ED Management
The monthly update on Emergency Department Management

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Camera crews carry serious risks — stringent precautions are necessary

'This is a very controversial topic, a real political hot potato'

[Editor's note: In this first part of a two-part series, ED Management *shows how important it is to exercise tight control over camera crews and what can go wrong if you don't. Next month, we'll explore how the Health Insurance Portability and Accountability Act (HIPAA) may complicate the issue and why a local news crew might be the riskiest of all.]*

How's this for a nightmare? You turn on the evening news one night and see your emergency department portrayed as a chaotic mess, with drunk patients urinating; screaming, ill-tempered staff ordering people around; and patients clearly identified on camera even though the news crew promised they wouldn't be.

Then you go to work the next day and find half a dozen patients threatening to sue for invasion of privacy. Wasn't this camera crew project supposed to be good public relations for your ED?

That nightmare can come true if you allow a camera crew in without extremely tight controls, say those who have been through the experience. Camera crews are becoming an increasingly common sight in EDs as documentary television shows flourish and long-held prohibitions on photography fall; but those who have hosted the media say the experience can be positive and beneficial *only* if you expend a lot of effort to do it right.

It used to be rare that an ED would allow journalists with a camera past the

Executive Summary

EDs increasingly allow camera crews to videotape patients and staff for commercial productions, but even those who have had positive experiences caution that such projects are tricky. They require tight controls and oversight.

- Closely control the camera crew's movement and activities.
- Retain complete control over what may be videotaped and aired.
- Ensure that patient confidentiality is a top priority.

waiting area, if they were allowed that far. But some experienced ED managers now say you should consider allowing them to videotape every nook and cranny of your ED because it can help educate the public about what really goes on in your workplace and the demands placed on staff. The experience even can be helpful to the patients who are photographed, says **Kathleen J. Clem**, MD, FACEP, chief of emergency medicine at Duke University Medical Center in Durham, NC. To her surprise, some patients told her that sharing their traumatic experiences with a viewing audience was therapeutic and helped them focus beyond their immediate pain and grief.

Duke recently hosted a camera crew from The Discovery Channel, in Silver Spring, MD, which videotaped Clem and the rest of the ED for about six months. The footage aired as part of the series *ER Stories* and still is repeated occasionally.

Though Clem says the experience was positive overall, she says ED managers would be justified in expressing some skepticism at the initial request to allow a camera crew in. And the request is likely to come sooner or later, Clem says.

"This is a very controversial topic, a real political hot potato," she says. "It raises a lot of questions about confidentiality and patient rights; but I think under the right circumstances, with the right preparation and the right standing rules, it can be a positive thing for the public and for the patients."

The Joint Commission on Accreditation of Healthcare Organizations first addressed the issue in July 2000 and then issued two standards clarifications that say filming or videotaping is acceptable under some circumstances. Patient consent must be obtained, and the hospital must retain control over what footage is aired, according to the Joint Commission. The American College of Emergency Physicians (ACEP) recently issued similar guidelines. **(For information on how to obtain copies of both sets of guidelines, see source box, p. 88.)**

Strict limits are a must

Rules and limitations are the key. That message is stressed by Clem and others who have allowed cameras in their EDs, such as **Jim Scheulen**, PA, administrator for the emergency medicine department at Johns Hopkins Hospital in Baltimore, which allowed unprecedented access to camera crews for ABC Television in 2000. The footage from the Hopkins ED and other areas of the hospital was used to create the series *Hopkins 24/7*, which aired that year.

Scheulen had some misgivings about the idea when the public affairs office first suggested allowing a camera crew in his ED, but extensive preparations resulted in "one of the smoothest, positive experiences you could imagine. Not at all what we expected."

A top concern is protecting the patient's right to consent for such videotaping. You must devise a system that ensures that the patients' rights trump any desire by the camera crew for good footage, Clem says. At Duke, the rule was that the patient had to give permission for the film crew to come in to the treatment area and videotape, with the only exception being for ambulances bringing

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in patients. In those cases, the crews were allowed to videotape and then ask for consent later.

"The controversy arises from the fact that you're filming before getting permission, even though the family has to give permission before it's aired," Clem says. "But in my six months of having a camera crew follow me around all the time, that was not an issue for any patient. It's a theoretical concern, but I've not actually seen that it's a real concern for patients. In fact, the people who were unhappy were the ones we didn't film. We got complaints saying they wanted to be on TV, too."

Clem and Scheulen say they were happy with what aired on television after the taping was complete, but they note that their written agreement with the camera crews allowed them to veto any scenes, so there were no surprises. The *Hopkins 24/7* show included a segment in which ED staff were shown after their shift ended, laughing at how a patient had urinated on a nurse's leg. Some critics claimed that the scene portrayed Hopkins in a bad light, but Scheulen says the scene showed the reality of working in an ED and was not disrespectful to the patient.

At Duke, Clem says the camera crews were allowed to film only after they agreed in writing to turn over all final control to the hospital. Any staff member had the power to veto the camera crew in any situation.

"If I, or a nurse, or anybody on staff said, 'This isn't appropriate to show the whole family crying because grandpa died,' they had to stop. No argument," Clem says. "Anybody could walk over and say, 'Turn the camera off.' The crew never argued about it because that was one of the ground rules."

Duke also had final veto rights over anything

Learn how to keep control of camera crews in your ED

ED managers experienced with camera crews offer this advice on how to tightly control the project:

- **Emphasize the need for minimal physical intrusion.**

This is a special concern in the ED, as opposed to other areas of the hospital, says **Kathleen J. Clem**, MD, FACEP, chief of emergency medicine at Duke University Medical Center in Durham, NC.

Train the camera crews — usually just one or two people — on how the ED works, and provide extremely specific instructions on what they can and can't do.

For example, you should show them where they are allowed to stand during a trauma, emphasize that that is *only* place they can stand, and strictly enforce that rule. The camera operator must not move around to get better shots.

- **Allow patients a period of time to rescind their consent.**

To ensure that patients truly consent to having their images used, Duke allowed patients six weeks to change their mind after signing the consent form in the ED. This policy addressed concerns that patients or family members might be too stressed to give informed consent during an emergency.

- **Make sure your staff are comfortable being videotaped.**

Your staff's privacy rights must be considered along with the patients' rights. At Duke, some staff did not want to be part of the project. At the beginning of every shift in the ED, the camera crew was informed who did not want to be videotaped, and it was the camera crew's responsibility to work around them.

- **Rely heavily on your hospital's news or public affairs office.**

The camera crew always should be escorted by a representative from your hospital who handles the media. That person should be responsible for ensuring that the camera crew follows all the ground rules, obtains consent, and doesn't interfere with patient care, Clem says. Do not expect your staff to baby-sit the camera crew; they don't have the time. Smaller hospitals may have more difficulty with such projects because the public affairs office might consist of one person, who can't be expected to work with the camera crew at all times, Clem cautions. In those situations, another hospital administrator may suffice.

- **Forbid the use of camera lights.**

The camera crew should make do with available lighting instead of using special lighting on the camera. Those lights are far too intrusive and can interfere with patient care, Clem says.

- **Demand that the ground rules be followed absolutely and without argument.**

If the camera crew balks or argues with you, inform the public affairs representative and consider ending the project. Do not let the camera crew become a nuisance by not following the rules it agreed to.

- **Make sure the camera crew is properly identified.**

When a camera crew visited the ED recently at Moses Taylor Hospital in Scranton, PA, emergency physician **Richard O'Brien**, MD, FACEP, made sure the five crew members wore identification issued by the hospital. He also had the hospital's chief of security escort the crew at all times, partly to reassure hospital staff.

"We wanted everyone to know they were formally invited to the campus, not like some news magazine [staff] snuck in and [were] creeping around on their own," he says. ■

Sources/Resources

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The Joint Commission on Accreditation of Healthcare Organization's standards clarification is available at: www.jcaho.org. Select the search option and enter "videotape."

Guidelines from the American College of Emergency Physicians (ACEP) can be found at http://www.acep.org/1,32402,0.html.

For a comprehensive review of the issue, see: Geiderman JM, Larkin GL. Commercial filming of patient care activities in hospitals. *JAMA* 2002; 288:373-379.

shown. The producers showed the raw footage to hospital representatives before it was shown to The Discovery Channel, and then they showed Duke the final edited version before it was aired. The hospital didn't demand any changes because the crew already had edited out anything that might be objectionable.

Clem acknowledges that there are many who criticize the intrusion of cameras in the ED, but she says the experience was worthwhile because it helps educate the public about "real emergency medicine, not just what's portrayed on *ER*. They get to see our struggles every day." The taping actually provided a direct benefit one day when a patient complained about poor treatment in the ED, claiming that staff had treated him roughly and used obscenities. The patient already had threatened a lawsuit when the hospital officials asked the camera crew to show the videotape of the encounter.

"It turned out that everyone was nice and gentle, and no one used any foul language at all," Clem says. "We let the patient see the tape, and that was the end of that."

Johns Hopkins had "two or three cases where things got a little testy" between patients and the camera crews, says **Gary Stephenson,** a spokesman in the public affairs office at Johns Hopkins who helped coordinate ABC's videotaping of *Hopkins 24/7*. Families sometimes complained that the camera was intruding on their grief, but the crews always stopped videotaping when anyone complained.

Clem underscores that you must retain control at all times. Though she is generally supportive of efforts to videotape in EDs, she cautions, "It won't be OK unless you can set it up the way we did. Without those controls, there's no way I'd let a film crew in my emergency department." ■

Patient satisfaction depends on staff morale

ED manager who scores high shares tips

If you want to improve your ED's patient satisfaction ratings, don't start by looking at how happy your patients are. Start by looking at satisfaction levels among your staff. That's the advice from an ED manager who can boast of patient satisfaction scores in the 99th percentile nationwide.

The ED at Hackettstown (NJ) Community Hospital has earned high patient satisfaction levels in recent years, which can be directly tied to improvements resulting in better employee morale and customer service, says **Loraine Skeahan**, RN, manager of the ED.

"The lesson may be that if you want to improve patient satisfaction, go deeper than that and address the fundamentals in the emergency department like how well you're staffed and how happy your staff are," Skeahan says.

If you start off by going to patients and asking how to make them happy, you might be wasting your time, she says. "Chances are, they don't really know what could be improved in your department to make their visit better," Skeahan says.

In a recent patient satisfaction survey conducted by The Jackson Organization, a health care research organization based in Columbia, MD, Hackettstown's ED patients gave the hospital an overall satisfaction grade of 4.27 (on a 5 point scale, where 1 is poor and 5 is excellent). This compared to an overall 3.97 grade for competing hospitals serving the area and gave Hackettstown a 99th percentile ranking among hospital EDs nationwide.

Expanded ED helped patient satisfaction

In its research, The Jackson Organization identified several key predictors of Emergency Patient Satisfaction. Hackettstown's ED scored especially well in three areas:

1. Staff Availability to Provide Assistance at all Times.
2. How Well the Hospital Did at Meeting its Mission.

3. Total Amount of Time Spent in the Facility from Arrival to Discharge or Hospital Admission.

The Hackettstown ED also ranked exceptionally well in four other key areas:

1. How Quickly Nurses Responded to Requests.
2. Kindness Shown by the Nurses.
3. Kindness Shown by the Doctor.
4. How Well the Staff Kept the Patient and Family Informed about the Patient's Care and Condition.

Part of the high satisfaction ranking can be related to physical improvements in the ED, Skeahan says. The hospital recently completely rebuilt its emergency area with 13 rooms, more than double the previous six rooms. The number of ED staff were doubled, and the number of secretarial support staff were increased to speed up paperwork and data entry.

"By streamlining waiting times and increasing space and staff, we reduced the average length of stay in the emergency department to less than an hour for those who were treated and released," Skeahan says.

Doubling its size was an absolute need, she says. "The population in Northwest Jersey is growing, and we went from 30 visits a day to 60 or 70 a day," Skeahan says.

The ED staff now make a priority of getting the patient triaged, evaluated, and to a physician as quickly as possible. Physicians now provide double coverage on high-volume days.

Peg Carolan, RN, the hospital's director of nursing and its former ED administrator, says she worked hard to create a better working atmosphere for the ED nurses, which in turn helped them provide better care to patients.

Nearly everyone in the ED, including lab and X-ray technicians, support staff, and nurses, went through a program called Spirit of Caregiving, offered by Lant & Associates in Winter Park, FL, which helped them bond as teammates and learn to work toward a larger goal of improved patient care. That kind of effort paid off over time with better morale, she says. **(For more information on the Spirit of Caregiving program, see source box, p. 90.)**

"Now, when a nurse calls in sick, those who are here either volunteer to take that nurse's place or else find a substitute," she says. "The keys to our success are the ability of our staff to create a warm and caring environment and patient-focused team, as we strive to achieve our mission of reflecting God's love in healing each patient's body, mind, and spirit."

Though the effort worked wonders for Hackettstown, bigger EDs with more challenges may have more trouble creating such a family atmosphere for staff.

That doesn't mean you shouldn't try, says **Marilyn Swinford**, director of emergency services at Saint Joseph Hospital, a 446-bed hospital in Lexington, KY. Her ED recently won the second place award for Overall Emergency Department Satisfaction for Large Hospitals given by The Jackson Organization.

Swinford says her ED's high patient satisfaction ratings came from some of the same morale-building initiatives used in Hackettstown, such as a new "Star of the Month" program to recognize efforts that improve patient satisfaction. But the Kentucky ED's overcrowding meant it also had to implement some specific strategies aimed at getting patients through the ED faster.

First, Swinford organized a focus group with triage and registration that helped trim registration times to an average of fewer than five minutes. Saint Joseph also put much more effort into keeping patients informed about expected wait times.

While EDs focus so much on reducing wait times, they too often overlook the importance of keeping patients informed, she says. Patients will be much more willing to wait, and ultimately express satisfaction with their visits, if they know how long they will wait and that there is a good reason for the delay.

"Customers want to know what to expect so proactive communicating is critical," Swinford says. "We are improving in informing patients reasons for wait times, focusing on keeping them informed of the overall expectation of what is happening related to their ED visit and what to expect."

Point-of-care laboratory testing also has shortened door-to-diagnosis times. Testing processes to provide chemistry and cardiac screening were implemented in January 2003. Swinford says these devices have shortened the average test time from 90 minutes to 20 minutes — a huge change for anxious and impatient patients.

She also credits focused teamwork between the ED and cath lab, along with bedside treatment "AMI boxes" that have critical IV access and medications for cardiac emergencies, for providing smoother patient flow.

Listen to staff and give them what they need

When trying to improve staff morale as a way to improve patient satisfaction, Carolan and Swinford emphasize that you must listen to your frontline employees and remember that improvements don't happen overnight.

"Our success took several years to accomplish," Carolan says.

ED managers should pay particular attention to fully staffing the ED and providing support services to clinicians, Skeahan says. She offers this advice for

Sources/Resource

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The Spirit of Caregiving program is offered by Lant & Associates, 1555 Howell Branch Road, No. C202, Winter Park, FL 33179. Telephone: (407) 740-8098. E-mail: info@spiritofcaregiving.com. Web: www.spiritofcaregiving.com.

improvements that can lead to high patient satisfaction scores:

• **Provide ancillary support staff.**

Nurses and other staff can be frustrated by having to do everything, including tasks that don't require their expertise. The Hackettstown ED operated for years without any ancillary or secretarial support, but Carolan added an ED tech position a few years ago. Now an ED tech works in the ED every night and every other weekend. The tech acts as an extra pair of hands wherever needed to assist with tasks such as performing a phlebotomy, transporting patients, and obtaining vital signs.

"This position works side by side with the nurse, rather than replacing a nurse," Skeahan says. "It's not the same as hiring another nurse, because that nurse would become busy with everything else and couldn't jump in wherever they're needed."

• **Provide secretarial support.**

Hackettstown now has two secretaries in the ED during the day and one in the evening. This removes a great deal of the paperwork burden from the nursing staff, Skeahan says.

• **Take educational opportunities to the ED.**

Staff usually are interested in learning, but ED staff can find it difficult to get out of the department for inservices. If they don't attend, they feel left out. If you don't offer any inservices because you think they're too busy, they may miss the opportunity to learn more about the field. The solution is to take the inservices to the ED, Skeahan says.

"When you have some downtime, go to the unit and start a troubleshooting session or discuss the latest topics like pediatrics in the ED," she says. "They really love it because they want to learn, but you have to be very flexible with inservices in this department." ■

EMTALA Q&A

[Editor's note: This column is part of an ongoing series that addresses reader questions about the Emergency Medical Treatment and Active Labor Act (EMTALA). If you have a question you'd like answered, contact Greg Freeman, Editor, ED Management*, 3185 Bywater Trail, Roswell, GA 30075. Telephone: (770) 998-8455. E-mail: Free6060@bellsouth.net.]*

Question: Is it true that we can violate EMTALA by not encouraging a patient to stay for treatment when he wants to leave? We've been told, for instance, that if a patient asks about financial liability for treatment, we must actively encourage the patient to stay until he can be examined rather than just stating the facts about payment.

Answer: You're right that you can violate EMTALA this way, says **Susan Lapenta,** JD, a partner with Horty Springer, a law firm in Pittsburgh that specializes in health care issues.

This facet of EMTALA is particularly confusing to health care providers, who often are surprised to learn that they violated the law when they merely answered a patient's question honestly and politely, she says.

To fulfill the intent of EMTALA — ensuring that people who need urgent care are not turned away from hospital EDs — the government expects providers to go beyond simply answering a question about possible financial liability. ED staff should actively encourage people to stay for treatment even if they are concerned about the ability to pay, Lapenta says.

"It's not enough to answer a question about payment factually and accurately," she says. "The government is looking for the hospital to reassure patients, to say 'Don't worry about payment. We'll take care of you.'"

The concern is that if you simply provide the facts about payment, a patient will leave the ED because of payment concerns when he or she actually had a medical condition that needed to be treated, Lapenta says. "The government considers [it] your responsibility to prevent" this from happening, she adds.

The issue can trip up ED staff because they often think of EMTALA violations as overt acts in which the staff purposefully turned the patient away. That is a dangerous misconception, Lapenta warns.

ED staff might not understand this point, she says. "I suspect they know in a general sense that they're not supposed to talk about payment, but I'm not sure they

fully understand that the government expects them to actively encourage people to stay for treatment," Lapenta says. "It confuses people when they know they meant no harm and didn't initiate the conversation about payment to try to scare people off."

The government has spelled out what it expects of ED staff in this situation, and the bar is set pretty high. In an advisory bulletin issued in 1999, the Health Care Financing Administration — now the Centers for Medicare & Medicaid Services (CMS) — explained exactly what the ED staff should do in response to a question about financial liability. (Financial inquiries are addressed in item 4 in the bulletin.)

In a nutshell, the government expects your ED staff to gently reassure people that they will be treated as needed without regard to payment, going to great lengths if necessary to avoid answering the question directly.

If the patient is insistent and keeps pushing for a straight answer, the government does allow the ED to respond, but only after a verbal tango in which all attempts to elude the answer are exhausted. The staff member has to work through a series of steps choreographed to reassure the patient and deflect payment inquiries. No matter how reasonable and serious the question sounds at first, you can't just blurt out the facts and let it go at that.

The Bush administration is sending signals that it is more flexible in investigating such slip-ups, she says, whereas the previous administration took more of a hard-line approach.

Of course, an EMTALA investigation is bad news even if you prevail in the end. Thus, Lapenta advises taking the necessary steps to educate your ED staff, especially those involved with patient triage and intake, about this particular risk with EMTALA. Some hospitals script out what employees can say, which she says can be a good idea.

Lapenta suggests a script that goes something like this in response to the first question, with parts repeated as necessary if the patient persists in asking: "You need to be taken care of first. That's our first concern. We can talk about money and what you might have to pay for later, after we make sure that you're safe. We have to do this screening examination first to make sure that you're OK, and then we can talk about payment later. We'll answer all your questions about that soon, but we really need to concentrate right now on making sure you're OK," she adds.

Educating your staff is a key concern with EMTALA because, if a complaint arises, investigators will take a hard look at whether a patient was illegally diverted intentionally or because your staff weren't adequately trained in EMTALA compliance. Either of those conclusions is much worse than your staff simply making a mistake with one patient.

"The government is usually more concerned with whether your staff are trained properly than whether they slipped up this one time," she says. ■

Source/Resource

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To see the entire EMTALA advisory bulletin, go to www.hortyspringer.com/content/EMTALA_SAB_Nov10_1999.htm. Financial inquiries are addressed in item 4.

Consider using electronic charts instead of dictation

Save more than $400,000 in transcription costs

Switching to an all-electronic system in the ED for charting and other functions is only a dream for some cash-strapped facilities, but an Ohio hospital is showing that the high initial cost can be recouped quickly through the money saved on transcription and other services. The hospital is saving more than $400,000 a year in transcription costs alone.

Mount Carmel St. Ann's, a community hospital in Westerville, OH, adopted an electronic system July 10, 2001, for physician and nurse documentation, triage, interfaces, and an ED tracking board.

With more than 65,000 annual patient visits for the 40-bed ED, hospital leaders hoped the updated systems would increase efficiency and improve the quality of patient charts, says **Sonja Howard**, RN, DSN, system administrator for the ED computer information system and clinical educator for the ED.

Hospital leaders anticipated the system eventually would pay for itself though improved efficiency, but Howard says they were surprised at how quickly they recouped the investment.

Mount Carmel St. Ann's uses a comprehensive electronic ED system manufactured by A^4 Health Systems in Cary, NC. Many other manufacturers offer similar

systems promising the same results. A spokeswoman for A[4] tells *ED Management* that the hospital spent about $1 million for the entire system.

That cost is being recouped in about two years almost entirely through the savings in transcription costs, Howard says.

"We were 100% transcription in the past, and we set a goal with the new system that wanted charts to be 80% on the new system and 20% transcription," she says.

"From the beginning, we were at 92% usage of the system, and we've never been below that. It's worked much better than we thought it would."

All of Mount Carmel St. Ann's emergency physicians and about 50 nurses are documenting patient information with the new electronic system. A 92% reduction in dictated charts means the ED no longer has to pay for transcribing about 58,500 charts per year.

At an average cost of $7 per transcription, the ED is saving about $409,500 per year. Two years of those savings almost covered the large start-up costs for the whole system, Howard says.

More savings with less use of paper forms

And those weren't the only savings. Switching to an electronic system helped Mount Carmel St. Ann's eliminate much of the paperwork that is standard in an ED, so there was the added savings of not having to buy the forms.

In the year before adopting the electronic format, Mount Carmel St. Ann's spent $41,200 on forms for the ED. The electronic system cut the need for those forms in half, saving $20,600 each year.

Processing written charts cost an estimated $16,000 per year in staff time, which is eliminated with the new electronic system. That amount went straight to the bottom line. So adding the savings from transcription costs, forms, and processing charts yielded a total savings in the first year of $446,100.

Two years after implementing the system, Mount Carmel St. Ann's had recovered $892,200 of its $1 million investment.

But if you add in other savings for the hospital, the break even point was passed even earlier. Improved charting and documentation led to an increase in gross charge capture per day of about $10,000, yielding a gross increase per year of $360,000.

With a contractual allowance of 50% and a collection rate of 60%, the facility improved charge capture by $1,080,000 in the first year. Better documentation also helped physicians increase their net collections per patient by an average of $20, yielding $1.2 million more reimbursement for ED physicians in the first year.

Howard says the switch to an electronic system was so successful partly because Mount Carmel St. Ann's adopted the entire system at once instead of phasing in the different parts.

After a 10-month installation and training process, more than 140 clinical and nonclinical users in the ED started using the entire electronic system one morning. One day the ED functioned on paper, and the next it was entirely electronic.

"That was painful, but it's the way you need to go to be successful," Howard says. People often want to phase in different portions to make it easier, but you get "stuck" when you do that, she says.

"No matter what you do, there will be difficulties, and that implementation over time gives naysayers the chance to say, 'I don't want to do this. It's not working,'" she says.

Howard also attributes much of the success to the time spent customizing the different screens used for information input. Some physicians were reluctant to adopt the system at first and cited justifiable concerns that the input screens might restrict the type of data they could put on patient charts and water down the quality of the information.

The biggest hurdle was the history of present illness (HPI). Physicians were concerned that telling the patient's story can be difficult on a screen where you select from a list of options, Howard says.

"But we worked with that concern and built lists that would meet the needs for the top chief complaints like chest pain and abdominal pain," she says.

They customized those enough that the doctors became comfortable using the lists" Howard says.

"If you look at dictated notes, they pretty much say the same thing over and over again," she says. "They may say it a little differently each time, but they follow a pattern, and you can build that pattern into the system."

Supportive physician can smooth transition

Enlist a physician to champion the adoption of such an electronic system, Howard advises. It is normal for physicians to be skeptical of a system in which they won't dictate notes in the style they're used to, she says. A physician champion can be the one who takes the heat from colleagues who aren't as enthusiastic and helps bring them around.

Nurses use the electronic system for triage, and then a physician reviews that information and can agree or amend it. Then the physician uses another screen to enter the HPI, with the system prompting the physician with

Sources

For more information, contact:

- **Sonja Howard**, RN, DSN, Emergency Department, Mount Carmel St. Ann's Hospital, 500 S. Cleveland Ave., Westerville, OH 43081-8726. Telephone: (614) 898-4000.
- **A⁴ Health Systems**, 5501 Dillard Drive, Cary, NC 27511. Telephone: (888) 672-3282. Web: www.a4healthsystems.com.

common questions about the patient's chief complaint.

The next step for the physician is to go to the review of systems, which can be minimal or extensive depending on the severity of the patient's condition. The system also includes screens for documenting the physician's examination of the patient.

They go through each one of those to build their documentation. "In the old world, they would have dictated all of that," Howard says.

They still have the option of dictating if they think they can't tell the story adequately with the system. "Physicians will still dictate notes for some psychiatric cases and others where they can't get everything they want in the system," she adds. ■

AMA to offer standardized bioterror training for EDs

Courses offered at 4 medical centers nationwide

The American Medical Association (AMA) in Chicago is working with four prominent medical centers to provide training courses that will help prepare ED personnel for bioterrorism and other mass-casualty events.

One goal of the courses is to standardize emergency response nationwide, says **James James,** MD, DrPH, MHA, director of the new AMA Center for Disaster Preparedness and Emergency Response.

There is a wealth of information available to EDs, but there is little consistency, he says.

The initial curriculum includes courses on natural and man-made disasters, traumatic and explosive events, nuclear and radiological weapon attacks, biological events, chemical events, medical decontamination, mitigating stress on health care workers, legal issues of disaster response, health care facility and disaster planning, and mass-fatality incidents, James explains.

The courses will help the country's emergency departments develop a more uniform response to the threat of terrorist acts, he points out.

"These courses cut across all specialties; nobody owns them," James says. "We're trying to educate physicians and other professionals about the basics they need to better respond to the health and safety of their communities."

Although the terrorist attacks of Sept. 11, 2001, increased the demand for a nationally recognized course in all-hazards training, several academic medical centers already were developing disaster education programs to meet a perceived lack of medical disaster preparedness.

Following the 2001 attacks, a National Disaster Life Support Education Consortium (NDLSEC), comprising national and international experts in disaster management, was formed under a federal grant managed by the Centers for Disease Control and Prevention.

All four institutions offering the courses — the Medical College of Georgia in Augusta, the University of Georgia in Athens, the University of Texas Southwestern Medical Center at Dallas, and the University of Texas at Houston School of Public Health — are members of NDLSEC.

The benefits of the course will go beyond terrorist acts, says **Paul Pepe**, MD, professor and chair of emergency medicine at the University of Texas Southwestern Medical Center in Dallas. "People have been focusing on terrorism and nuclear threats, or smallpox," he says.

"But things like explosions or hurricanes can be a major threat, and we need a common way to approach these mass-casualty events as well," Pepe adds. ■

Sources

Dates and locations for specific courses are being finalized. For the latest information on available courses, contact:

- **Lise Stevens**, Public Information Officer, American Medical Association, Chicago. Telephone: (312) 464-5926.

For more information on disaster preparedness, contact:

- **James James**, Director of the AMA Center for Disaster Preparedness and Emergency Response, American Medical Association, 515 N. State St., Chicago, IL 60610. Telephone: (312) 464-5000.
- **Paul Pepe**, MD, Chair of Emergency Medicine, The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd., Dallas, TX 75390. Telephone: (214) 648-3111.

CDC reports sharp increase in ED visits

Numbers blamed partly on boarding of patients

New data from the federal Centers for Disease Control and Prevention (CDC) show that the number of ED visits increased by 20% over a 10-year period, from 89.8 million in 1992 to 107.5 million in 2001. Much of the increase can be attributed to the practice of boarding patients in the ED, according to another federal report.

The CDC notes that, over the past decade, the number of EDs decreased by 15%, contributing to increased patient volumes and waiting times at the remaining facilities. Patients spent an average of three hours in the ED, from arrival to discharge, but more than half spent two to six hours. More than 400,000 visits lasted 24 hours or longer. **(For information on how to obtain the CDC report, see resource box, at right.)**

Much of the pressure on EDs is caused by the practice of boarding patients, in which patients are kept in the ED because no inpatient bed is available, according to a recently report by the General Accounting Office (GAO) in Washington, DC. **(For information on how to obtain the GAO report, see resource box, above right.)**

That report found that ED overcrowding is most severe in areas with large populations, with nearly one in 10 hospitals diverting ambulances to other hospitals more than 20% of the time. The GAO report confirms what many ED managers have long argued with hospital administrators, says **George Moltzen**, MD, president of the American College of Emergency Physicians (ACEP).

"It clearly shows that failure to move patients from the emergency department into hospital inpatient beds plays a major role in crowding," he says. "This practice results in patients being boarded in emergency departments who require equipment and staff time, which further shrinks emergency department resources to treat severely injured and sick patients. It also limits a hospital's ability to meet periodic surges in demand, such as those from disasters."

The GAO report indicates that hospitals in areas with populations of 2.5 million or more reported higher levels of all three crowding indicators identified by the government auditors: ambulance diversion, the percentage of patients boarded in the ED for two hours or more, and the proportion of patients who leave without medical evaluations.

Two-thirds of all EDs diverted ambulances to other hospitals at some point in 2001, and one-third of hospitals reported that three-fourths or more of their patients were boarded for at least two hours in the past year.

Boarding of patients also is cited as a primary reason for ED crowding by **Mel Wilson**, RN, MS, FNP, CEN, president-elect of the Des Plaines, IL-based Emergency Nurses Association (ENA) and nurse trauma coordinator for New Hanover Regional Medical Center in Wilmington, NC. The latest statistics indicate a growing problem for EDs, she says.

"When emergency departments become overcrowded, the risk of medical errors increases," Wilson says.

"It reduces the time available to care for critically ill patients and forces hospitals to go on diversion, putting other patients at risk of not receiving emergency care when they need it most," she adds. ■

Sources/Resources

For more information, contact:

- **American College of Emergency Physicians**, 1125 Executive Circle, Irving, TX 75038-2522. Telephone: (800) 798-1822.
- **Mel Wilson**, Nurse Trauma Coordinator, Emergency Department, New Hanover Regional Medical Center, 2131 S. 17th St., Wilmington, NC 28401. Telephone: (910) 343-7000.

The Centers for Disease Control and Prevention report is available at www.cdc.gov/nchs/. Click on "National Hospital Ambulatory Medical Care Survey: 2001 Emergency Department Summary."

The General Accounting Office report, *Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities*, is available at www.gao.gov. Select "more search options," then "GAO Reports," and then enter report number GAO-03-460.

ENA offers ideas about overcrowding to JCAHO

The Joint Commission on Accreditation of Healthcare Organizations recently announced its intention to create a new standard addressing ED crowding for the *2004 Hospital Accreditation Manual*, and the Emergency Nurses Association (ENA) in Des Plaines, IL, responded immediately with suggestions for how the accrediting body might address the problem.

Writing for the ENA, president **Kathy Robinson**,

RN, says the group is concerned that the proposed standards "are not substantive enough and fall short of imposing meaningful requirements on hospitals t o address the critical issue of emergency department overcrowding." The standard fails to address some key causes of overcrowding, Robinson says.

The ENA urges the Joint Commission to address other factors such as the increasing age and medical complexity of the patient population, hospital capacity and patient flow patterns, surge capacity for unexpected influx of acute patients, and what Robinson calls "the inherent conflict between the ability of inpatient units to close beds to patients and the emergency departments' federal mandate to screen and stabilize patients regardless of capacity."

The ENA also urged the Joint Commission to remove from the proposed standard a passage that addresses holding patients for observation in the ED, saying it seems to condone the practice of boarding patients in the ED. Instead, ENA recommends developing direct admission policies that divert incoming patients from other facilities to an inpatient bed, rather than to the ED to await availability. ■

Source

For more information, contact:

- **Emergency Nurses Association**, 915 Lee St., Des Plaines, IL 60016-6569. Telephone: (800) 900-9659.

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 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*

25. When Duke University Medical Center allowed a camera crew in the ED, how much control did the hospital have over the final footage aired on TV?
    A. No control once the footage was taped
    B. The hospital asked that some scenes not be shown but did not see any footage before it aired.
    C. The hospital was able to review raw footage but could not veto anything once the final version was prepared.
    D. The hospital had complete veto power over any footage during any stage of the project, including the final version.

26. Which of the following statements accurately reflects one of the ground rules for the camera crew at Duke University Medical Center?
    A. Camera lights could be used at the photographer's discretion.
    B. Camera lights were forbidden.
    C. Camera lights could be used in the ED unless a nurse or physician complained.
    D. Camera lights could be used in all ED areas except treatment rooms.

27. When Saint Joseph Hospital in Lexington, KY, organized a focus group with Triage and Registration to help reduce registration times, what was the average registration times reduced to?
    A. fewer than 5 minutes
    B. fewer than 10 minutes
    C. fewer than 12 minutes
    D. fewer than 17 minutes

28. Saint Joseph Hospital in Lexington, KY, implemented point-of-care laboratory testing to shorten door-to-diagnosis times. How much has this system shortened average test times?
    A. from 120 minutes to 90 minutes
    B. from 90 minutes to 20 minutes
    C. from 60 minutes to 40 minutes
    D. from 30 minutes to 10 minutes

29. According to Susan Lapenta, JD, a partner with Horty Springer, which of the following statements is true regarding EMTALA?

COMING IN FUTURE MONTHS

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■ Make over your ED: Affordable options with big impact

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■ $500 monitoring system shows if beds are available

A. ED staff are not obligated to reassure patients that they will be treated as necessary, without regard to payment concerns.
B. ED staff must answer factually in response to questions about payment, but they are not required to say anything else.
C. ED staff may ask a patient about the ability to pay before the patient is evaluated medically.
D. ED staff should deflect questions regarding payment as much as possible until the patient is evaluated and treated as necessary, reassuring the patient that care will be provided without regard to the ability to pay.

30. If an EMTALA violation is alleged, what does Lapenta say will be the primary concern for investigators?
A. Your documentation of the incident
B. Whether your staff were trained adequately in EMTALA
C. Whether your staff technically violated the law in this particular incident
D. Any history of such allegations

Answer Key: 25. D; 26. B; 27. A; 28. B; 29. D; 30. B

CE/CME objectives

For more information about 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 *"Camera crews carry serious risks — stringent precautions are necessary"* 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 *"Patient satisfaction depends on staff morale."*)
- Implement managerial procedures suggested by your peers in the publication (See *"Consider using electronic charts instead of dictation."*) ■

ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

Environment of care: Joint Commission wants to know how well your emergency department protects itself

Security and safety of patients and staff considered 'hot button' topic among standards for EDs

A hospital invests hundreds of thousands of dollars to install a state-of-the-art security system, but administrators resist conducting drills to educate employees on how to respond, because they're afraid of sending a message to the community that the hospital is not secure.

A nurse in a busy emergency department (ED) is entering information in a patient's electronic record when she's called away on another patient matter. She walks away, leaving the record open and visible on her computer monitor.

Each of the above examples illustrates a threat to an ED's security — the first highlights a potential risk to the safety of employees and patients, and the second shows a break in keeping records secure.

Security is the "hot button" topic in the area of environment of care these days, according to **Steve Wilder,** CHSP, of Sorensen, Wilder, and Associates, a consulting agency in Bradley, IL.

Environment of care is the accreditation focus area that requires a hospital to provide a "safe, functional, supportive, and effective environment for patients, staff members, and others who may be in the hospital. Safety, security, equipment maintenance, aesthetics, privacy, access, and physical layout of the facility fall under the umbrella of the environment of care standard.

The Joint Commission on Accreditation of Healthcare Organizations specifies that the environment of care consists of three basic components: buildings, equipment, and people.

Leslie Furlow, PhD, RN, C-FNP, president of AchieveMentors management consulting firm in Tolar, TX, says the element of safety that must be considered under environment of care consists of reducing environmental hazards; preventing accidents; maintaining security; and emergency preparedness.

Furlow further breaks down those components into eight elements:

- Signage
- Access
- Space, size, and configuration
- Physical layout
- Patient flow
- Privacy
- Safety
- Aesthetics

"The Joint Commission is getting much [stronger] in its interest in EDs' ability to protect themselves," says Wilder. "One of the big concerns is terrorism, obviously. Hospitals are vulnerable targets. The basic concern is, 'How do we bring in the people who need to be here, and keep out the people who don't?' "

The first thing surveyors look at when entering an ED is its physical layout and how access is controlled, Wilder says.

As security concerns have grown, hospitals and EDs have been challenged to make their existing facilities — that in many cases were designed and built during a time when access to a hospital was wide-open — secure yet accessible.

According to **Mike Bundy**, System Director for Safety, Security, and Emergency Management for Wellmont Health Systems in Kingsport, TN, living up to what you say your facility is going to do is critical when surveyors arrive.

Sources and Resource

For more information on the Joint Commission's standard for environment of care, contact:

- **Steve Wilder,** CHSP, Senior Partner, Sorensen, Wilder and Associates, 596 North Van Buren Avenue, Bradley, IL 60915. Telephone (800) 568-2931. E-mail: swa@swa4safety.com.
- **Britt Berek,** Associate Director for Standards Interpretation, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5900. Fax: (630) 792-5005. E-mail bberek@jcaho.org.
- **Leslie Furlow,** PhD, RN, C-FNP, President, AchieveMentors Inc., P.O. Box 185, 200 N. Oak Lane, Tolar, TX 76476. Telephone: (254) 834-3333; toll-free: (877) 331-4321. Fax: (254) 835-4993. E-mail leslie@achievementors.com. Web: www.achievementors.com.
- **Mike Bundy,** System Director for Safety, Security, and Emergency Management for Wellmont Health Systems, 130 Ravine Road, Kingsport, TN 37662. Telephone: (423) 224-4000. E-mail michael_n_bundy@wellmont.org.
- **Pre-publication Edition of 2004 Standards** are available for viewing at www.jcaho.org. Click on "accredited organizations," then "hospitals," "standards," and "environment of care." Crosswalk charts that compare current standards with new standards also are featured on the site.

"If you don't say your ED is a sensitive area, you don't have the [access control requirements] to meet," Bundy says. "But we're a Level I trauma center, so any surveyor is going to think that our trauma suites are sensitive areas."

Britt Berek, Associate Director for Standards Interpretation for the Joint Commission, says establishing and maintaining security in the ED can be frustrating, because there are so many issues to consider.

"The ED and the [hospital] nursery are two areas you think of when you talk about security issues." Berek says. "If you're going to [examine your hospital] for security issues, the ED is where you're going to wind up."

Wilder says hospitals historically have been reluctant to lock down their EDs.

"They don't want to give the impression that it's not safe," he observes.

Security measures to control access range from installing bar gates that prevent access from the ED to other areas of the hospital, to using staff as human gatekeepers to monitor and control access to and from the ED.

Bundy says the two largest hospitals in the Wellmont system, Holston Valley Hospital and Medical Center in Kingsport, TN, and Bristol Regional Medical Center in Bristol, TN, have different security demands than the smaller hospitals in the system.

Patient volume and the risk analysis associated with the community vary from facility to facility, he says. So while armed security guards may be present in the ED in some situations that involve higher risk (e.g., if a victim of a gang shooting is brought into the ED), during times of low patient volume and lower risk (e.g., 10 a.m. on a weekday), there may be no security staff present at all.

Wellmont uses barcode-activated controls to limit entry into the sensitive areas of the ED. Egress from the ED is restricted only under certain conditions, and must comply with Life Safety Codes.

"Security in the ED [can be] problematic," says Berek. "You are trying to make it accessible 24 hours a day, but also to make it inaccessible, in a way, 24 hours a day.

Furthermore, some technology that works well in other locations (e.g., metal detectors) isn't practical in the health care setting, Berek says.

Wilder points out that hospitals that use personnel for security, rather than relying on technology, seek to establish "an atmosphere of 'Come in. We're here to serve your needs, but we are employing a security guard to make sure you're safe.'"

Further challenging hospitals, Wilder says, is the fact that some environment of care standards are seen as being somewhat ambiguous. For example, environment of care standard EC.1.20 states, "The hospital maintains a safe environment of care." Such standards may be open to broad interpretation, Wilder says.

"Add to that the fact that most of the [Joint Commission] surveyors who are looking at security issues have had no background in health care safety and security," he adds. "There is so much conflict between safety issues and facility management issues, that hospitals now are spending more time to prepare for the environment of care survey than for anything else.

"The environment of care standards are the toughest to be in compliance with now."

Bundy says the ED may be one of the easier departments in a hospital in which to maintain constant compliance with environment of care standards pertaining to security, however.

"We are getting tested every day," he points out. "If you are not ready to control access to your ED, it is going to cause you operations problems on a daily basis. For example, if you can't keep 30 rowdy visitors out of patients' rooms in the ED, it's going to cause problems, and you're going to know that immediately.

"Our ED is tested every night after 9 p.m., especially on weekends," Bundy says, referring to high-volume times for the ED. "That's my survey."

Wilder said it's easy for hospitals to forget that the three components of environment of care — people, equipment, and buildings — are intertwined.

A suggestion Wilder makes to clients is to use the P^2T^2 formula: people, programming, training, and technology.

"Written programs, training programs, people, and technology all are important, but you have to have all of them in order for the system to work, he says. "We see hospitals that have written programs that are superb, and that have spent thousands of dollars on security technology, but their people aren't trained to use it, or they're not staffed adequately."

Hospitals, and EDs in particular, are having to re-educate themselves and accept that EDs can no longer afford to be the wide-open doors to the hospital that they once were.

Wilder says many seasoned ED staff are having to get used to a new way of looking at security.

"No one used to force us to be cognizant of security. No one enforced information [records] security. Now, we have to control access to the ED," he points out. "We have to pay attention to information security. You can't leave a patient's confidential information up on an unattended computer screen. You can't leave charts lying around."

When it comes to terrorism threats against hospitals, one mistake Wilder says he sees rural hospitals make is to assume that, because they are smaller and in more remote locations, that they are immune from terrorist attack, when just the opposite may be true.

"If you look at an inner city hospital, if one

Accreditation Q & A

Accreditation carries with it questions, some specific to individual organizations, but many that apply universally. In this section, ED Accreditation Update *will provide experts' answers to your accreditation questions, as well as tips from organizations that fared well during their survey process. Submit questions or suggestions for this section to Joy Daughtery Dickinson, Senior Managing Editor. E-mail: joy.dickinson@ahcpub.com.*

Q: "The first patient safety goal requires us to use at least two patient identifiers (not the patient's room number) whenever taking blood samples or administering medications or blood products. What are some suggested identifiers?"

A: According to the Joint Commission's explanation of patient identifiers, there are several acceptable means of identifying a patient — including asking the patient his or her name.

"Asking the patient's name is good not only from a patient safety standpoint, but also from a public relations standpoint," advises **Steve Wilder**, CHSP, senior partner with Sorensen, Wilder and Associates, a consulting firm in Bradley, IL.

The two identifiers even may be drawn from the same location — as in, the patient's name, ID number, or date of birth from his or her wristband.

It is the person-specific information that is the "identifier," not the medium on which that information resides, the Joint Commission guide to National Patient Safety Goals states.

Patients brought into the ED unconscious or without identification usually are assigned temporary names (e.g., John Doe) and a record number for identification, which may be used later to match him or her with specimen labels, medication orders, or blood product labels.

For more information on National Patient Safety Goals, see the Joint Commission's web site, www.jcaho.org; click on "accredited organizations" and "patient safety." ■

Quick Fact

The emergency department was the setting for 4% of all sentinel events reported since 1995 (83 out of 2,165 total events), according to the Joint Commission's June 2003 report on sentinel event statistics. The top five sentinel events occurring in the ED were, in order of frequency: delay in treatment; suicide; medication error; restraint-related event; and assault/rape/homicide.

comes under attack, you have several others close by that can care for the community," he points out. "But in a rural community, the one hospital might be the only one for 20 miles, and if you take it out, the community vulnerability goes up proportionally."

The Joint Commission has posted a pre-publication edition of the newly revised 2004 standards, including a "crosswalk" that compares the 2003 standards to the 2004 standards, on its web site. **(See source box, p. 2.)** The pre-publication edition will be posted online until the official accreditation manuals are published in the fall.

Berek says accredited organizations should keep in mind that the changes to the standards manual are largely organizational and do not change the standards themselves.

"The standards review task force took out some redundancies and also shuffled some of the standards to other parts of the manual," Berek states. "We tried to not change the standards per se; we reorganized and renumbered some things, so some requirements may be in other chapters, and people need to be aware of that." ■

Review of infection control standards under way

Joint Commission seeks to curb nosocomial infections

The Joint Commission is analyzing input received during an online field review of proposed changes to its infection control standards as part of a push to curb the occurrence of deadly nosocomial infections.

Feedback on the changes proposed for hospitals and other accredited organizations was due to the Joint Commission by Aug. 1, 2003, and full implementation of the modified standards is targeted for January 2005.

Nosocomial infections, acquired by patients hospitalized for other causes, strike more than 2 million patients annually, and 88,000 of those patients die each year as a result, according to the Centers for Disease Control and Prevention (CDC).

Emergency departments in Canada and several Asian countries were the source sites of nosocomial cases of severe acute respiratory syndrome (SARS) in hospital employees, visitors, and patients.

"At the close of the field review, we will review and analyze comments, then modify standards accordingly, and then the standards will undergo a series of approvals, which will extend well beyond 30 days after the field review closes," said Joint Commission spokeswoman **Charlene Hill**.

Because infection control has evolved significantly in recent years, the Joint Commission launched a complete review of its infection control standards.

A panel of experts identified six areas upon which to focus in the process of updating the standards. Those areas are: staffing and personnel issues; adherence to national guidelines; employee health; data collection and analysis; environment of care; and infection control program evaluation.

While the draft revisions incorporate infection prevention and control issues important to each accreditation program, Joint Commission president **Dennis O'Leary** said much of the 2003 standards would largely be unchanged.

"In many instances, the standards would retain their current focus, but become more prescriptive in nature," he said. ■

Resource

For more information on the Joint Commission's proposed revisions to its infection control standards, visit:

- **Joint Commission on Accreditation of Healthcare Organizations** web site for information on the proposed revisions (go to http://www.jcaho.org; click on "accredited organizations," "hospitals," "standards," and "infection control").

A supplement to answer your accreditation questions

ED Management is pleased to offer this periodic supplement that will give you greater coverage of topics pertaining to the Joint Commission and its impact on the emergency department. This value-added supplement makes your subscription to *ED Management* even more essential. Reader feedback is welcome may be directed to Joy Daughtery Dickinson, Senior Managing Editor, at joy.dickinson@ahcpub.com.