Healthcare Organizations and community preparedness, contact:

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The Joint Commission's white paper, *Health Care at the Crossroads: Strategies for Creating and Sustaining Communitywide Emergency Preparedness Systems,* can be accessed at no charge at www.jcaho.org/news+room/press+kits/emergency+prep.htm.

through the system's resources, says Gabriel.

This drill allows for identification of real problems that might not otherwise be noted, she explains. "For example, is the number for the Office of Emergency Management [OEM] correct and easy to locate? Does a person answer it, or is it voice mail hell? If no one calls it, the hospital never knows," Gabriel says.

Other important questions to address are what communication is available from the site, does it go directly to the ED or to a hospital command center, and how long does it take for the information to reach health care providers, she says.

Instead of using the drills as teaching moments, have observers document the event in real time and then have a debriefing as soon as possible, advises Gabriel. "Allowing the drills to continue without intervention allows for the real consequences of the decisions to be seen, felt, and heard," she says.

• Include all areas that receive patients.

Biological events can be identified from many points, such as laboratories, hospital clinics, or the labor and delivery area, so these should be included in disaster planning, says Gabriel.

"These areas frequently are left out of the loop regarding training," she says.

• Participate in community drills.

"When you feel that you have the kinks worked out and under control, go for community based, multiagency drills," advises Gabriel. "The volunteer EMS folks love to participate, especially when it is scheduled on weekends."

• Develop relationships.

ED staff should develop relationships with local police, fire, and EMS, says Gabriel. "The roles and responsibilities of each group need to be clearly understood," she emphasizes.

Contact the local OEM agency and the local board of health and invite them to a roundtable discussion of resources, best practices, and new ideas, she suggests.

"Ongoing meetings would be best, and they allow for excellent networking," Gabriel says. "In our area, the community health folks have lots of contacts and were willing to help us set things up."

Every year during EMS week, the ED holds a dinner to honor them, says Gabriel. A guest speaker does a 30-minute presentation, and the hospital recognizes one member of each area EMS unit who is selected based on a recommendation by the squad captain, she says.

"It is always well attended and not too costly because the catering is done on site by food services," Gabriel adds. ■

TECH WATCH

New tool avoids sticking patients 10-15 times

It happens in every ED: Patients with difficult line access are stuck multiple times — some as many as 10-15 times — in an attempt to access an intravenous (IV) line.

"Eventually, someone gets a small IV that works, or a central line is placed," says **Michael Blaivas**, MD, RDMS, director of emergency ultrasound at Medical College of Georgia in Augusta.

Imagine what that scenario does to your patient satisfaction scores.

In some cases, patients may have almost no peripheral veins left, notes Blaivas. "The nurses or physicians cannot palpate any, or all are clotted off," he explains.

The Medical College of Georgia's ED recently invested in the ilook 25, a tool for ultrasound-guided line placement manufactured by Bothell, WA-based SonoSite, says Blaivas. **(See contact information for two manufacturers of this technology in resource box, p. 79.)** "It allows you to look for different locations, look deeper, or simply find veins that are there all the time but cannot be felt seen or easily hit with a blind stick," he explains.

The tool is easy to operate and provides good image resolution for better accuracy in detecting blood vessels for any patient who is a difficult access, either peripheral or central, he says.

Both nurses and physicians use ultrasound for line

Source/Resources

For more information about the use of the ilook 25 in the ED, contact:

- **Michael Blaivas**, MD, RDMS, Director of Emergency Ultrasound, Medical College of Georgia, 1120 15th St., AF-2039, Augusta, GA 30912-4007. Telephone: (706) 721-2613. E-mail: blaivas@pyro.net.

- **The iLook 25** personal imaging tool is an ultrasound designed for vascular access, with all-digital broadband imaging for clear visualization of veins and arteries. For more information, contact SonoSite, 21919 30th Drive S.E., Bothell, WA 98021-3904. Telephone: (888) 482-9449 or (425) 951-1200. Fax: (425) 951-1201. E-mail: admin@sonosite.com. Web: www.sonosite.com. Under "Vascular Access," scroll down to "Products/Solutions" and click on "iLook25."
- **Site-Rite Ultrasound System** is a series of ultrasound scanners designed for vascular access and equipped with disposable needle guides. They range in price from $10,040 to $17,275. For more information, contact Dymax Corp., 271 Kappa Drive, Pittsburgh, PA 15238. Telephone: (800) 296-4146 or (412) 963-6884. Fax: (412) 963-6179. Web: www.site-rite.com.

placement, and nurses often bring out the tool without involving a physician, says Blaivas.

"This saves time in itself as the nurse does not need to hunt down another person," he says. "Our nurses stop after two or three attempts as they quickly realize someone is an access problem, then the ilook comes out, a vein is visually located, and an IV is placed."

There is a risk of central lines leading to infection and deep vein thrombosis, both of which can lead to death, notes Blaivas. "In the case of patients getting a central line just for access or convenience, one needs to think twice," he says. "That is where the ilook 25 can also make a big difference."

Before you invest in this technology, it is essential to consider the following items:

• Cost.

The ilook 25 costs approximately $12,000 to $15,000, says Blaivas. However, staff resources and delays are significantly reduced, he adds.

A patient who used to be stuck by three or four nurses and waited an hour or more to get labs can be accessed much more quickly, he says. "It frees up the nurse to do other things," Blaivas says. "Also, fewer IVs are used, and antibiotics or other vital medications can be given right away."

• Patient and staff satisfaction.

Patient satisfaction is likely to improve, because patients who previously were stuck multiple times now may be accessed after only one or two attempts, says Blaivas.

"Staff satisfaction also increases as nurses and physicians placing these lines feel a higher mastery of this technology, more self-reliance, and improved care delivery to their patients," he adds.

• Training.

A short training program includes an introductory lecture followed by practice on an inanimate arm with a vein that appears similar to human tissue on ultrasound, says Blaivas.

"Then we encourage the students to take their first try using the machine on a live patient that is not a horribly difficult stick, so that the time pressure is not as great," he says. "Thus, their first experience is less anxious on a real patient." ■

COST-SAVING TIP

Save up to $700,000 by making this change

You can dramatically reduce costs by not routinely ordering coagulation studies for all patients with acute coronary syndromes, says **Charlene Babcock Irvin**, MD, FACEP, assistant vice chief for the Department of Emergency Medicine at St. John Hospital and Medical Center in Detroit.

The facility's ED has stopped routinely ordering these tests and expects to save up to $700,000 this year as a result, she reports.

"In this era of cost containment, ED managers need to critically evaluate whether routinely ordered tests are really necessary," she says. "Frequently, we order tests that don't influence the management of the patient."

She points to research showing that routine prothrombin time (PT) and partial thromboplastin time (PTT) testing is not necessary for all acute coronary syndrome patients.[1]

"Healthy adults without evidence of bleeding disorders based on history and physical examination, and who are not taking anticoagulants, do not require these tests prior to heparinization," she says. "Residents have been asked not to routinely order these tests unless a clear indication exists."

The indications that do require these tests include

Source

For more information about ordering of coagulation studies in the ED, contact:

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active bleeding, history or evidence of liver disease, history of alcohol abuse, history or evidence of active coagulopathy, or the patient taking warfarin or Coumadin, she says.

"For instance, if the patient is taking Coumadin, then clearly they are likely to have an induced coagulopathy from the medication," she says. "Those patients should not be started on heparin until their coagulation profiles come back."

A good history and physical examination should identify those patients for whom the coagulation profile is indicated, she adds.

Since the change was made, ordering of coagulation testing has decreased about 30%, reports Irvin.

"Previously, we ordered about 1,000 of these tests each month," she says.

When patients are taking Coumadin, it may be a reflex response to order the PT and the PTT, Irvin notes. "However when the patient is taking Coumadin, you really only need to order the PT, not both. So that should reduce further studies ordered," she says.

Reference

1. McKinley L, Wrenn K. Are baseline prothrombin time/partial thromboplastin time values necessary before instituting anticoagulation? *Ann Emerg Med* 1993; 22:697-702. ■

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 Greg Freeman, 4880 Lower Roswell Road, Suite 165, No. 210, Marietta, GA 30068-4385. Phone: (770) 998-8455. E-mail: Free6060@bellsouth.net.]

Question: Our in-house policy states that when our hospital campus is used for helicopter rendezvous with EMS [emergency medical services], the patient must be brought into our ED for a medical screening examination. Many local hospitals allow EMS to rendezvous with the helicopter services on their campus helipad, and the ED physician never sees the patient. Is this an EMTALA violation?

Answer: No, according to **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC.

For EMTALA to apply, the patient must "come to the ED" of the hospital *and* request a medical screening examination (MSE) or treatment for a medical condition, he says.

"Both prongs must be met before EMTALA applies to the situation," says Bitterman.

In the helipad scenario, the patient has "come to the ED," as defined by the Centers for Medicare & Medicaid Services, by virtue of being on hospital property, he explains.

"However, neither the patient, nor someone on behalf of the patient, has requested an MSE from your hospital; therefore, you have no duty under the law to provide one," he says.

If the patient's condition deteriorates, or if the medics believe the services of your ED are necessary to examine or stabilize the patient prior to helicopter transport (such as secure the airway, insert a central line or chest tube, or provide blood), then the medics' request constitutes the second legal prong — that of a request on behalf of the patient, which triggers an EMTALA duty upon the hospital to screen and stabilize, Bitterman explains.

EMS providers, helicopter transport crews, and hospital personnel should not feel hamstrung by EMTALA in this situation, he advises.

"They should do what, in their judgment, is in the patient's best interest, and then carefully document their actions and reasoning, just in case their decision making is reviewed retrospectively," he says.

As for mandating that the patient be brought into the ED for an MSE, let the EMS personnel and medical control decide whether the patient needs to be examined or treated in your facility prior to helicopter transport elsewhere, Bitterman says.

"EMTALA does not require the patient be brought into your ED, and in many cases, to do so would jeopardize the health of the patient by delaying access to the appropriate level of services required by the patient," he adds.

If there has been no request for your services to screen or stabilize the individual, then you have no duty under EMTALA to provide those services, regardless of where the person is on your hospital

campus, explains Bitterman. "The operational and communication issues you raise, however, should be addressed in advance through policy, procedure, and the education of all involved parties," he adds.

Question: When a combative patient with altered mental status presented to our ED, the nurses and doctor were unable to draw blood to medically clear him because he was combative even after being medicated. The ED physician attempted to have police remove the patient from our ED and sent to a psychiatric ED to be evaluated. At that point, the patient suddenly became more cooperative, and blood was drawn and sent for analysis. If this patient had been sent to the other facility without being medically cleared, would it have constituted a transfer under EMTALA, and would this have been a violation?

Answer: "Yes, this is an EMTALA violation, and worse, it's bad medicine," says Bitterman. First, you have a legal and medical duty to appropriately screen the person to determine if an emergency medical condition exists, he emphasizes.

"Involve security and/or the police, but do whatever it takes to sedate and control the individual in your ED, in order to do an adequate medical screening exam as required by the law," says Bitterman.

This advice is simply good medicine, he says.

"What would you want done if the patient was a member of your family?" Bitterman asks.

Furthermore, psychiatric facilities typically do not have the necessary medical resources or expertise of a full-service ED to adequately evaluate patients for organic causes of their psychotic behavior, he adds.

Sending the patient to another facility for evaluation does constitute a transfer, says Bitterman.

If for some reason the hospital's ED and staff are unable to stabilize the patient's condition, and it is medically required that they transfer the patient to a higher level of care, then they must arrange the transfer as an "appropriate" transfer, as defined by EMTALA, he adds.

"That would include formally obtaining the receiving hospital's acceptance of the patient and transporting the patient via appropriate personnel and equipment," Bitterman says.

However, he notes that EMTALA does not require a *physician* to accept the patient in transfer, only that the *hospital* accept the patient in transfer. The hospital may delegate its duty to accept transfers to whomever it deems most appropriate, explains Bitterman.

"Typically that's a physician, either the ED physicians or the on-call physicians, but it could be a nurse or hospital administrator," he says.

However, some states, such as California and Texas, do require physician-to-physician contact for all transfers, notes Bitterman. "The circumstances of the case coupled with the local standard of care may mandate physician-to-physician contact, but EMTALA does not," he says. "It is a common misconception." ■

Act now to prepare for new E/M coding regs

Your reimbursement will change dramatically when nationally uniform facility assessment criteria are implemented by Medicare, probably in January 2004, predicts **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources in Jacksonville, FL.

"This will be huge news for the ED," she predicts.

At press time, the proposed guidelines were expected to be released this summer by the Dallas-based American Hospital Association and the American Health Information Management Association in Chicago.

Once analyzed by the Centers for Medicare & Medicaid, there will be a comment period, followed by anticipated implementation in January, Edelberg predicts.

Expect to see a transition from the five-level evaluation and management (E/M) coding system (99281-99285), currently used for facility coding, to a three-level system based primarily on case examples for each level, says Edelberg.

You will need to prepare for a financial impact analysis to determine how this new coding and payment system will affect your ED's revenues, she advises.

The jury is out on whether your reimbursement will increase or decrease, but you can expect a significant change, she says.

"Once the new guidelines are released, a field testing of the new criteria will be performed on previously coded records to determine whether the new criteria will increase or lower ED facility revenues for facility E/M levels," she explains.

To be sufficiently prepared for the transition, take these steps recommended by Edelberg:

• Collect data on the hospital distribution of ED nursing levels for discharged Medicare patients.

"You will need to compare current facility distribution to the projected distribution with the new code levels," says Edelberg. "Then determine the financial impact."

• Determine the Medicare payment per patient for the existing facility nursing level distribution (currently billed with E/M levels 99281-85).

"You will need to know the current payment per level

Source

For more information on the proposed new evaluation and management coding levels, contact:

- **Caral Edelberg**, CPC, CCS-P, President/CEO, Medical Management Resources, 8001 Belfort Parkway, Suite 200, Jacksonville, FL 32256. Telephone: (904) 296-0671. E-mail: csemmr@earthlink.net.

to compare to the new payment per level, assuming it is changed," says Edelberg. "If not, many services will track to a new level, thus, a different payment amount."

• Have the hospital pull a sample of ED records to code with the new coding system once it's introduced.

Record the codes that originally were assigned so that the difference can be tracked, says Edelberg.

"You'll need to compare the historical coding utilizing existing criteria with the revised coding under new criteria to determine the impact," she says.

This also will help you determine how ED nurses must document services to ensure they are identified for the correct code level, Edelberg adds.

• Form a committee with nursing, physician, coding, and business office representation to participate in identifying any problems that arise from the transition.

Here are some examples of potential problems for each area:

— Nurses and physicians will need to understand the criteria and document accordingly.

— Medical records coders may be responsible for assigning the codes, so they will need to understand clinical interventions that make up the content of the levels.

— The business office staff will be managing denials and problems, and they should be aware of this major change.

— Compliance officers should be included to ensure that the coding is audited for compliance to the new criteria. ■

Report: EDs are at high risk for dosage errors

More dosage errors are made in the ED than other hospital departments, and fewer potential dosage errors are caught before they occur, according to a new report from the Rockville, MD-based United States Pharmacopeia (USP), which analyzed medication error reports submitted to its national database in 2001.

According to the report, the most common errors in the ED involved improper dosing, with more than 75% of errors occurring during prescribing or administering. ED staff intercepted only 23% of errors, whereas 39% of errors were intercepted in other areas.

To dramatically reduce errors in your ED, use these strategies:

• Assess automated medication dispensing machines units.

Collaborate with pharmacists to survey the contents on a regular basis, advises Lt. Cmdr. **Christopher Schmidt**, RN-CS, MSN, CEN, emergency/trauma nursing specialty leader for Jacksonville, FL-based Nurse Corps, United States Navy, and division officer for the ED at Naval Hospital Jacksonville.

Check for similar appearance, name

Make sure that drugs similar in appearance or name are not stored in the same drawer, check that all medications are stored in the correct spot, and remove items that may not be necessary, such as multiple-dose formulations, Schmidt recommends.

For example, instead of storing both 1 g and 2 g vials of cefazolin, stockpile more of the 1 g, so nurses can take two vials if needed, which eliminates the potential for an overdose, he suggests.

• Eliminate the need for nurses to prepare dosages.

Consider using pre-filled or prepackaged medications for vasoactive drugs requiring mathematical computation, says Schmidt.

At Naval Hospital Jacksonville, a "stat pharmacy

Source/Resource

For more information on medication errors in the ED, contact:

- **Lt. Cmdr. Christopher Schmidt**, RN-CS, MSN, CEN, Division Officer, Emergency Department, Naval Hospital Jacksonville, 2080 Child St., Jacksonville, FL 32214. Telephone: (904) 542-7350. E-mail: c_e_schmidt@sar.med.navy.mil.

- A free copy of the United States Pharmacopeia recommendations can be accessed on the organization's web site: www.usp.org. Click on "Practitioner Reporting," "Summary of Information Submitted to MEDMARX in the Year 2001: A Human Factors Approach to Medication Errors." Under the "Medmarx 2001 Data Details," section, click on "A look at Emergency Departments."

request" system was implemented, with nurses calling the pharmacy to ask for rush orders of certain medications, such as intravenous drugs that require calculations to ensure proper dosing, says Schmidt.

This practice is effective in reducing errors and anxiety of nursing staff, but it must be continuously evaluated, he cautions.

"As good as it sounds, if it's not consistently done, the nurses may go right back to the old way of doing things," he says.

• Perform verbal check backs.

Have a system in which verbal orders are communicated back to the physician, says Schmidt.

"If the order is called back incorrectly, it can quickly be clarified and corrected on the spot," he says. "That will help reduce errors related to prescribing."

The key is to encourage ED staff to report potential errors, he says. "People are fearful of financial and professional retribution if they report their own actual errors or near misses," Schmidt adds.

"We are all human and make mistakes. A quiet health care provider may not always be the safest one," he contends.

(Editor's note: The views expressed by Schmidt in this article are his and do not reflect the official policy of the Department of the Navy, the Department of Defense, or the U.S. government.) ■

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 to test their knowledge.

To clarify confusion on any questions that are 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. ■

CE/CME *questions*

19. Which of the following is recommended to prevent violence in the ED, according to Marc Augsburger, RN, BSN, BC, manager of the emergency care center at Covenant HealthCare?
    A. Wait until a violent incident has occurred to alert security.
    B. Avoid addressing co-worker abuse in violence prevention policies.
    C. Use push buttons to call for security.
    D. Avoid security dogs because of infection control issues.

20. Which is a result of using screening guidelines for medical clearance of psychiatric patients in the ED, according to Mark Pearlmutter, MD, chief of Caritas Emergency Medical Group?
    A. Additional diagnostic tests are needed.
    B. Patients receive care with fewer delays.
    C. Life-threatening emergencies can be overlooked.
    D. The same number of tests are ordered for all patients.

21. Which of the following is recommended for disaster planning, according to Patricia Gabriel, RN, BSN, CEN, ED nurse manager at Overlook Hospital?
    A. Invite local police and emergency medical services to attend disaster drills.
    B. Only ED managers or directors should represent the hospital.
    C. Invite outside agencies to attend drills only after you have resolved existing glitches.
    D. Educate staff during disaster drills.

22. Which is true regarding routinely ordering coagulation studies for all patients with acute coronary syndromes, according to Charlene Babcock Irvin, MD, FACEP, assistant vice chief for the department of emergency medicine at St. John Hospital and Medical Center?
    A. Routine coagulation studies are not needed for all acute coronary syndrome patients.
    B. Routine coagulation studies should be done for all acute coronary patients.
    C. Avoid performing coagulation studies for patients taking coumadin prior to heparin being administered.

COMING IN FUTURE MONTHS

■ Should you let camera crews in your ED?

■ How to create a bed control office

■ Tips on reaching the 99th percentile in patient satisfaction

■ When a patient asks about financial liability for treatment

■ Save an average of $161 per influenza patient

D. It is not possible to identify patients who need coagulation studies with history and physical examination alone.

23. Which of the following interventions is recommended to reduce medication errors, according to Lt. Cmdr. Christopher Schmidt, RN-CS, MSN, CEN, emergency/trauma nursing specialty leader for Nurse Corps, United States Navy?
    A. Avoid using automated medication dispensing units.
    B. Increase the number of multiple dose formulations stored.
    C. Use prepackaged medications for vasoactive drugs.
    D. Ensure that all dosages are prepared in the ED instead of the pharmacy.

24. To comply with the Emergency Medical Treatment and Labor Act, which of the following is true for a patient with altered mental status who is being transferred, according to Robert A. Bitterman, MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center?
    A. A medical screening examination is required to determine if an emergency medical condition exists.
    B. No medical screening examination is needed.
    C. Law enforcement must be involved.
    D. A physician must accept the patient in transfer.

Answer Key: 19. C; 20. B; 21. A; 22. A; 23. C; 24.A

CE/CME objectives

- Discuss and apply new information about various approaches to ED management (See "*New screening guidelines cut hours off delays*" and "*Include your community in disaster planning"* in this issue.)
- Explain developments in the regulatory arena and how they apply to the ED setting (See "*EMTALA Q&A*.")
- Share acquired knowledge of these developments and advances with employees. (See "*Save up to $700,000 by making this change*.")
- Implement managerial procedures suggested by your peers in the publication (See "*Are you losing nurses due to violence in your ED? You should take action now!"* and *"Report: EDs are at high risk for dosage errors.")* ■

Northwest Community Hospital 'Mr. Strong' Procedure

Purpose
To maintain safety and security for all individuals in the hospital environment, in the least restrictive and safest way during an episode of escalation.

Policy
It is the policy of Northwest Community Healthcare to effectively assess the potential need for de-escalation and/or physical control and implement only strategies approved by Northwest Community Healthcare.

I. Definitions:

A. Silent Mr. Strong is called when the potential need exists for implementation of restraint procedures. The Hospital overhead page is not used for a silent Mr. Strong. To initiate a silent Mr. Strong, Security is notified by paging #4141. Give location and brief description of circumstance.

B. An overhead page Mr. Strong is called when need for assistance with restraint procedures is imminent. To initiate an overhead Mr. Strong, dial 3333, notify operator of Mr. Strong, and give location.

II. Roles and Responsibilities:

A. Person de-escalating the individual:

1. This staff member shall remain with the individual with appropriate distance, i.e., do not block doorway to allow easy exit as well as communication with other staff. Other staff should be aware and available should a Mr. Strong be needed.
2. It is vitally important that only one staff member verbally interact with the individual.
3. If a Mr. Strong is necessary, a second staff member will initiate the procedure, at the discretion of the staff member interacting with the individual.

B. Respondents:

1. Specific staff members, trained in Crisis Prevention Intervention techniques, have been designated to respond to the overhead Mr. Strong.
2. The following people may respond:
   a. Security
   b. Administrative Consultant
   c. Mental Health staff (if available)
   d. Engineering
   e. Maintenance
   f. Emergency Department staff (if available)
   g. Other trained personnel

C. Team Leader:

1. Upon arrival, designated trained staff from either Security, Mental Health, or Nursing Administration will assume the role of Team Leader.
2. Assess the situation, based on reports from hospital staff in the location.
3. If the situation requires more assistance than initially arrives, then the overhead page should be repeated, and department heads should designate extra help.
4. Determine the need and send for the appropriate restraints.
5. Direct and assign staff members to clear area of others in the milieu, as well as potentially harmful objects.
6. Remind staff that only one person is to communicate with the individual.
7. Assign staff (two if available) to apply restraints to appropriate bed or gurney in the area.
8. Direct incoming personnel as indicated.
9. Designate one staff member to each limb for the "takedown" procedure.
10. Give direction for "takedown."
11. Give direction for transport to appropriate restraint site if necessary.
12. Follow direction for "Application of Restraint" per hospital policy.

Source: Northwest Community Hospital, Arlington Heights, IL.

Initial Management of Potential Suicidal/Homicidal or Potentially Violent Patients

Purpose: To establish staff guidelines for the management of patients in need of a psychiatric assessment that will help ensure the safety of patients and staff in the Emergency Department.

1. **Triage of patients with psychiatric complaints will be done expeditiously.**

   Patients with suicidal or homicidal thoughts; those involved in violent altercations before coming to the ED, those who verbalize threats, or those who are psychotic will be classed as TRIAGE CAT I and placed immediately and have a sitter assigned. At no time during the handoff between triage staff or ambulance staff to primary staff will the patient be left alone. At least two staff members, preferably one a security guard and one ED staff member, will disrobe patient. (All Peds patients who meet these criteria will be assigned to the Main Room.)

   Patient with psychiatric complaints and who are not suicidal or homicidal may be classified as TRIAGE CAT II but need frequent re-evaluation every 60 minutes and should remain in sight line of staff. (Pediatric patients who meet these criteria will be evaluated for safety in Pediatric ED and, if necessary, transferred to the Main Room through the coordinator.) Preferred placement of these patients is in room 10 or 11 in the Main Room.

2. **All patients presenting for a psychiatric assessment will be totally undressed upon room placement, and clothes and personal belongings will be secured in department lockers.**

   Any psych patient or those with alcohol or substance abuse, those brought involuntarily by family or police, or those expressing suicidal ideation or homicidal thoughts will have security present to assist with disrobing and placing patient in a gown.

   All patients' belongings will be searched by security for weapons. All medications will be secured and removed. If patient is admitted and meds are unable to be sent home, forward to pharmacy at the time of admission.

3. **Preferred location for those needing a patient safety evaluation is Room 10 and 11 in the Main Room. If those rooms are unavailable, the coordinator will assign another appropriate room with immediate "sitter" observation. Procedures for disrobing and evaluation will occur quickly. This assessment and evaluation is not dependent on room assignment.**

   All belongings will be bagged, labeled, and removed to department lockers where patient/family is not allowed easy access. Never give clothes to family prior to completing evaluation. Security staff will secure any weapons found. Patient's belongings will be transferred with them upon admission or returned upon discharge. CONSIDER SECLUSION for those patients who were involved in significant violent events prior to coming to the ED or who exhibit threatening behavior or language.

4. **An assessment for safety and cooperation needs to occur within the first 15-30 minutes the patient is in the room. It is preferred that psych liaison staff participate in this assessment with the RN or MD. If they are not immediately available for this assessment, they will evaluate the patient and communicate with the primary RN within 45-60 minutes.**

   - Is the patient directable?
   - Does the patient appear agitated or irritable?
   - Is the patient's physical stance threatening?
   - Is behavioral decontrol evident?
   - Is the patient making threatening remarks?
   - Was the patient acting erratically before coming to the Emergency Department?
   - Is the patient an elopement risk?

5. **Medical evaluation of the patient needs to occur within the first 30-45 minutes the patient is in the department.**

   - Complete vital signs.
   - Complete medical and psych history.
   - Lab evaluation according to the following protocol: Upon arrival of patients needing a mental health evaluation in the Emergency Department, the following panel of tests will be done:
     — complete blood count;
     — comprehensive metabolic panel;
     — urine drug screen;
     — point-of-care pregnancy tests on all childbearing age woman.

   The Emergency Department physician or mental health liaison staff may request the following tests upon further evaluation:
   — electrocardiogram if patient is currently using cocaine or history of heart disease;
   — blood alcohol level if patient is under the influence of alcohol;
   — computed tomography scan of the head in patients with altered mental status, in all age groups, or new onset psychotic/agitated behavior in older adults;
   — acetaminophen/salicylate levels if suspicion of overdose;
   — medication levels such as Depakote, Tegretol, lithium, etc.;
   — urinalysis in elderly or if patient is symptomatic.
   — neuro exam;
   — pain assessment;
   — physical exam;
   — determination of capacity, which may be done only by a physician.

6. **A psychological assessment will be conducted ASAP by the psych liaison staff to determine continued safety and disposition. Need for a sitter or restraints may change based on this assessment. Goal is to have assessment under way within 45-60 minutes of patient's arrival in ED.**

   Assessment will include but not be limited to:
   - appearance;
   - level of consciousness;
   - emotional state;
   - speech;
   - memory (recent/remote);
   - orientation;
   - reality testing;
   - judgment and insight.

7. **Based on the evaluation, and consultation with the Emergency Department physician, patient may require sitter, seclusion, and/or medication or physical restraints to maintain patient and staff safety. Seclusion and restraints will be carried out in keeping with the hospital administrative policy on restraints.**

8. **Any patient deemed to be at risk for violence, elopement, or suicide requires continuous observation while in the Emergency Department.**

   - Only staff trained in observation will be assigned this role.
   - Observation assistants (OAs) sent from nursing service.
     1. ED transporters with OA class;
     2. ED techs with Crisis Prevention Institute training (CPI);
     3. NO FAMILY MEMBERS may be used as sitters.

9. **Continuous observation responsibilities are as follows (continuous observation may be done in person or via video/auditory monitoring):**

   - ultimately responsible for patient and observer;
   - RN responsible for introducing observer to patient; informing observer of patients plan of care and rationale for 1:1;
   - assess the need for intervention and checks in with observer each hour;
   - checks that the observer has adequate meals and breaks;
   - documents according to administrative policy.

10. **Key role and responsibilities for observers/sitters:**

    - Their ONLY responsibility is observation of the patient and documentation of assessments, in person or via monitors. **(They cannot read a book or newspaper, speak on the telephone, etc. The patients in the ED still are being diagnosed and are not deemed stabilized.)**
    - Sitters need to identify and maintain open communication with respective primary RN.
    - They immediately notify ED staff for assistance, by voice or use of alarm.
    - They are not expected to intervene physically in a crisis situation unless CPI-trained.
    - They can observe both monitor screens simultaneously.
    - They can directly observe up to two patients requiring safety precautions.
    - They cannot leave the patient or monitored area without replacement.
    - They know the patient's plan of care.
    - They know how to obtain help.
    - They inform RN of behavior changes.
    - They notify RN before moving patient from the room.
    - They identify alternate contact, i.e., coordinator.
    - Observers are responsible for documentation every 15 minutes, according to policy.

11. **Staff safety needs to be maintained**.

    NO staff entering seclusion rooms should have objects that could be used to hurt them, i.e., scissors, hemostats, etc. Staff need to secure stethoscopes, pens. etc., and take as little as possible into the room. When the patient has exhibited violence toward the staff, security or police also should be present when staff members enter the room.

Reportable Cases

Northwest Community Hospital has zero tolerance for abuse, or threats of abuse, against any employee. All abuse or threats of abuse need to be documented in patient's record and via occurrence reports.

If patients injure employees, they have the right to notify the police and press charges. Employees need to complete form for work-related injury.

If a patient injures another patient, Security and Risk Management will follow up as necessary with authorities.

Source: Northwest Community Hospital, Arlington Heights, IL.

ED Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Fill in the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- ☐ A. chair
- ☐ B. director of emergency services
- ☐ C. director of nursing services
- ☐ D. medical director
- ☐ E. nurse manager

2. Please indicate your highest degree.

- ☐ A. BA
- ☐ B. BS
- ☐ C. BSN
- ☐ D. MA
- ☐ E. MBA
- ☐ F. MD
- ☐ G. MS
- ☐ H. MSN
- ☐ I. PhD
- ☐ J. RN

3. How long have you worked in your present field?

- ☐ A. less than 1 year
- ☐ B. 1-3 years
- ☐ C. 4-6 years
- ☐ D. 7-9 years
- ☐ E. 10-12 years
- ☐ F. 13-15 years
- ☐ G. 16-18 years
- ☐ H. 19-21 years
- ☐ I. 22-24 years
- ☐ J. 25 or more years

4. How long have you worked in health care?

- ☐ A. less than 1 year
- ☐ B. 1-3 years
- ☐ C. 4-6 years
- ☐ D. 7-9 years
- ☐ E. 10-12 years
- ☐ F. 13-15 years
- ☐ G. 16-18 years
- ☐ H. 19-21 years
- ☐ I. 22-24 years
- ☐ J. 25 or more years

5. What is your age?

- ☐ A. 20-25
- ☐ B. 26-30
- ☐ C. 31-35
- ☐ D. 36-40
- ☐ E. 41-45
- ☐ F. 46-50
- ☐ G. 51-55
- ☐ H. 56-60
- ☐ I. 61-65
- ☐ J. 66 or older

6. On average, how many hours a week do you work?

- ☐ A. less than 20
- ☐ B. 20-30
- ☐ C. 31-40
- ☐ D. 41-45
- ☐ E. 46-50
- ☐ F. 51-55
- ☐ G. 56-60
- ☐ H. 61-65
- ☐ I. more than 65

7. What is your sex?

- ☐ A. male
- ☐ B. female

8. What is your annual gross income from your primary health care position?

- ☐ A. Less than $30,000
- ☐ B. $30,000 to $39,999
- ☐ C. $40,000 to $49,999
- ☐ D. $50,000 to $59,999
- ☐ E. $60,000 to $69,999
- ☐ F. $70,000 to $79,999
- ☐ G. $80,000 to $89,999
- ☐ H. $90,000 to $99,999
- ☐ I. $100,000 to $129,999
- ☐ J. $130,000 or more

9. In the last year, how has your salary changed?

- ☐ A. salary decreased
- ☐ B. no change
- ☐ C. 1% to 3% increase
- ☐ D. 4% to 6% increase
- ☐ F. 7% to 10% increase
- ☐ G. 11% to 15% increase
- ☐ H. 16% to 20% increase
- ☐ I. 21% increase or more

10. In the past year, how has the number of employees in your department changed?

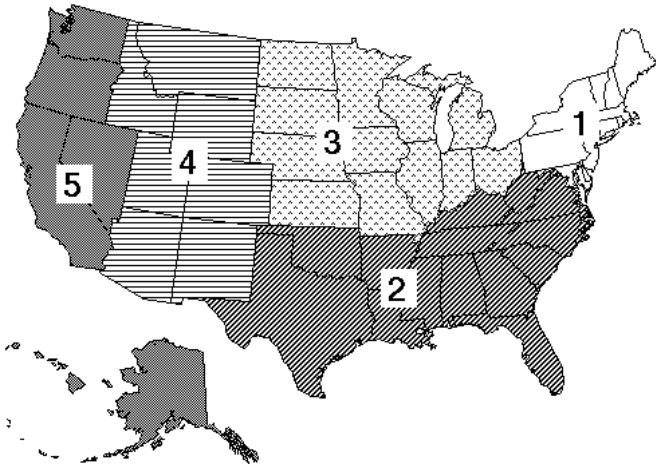
- ☐ A. increased
- ☐ B. decreased
- ☐ C. no change

11. Which of the following best describes the location of your work?

- ☐ A. urban
- ☐ B. suburban (outside large urban area)
- ☐ C. medium-sized community
- ☐ D. rural

12. Using the map (right), please indicate where your employer is located.

- ☐ A. region 1
- ☐ B. region 2
- ☐ C. region 3
- ☐ D. region 4
- ☐ E. region 5
- ☐ F. Canada
- ☐ G. other_____



13. Which best describes the ownership or control of your employer?

- ☐ A. college or university
- ☐ B. federal government
- ☐ C. state, county, or city government
- ☐ D. nonprofit
- ☐ E. for profit

14. Which of the following best categorizes the work environment of your employer?

- ☐ A. academic
- ☐ B. agency health department
- ☐ C. city or county
- ☐ D. clinic
- ☐ E. college health service
- ☐ F. consulting
- ☐ G. hospital
- ☐ H. private practice

15. If you work in a hospital, what is its size?

- ☐ A. <100 beds
- ☐ B. 100 to 200 beds
- ☐ C. 201 to 300 beds
- ☐ D. 301 to 400 beds
- ☐ E. 401 to 500 beds
- ☐ F. 501 to 600 beds
- ☐ G. 601 to 800 beds
- ☐ H. 801 to 1,000 beds
- ☐ I. >1,000 beds
- ☐ J. I don't work in a hospital

Deadline for responses: August 15, 2003

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, Thomson American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.