ED Management®
The monthly update on Emergency Department Management

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

JANUARY 2004
VOL. 16, NO. 1 • (pages 1-12)

ED is hotbed for lawsuits; take simple steps to address riskiest conditions

Most claims result from what you didn't do, not what you did

(Editor's note: This is the first of a three-part series addressing the top five issues that lead to malpractice claims in the emergency department and how you can address them. In this issue, ED Management *examines how the ED is at especially high risk and how you can reduce lawsuits. This first article provides detail on chest pain, one of the five riskiest conditions. Next month, look for the next installment on headache and abdominal pain, and the last article will address head injury and stroke.)*

What happens in your emergency department when a patient shows up complaining that he still has that terrible headache you sent him home with six hours ago? Do your staff label him a whiner and send him back out the door with some Tylenol?

If so, you probably just created a lawsuit. You might as well call him a taxi and send him straight to a plaintiff's attorney.

That is only one of the most common situations leading to ED malpractice cases. The very nature of the ED, with patients arriving with unknown conditions and staff pressed to act quickly, is a recipe for disaster, say legal experts. Malpractice lawsuits are almost certain to happen, but you can reduce your chance of being sued significantly by paying more attention to the top five issues that are likely to take you to court, they say.

The ED is the source for a disproportionate number of malpractice claims at most hospitals, with about 20% of all of the hospital's claims originating there, says **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens in Flushing.

In addition to her extensive ED experience, Sixsmith has been an expert witness and malpractice consultant for 25 years. She spoke on the topic at the recent meeting of the American Society for Healthcare Risk Management (ASHRM) in Nashville, TN, along with **Andrew S. Kaufman**, JD, a partner with Kaufman, Borgeest, & Ryan in New York City, a prominent law firm defending health care malpractice claims.

"You can't make your ED litigation-proof," Sixsmith says. "But most EDs could make themselves less of a target."

Sixsmith and Kaufman point out that when patients sue after being treated in the ED, they often are motivated not so much by the actual care received but by how they felt they were treated personally.[1] That is especially true after an adverse event.

Even if the clinical care actually was subpar in some way, patients will be more likely to forgive that error if they perceive the ED staff as caring and attentive. But in the typically overcrowded ED, personal niceties often become a lesser priority. That atmosphere puts you at more risk of being sued, says Sixsmith, but it also may increase the risk of actually providing substandard care.

"My theory is that the physician/patient and nurse/patient relationship is very much a part of health care," she says. "A bad relationship actually interferes with care." For example, not getting a good history or not talking to the patient enough to get good information affects the actual care, not just the perception of care, Sixsmith says. "If you're unpleasant with the patient, the patient won't be forthcoming with the information you need to provide optimal care," she says.

Focus on the top-five risky conditions

Because ED physicians and staff start at a distinct disadvantage when it comes to avoiding liability, Kaufman says it is important to concentrate on those patients and situations that put you most at risk. For example, 90% of ED malpractice claims involve discharged patients, not those who were admitted for further treatment, he says.

Sixsmith agrees and says most ED malpractice claims stem from what physicians and staff *didn't* do, not the treatment they provided. Even though Sixsmith acknowledges that emergency physicians and nurses should not do unnecessary tests and procedures, she does recommend that "action is better than no action. My mantra in the ED is, 'if you think of it, do it.'"

When deciding where to focus your risk-reduction efforts, Sixsmith and Kaufman point to these conditions as the most likely to lead to malpractice lawsuits in the ED:

1. chest pain;
2. headache;
3. abdominal pain;
4. heady injury;
5. stroke.

Those conditions are the most risky because they can present in difficult ways, and it is easy for busy ED staff to overlook crucial signs. **(For more on chest pain, see related article, p. 3. Upcoming issues of *EDM* will focus on the other conditions.)**

Reducing your liability risk requires a concerted effort, Sixsmith says. It's not good enough to just urge everyone to practice good medicine and then hope for the best. You must take very specific steps that address the known hazards.

Sixsmith and Kaufman suggest taking these actions:

• **Focus more on customer service.** Though this might seem like an unreasonable demand for overworked staff, it is crucial if you are to avoid lawsuits. When people walk away unhappy, they are far more

ED Management® (ISSN 1044-9167) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

ED Management® is approved for approximately 18 nursing contact hours. This offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours. This program (#0904-1) has been approved by an AACN Certification Corp.-approved provider (#10852) under established AACN Certification Corp. guidelines for 18 contact hours, CERP Category A. Thomson American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. Thomson American Health Consultants designates this educational activity for a maximum of 18 hours in Category 1 credit toward the American Medical Association Physicians' Recognition Award. Each physician should claim only those credits that he/she actually spend in the activity. This activity was planned and produced in accordance with ACCME Essentials. **ED Management**® is also approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291 (customerservice@ahcpub. com). **Hours of operation:** 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST. Subscription rates: U.S.A., one year (12 issues), $465. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $372 per year; 10 to 20 additional copies, $279 per year; for more than 20, call (800) 688-2421 for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

Editor: Greg Freeman (Free6060@bellsouth.net).
Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: Valerie Loner, (404) 262-5475, (valerie.loner@thomson.com).
Senior Managing Editor: Joy Daughtery Dickinson, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: Ann Duncan.

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (229) 551-9195.

Statement of financial disclosure: To reveal any potential bias in this publication, and in accordance with the Accreditation Council for Continuing Medical Education guidelines, we disclose that Dr. Auer (editorial advisory board member) discloses that she has no conflicts of interest; Dr. Bukata (advisory board member) is president of the Center for Medical Education and is the developer of EDITS software; Dr. Joseph discloses that he is a stockholder in AMC Registry. Dr. Mayer (advisory board member) is a stockholder in Emergency Physicians of Northern Virginia Ltd. and Patient Care and ED Survival Skills Ltd.; Dr. Yeh (advisory board member) serves as a consultant to Dynamics Resource Group, a spokeswoman for Medic Alert, and a member of the board of directors for Vital Solutions and MassPRO.

THOMSON
AMERICAN HEALTH CONSULTANTS

likely to sue over any perceived wrongdoing in the ED.

• Make sure ED physicians have the authority to admit patients to the hospital when they see fit. Lawsuits occur when the ED physician can't convince the doctor in another unit, a hospitalist, or the patient's private physician to admit and the patient is discharged. In many cases, the record shows that the emergency physician thought the patient should be admitted but then discharged him or her. Work with hospital administrators and medical staff leadership to give ED physicians the authority to admit a patient in such situations, Kaufman says.

• Improve change-of-shift continuity. Many problems arise when patients are handed off from one physician or nurse to another at the change of shift, he says. Kaufman recommends a policy requiring the incoming shift to evaluate the patient as a new patient.

Never allow staff or physicians to rely on a general statement of the patient's condition from the outgoing shift. Patients are at great risk if the incoming shift assumes the patient is stable because the outgoing shift didn't say otherwise or the patient's condition changed.

• Examine the patient twice as carefully on the second visit. ED staff *always* must pull the patient's chart from the previous visit to review it for condition insights, oversights, and in light of the patient's current condition, Kaufman says.

Sixsmith says a return visit to the ED is a pivotal moment, in which you can protect the patient and save yourself or make things much worse. When a patient returns to the ED, "he's giving you a chance to right your wrong," she says. "And juries have no sympathy when you turn them out on the street again."

• Evaluate the patient thoroughly even if you consult the patient's primary care doctor. The malpractice liability rests with the ED and hospital while the person is your patient, Kaufman says. That doesn't change because of anything the primary care physician says over the phone.

"Either the primary care physician comes in and takes responsibility for the patient, or you evaluate that patient as if he had no doctor at all," he says. "You can't forego anything just because you talked to the patient's doctor."

• Get the patient's family involved with decisions to leave against medical advice. "The family [members] will be the ones suing you if he dies," Kaufman adds. "They need to know that you tried your best to get him to stay for treatment." Enlist the family to try to persuade the patient to stay for treatment, he advises. Explain to the family that the patient needs to stay, and ask for their help. Even if they are unsuccessful in preventing the departure, they will see for themselves that you did your best to convince the patient and did not just let him or her leave because you didn't care.

• Provide more specific discharge instructions about when to return. Discharge instructions often don't say anything about the patient returning because symptoms remain the same. For some serious conditions requiring emergency care, the symptoms may remain exactly the same until the patient suddenly dies, Kaufman says.

He suggests that discharge forms include two boxes for the physician to check, depending on the circumstances: One can say "return to ED if you feel worse," and the other can say "Return to ED if you don't feel better."

"I've had cases where the patient was discharged and had a bad outcome and then said he didn't return to the ED because they didn't tell him to," Kaufman adds. "The doctor told him to return if he felt worse, but the patient says, 'I didn't feel worse. I just didn't feel better.'"

Sources

For more information, contact:

- **Diane M. Sixsmith**, MD, MPH, FACEP, Chairman of Emergency Medicine, New York Hospital Medical Center of Queens, 56-45 Main St., Flushing, NY 11355-5045. Phone: (718) 670-1231.
- **Andrew S. Kaufman**, JD, Partner, Kaufman, Borgeest, & Ryan, 99 Park Ave., 19th Floor, New York, NY 10016. Phone: (212) 980-9600.

Reference

1. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994; 343:1,609-1,613. ■

Chest pain treatment options increase liability

Chest pain is one of the conditions most likely to lead to a charge of malpractice for two main reasons, says **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens in Flushing.

The cause of chest pain can be difficult to diagnose and treat properly; but at the same time, current treatment strategies also mean that even the sickest patients can fare well if ED staff make the right decisions, she says. Thus, the stakes are high for both the patient and the ED, Sixsmith adds.

"Plaintiffs' attorneys can easily claim that the patient

would have fared better 'if only . . .'" she explains. "Risk factors are very important. If a smoker comes to my ED with chest pain, he gets admitted. No question."

Once acute myocardial infarction or acute coronary syndrome has been diagnosed, you must meet the standard of care for certain types of treatment, Sixsmith emphasizes. Not only is that approach best for the patient, but plaintiff's attorneys also will seize the opportunity to show that you did not meet certain standards that are measurable and not a matter of judgment. For instance, you should require that appropriate drugs be administered within 30 minutes of the patient's arrival and that the patient goes to the cath lab within 90 minutes of arrival, she continues.

Heparin, beta-blockers, and aspirin must be administered promptly when appropriate. Also, the ED should have a policy of obtaining a cardiology consult as soon as possible if the patient is unstable, Sixsmith says.

She outlines these other risk-reduction strategies for chest pain:

• Ensure that consult or admitting physician response times are well-defined. For unstable patients, 30 minutes or less is the usual standard.

• Remember that not all chest pain in middle-aged males is coronary disease.

• With chest pain, as with many conditions, unsupervised care by residents can be a formula for disaster.

• Always review test results prior to discharging a patient with chest pain.

Missed aortic dissection a big risk

Be especially cautious with the possibility of an aortic dissection — the cause of actor John Ritter's recent sudden death, Sixsmith says. Your defense attorney will have a difficult job ahead if a patient came to you with an aortic dissection, but you diagnosed indigestion and sent him home with an antacid.

Patients most at risk for aortic dissection are hypertensives, those with a family history or known history of aortic disease, and those with Marfan's disease or Marfan's-type features, she states.

The presenting symptoms of aortic dissection often are confusing but usually start with sudden tearing chest pain, which may then migrate to the abdomen or lower back. Twenty percent of the patients present with neurological signs and symptoms.

Mortality for aortic dissection is 1% per hour after symptom onset, so early diagnosis is crucial. "A well-defined plan should be in place for prompt diagnosis of aortic dissection at any hour," Sixsmith adds. "That may mean making sure that your ED personnel can obtain a CT scan or transsophageal echo at any time, including 3 in the morning." ■

Take tip from restaurants to ease waits, ED advises

As EDs look for any solution that will help ease the problems of overcrowding and long wait times, one is finding that a technique already used in the restaurant industry can work in a health care setting as well.

Restaurants have found they can manage waiting patrons much better if they hand out pagers instead of just screaming the next party's name, so the ED at St. Joseph's Hospital in Savannah, GA, is trying the same approach.

So far, the results are impressive: Patients and staff are happier, and the ED is reaping some of its highest patient satisfaction scores ever — the 90th percentile. As an added bonus, the benefits come at relatively low cost.

The idea came about because the administration was looking for new and creative ways to address the perennial challenges of overcrowding and long waits in the ED, says **Judy Peterman**, RN, MSN, director of critical care and emergency services. The ED sees about 47,000 patients a year.

"We're accustomed to the idea that there's no perfect overall solution to the problem of overcrowding," she says. "All you can do is sort of nibble away at it and try to make a positive impact in different little niches throughout the problem. This is one of those."

Same beepers used in restaurants

The hospital decided to try using the same devices that are found in many restaurants. Though most people call them "beepers," they don't actually beep. They're flat, square devices about 5 inches by 5 inches; and when activated, they vibrate and red lights flash. Peterman says they're exactly the same as the devices used in some popular restaurants.

The hospital invested about $3,000 for a docking system to charge the devices and 20 hand-held units. The system was purchased from JTECH Communications in Boca Raton, FL. **(For contact information, see source box, p. 5.)**

Each pager has a number on it that is recorded in the triage record. The hospital had the devices programmed so they would allow the patient to go all the way to the other side of the hospital — to the cafeteria, for instance — or for a walk outside.

The triage nurse has the pagers and docking station at her desk and hands them out when assessing the patient. The units are completely sealed plastic, so

Sources

For more information, contact:

- **Judy Peterman**, RN, MSN, Director of Critical Care and Emergency Services, St. Joseph's/Candler, 5353 Reynolds St., Savannah, GA 31405. Phone: (912) 692-6000.
- **JTECH Communications**, 6413 Congress Ave., Suite 150, Boca Raton, FL 33487. Phone: (800) 321-6221. Web: www.jtech.com.

infection control only requires wiping them down like any other surface. The pagers are used only for low-acuity patients who probably will wait for a while. If the ED is not busy at the moment and no long wait is expected, the nurse doesn't bother handing out the devices.

The system has been in place in for about four months. Though there was some initial concern that the system might seem unprofessional in a medical setting, Peterman says she understands now that patients expect this kind of technology as a part of customer service.

"Patients' expectations of us are more and more like their expectations of customer service at the rental car outlet, the hotel, and the restaurant," she says. "We're at a disadvantage from the start because people come to the ED and just expect to wait a while. We don't get off on a good relationship with them from the beginning. Innovative ideas like this put a positive spark back into the experience."

The pagers lower the overall anxiety level of the ED because patients don't worry that they will be bumped to the end of the line if they step outside for a minute and miss their names being called.

Staff also appreciate the way the pagers decrease the stress level in the ED, Peterman says. Patients feel like they have been treated better while waiting, she says, and that makes them more pleasant when the staff treat them.

"They also don't have to go out screaming for the patient, and then go back a few minutes later and scream for them again," she adds. "That creates rework for the staff."

Because there is no need to call out patient's names, the pagers also help the ED comply with the privacy protections of the Health Insurance Portability and Accountability Act, she explains.

Peterman and ED staff knew patients responded favorably to the pager system, but she says she was surprised when she found out just how much. The ED's patient satisfaction scores, as measured by an outside company, Omaha, NE-based Professional Research Corp., always reflected patients' frustration with waiting so long for treatment, she says. The hospital strives to be in the 75th percentile for ED patient satisfaction.

In the past, the ED has struggled to meet that 75th percentile goal, Peterman says. In the first quarterly report after introducing the pager system, the ED's patient satisfaction score jumped to the 90th percentile.

"That's a real morale booster for the staff," she notes. "They know the patients are out there saying something positive about them, and it encourages them to take a look at all of their processes. What are some other ways to revise processes and tweak what we're doing? When you see happy customers, you want to do everything possible to keep them that way." ■

Flu season severe: FluMist may pose little risk

With this year's flu season shaping up to be the worst in years, encouraging your own staff to get vaccinated is one of the best things you can do to prepare for the onslaught. The new intranasal flu vaccine may be fine for emergency department staff, contrary to some initial fears about shedding the virus to patients, say some experts.

There are discussions between the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and MedImmune Vaccines, but at press time, the CDC did not have an official recommendation on whether health care workers vaccinated with the new FluMist intranasal vaccine (MedImmune Vaccines, Gaithersburg, MD) should avoid close contact with immunocompromised individuals and for how long. In the interim, the CDC has referred clinicians back to a statement from its Advisory Committee on Immunization Practices that essentially discourages health care workers from taking the live vaccine in the first place.[1]

It always is important to remind staff that they put patients at risk when they are febrile from a natural exposure to the flu, and now because FluMist uses a live virus, there has been some talk in the health care community about the risk of shedding the virus to patients after vaccination. But the risk is very low and there is no need to prohibit ED staff from seeking the intranasal vaccine, says **David Wilcox**, MD, FACEP, spokesman for the American College of Emergency Physicians and an emergency physician at St. Francis Medical Center in Hartford, CT.

"It is possible to shed virus to immunocompromised people for a short time period, but that risk is so low that I don't think emergency department staff have to avoid

Sources

For more information, contact:

- **David Wilcox**, MD, FACEP, American College of Emergency Physicians, 1125 Executive Circle, Irving, TX 75038-2522. Phone: (800) 798-1822.
- **Jeffrey Stoddard**, MD, FAAP, Senior Director of Medical Affairs, MedImmune Vaccines, 35 W. Watkins Mill Road, Gaithersburg, MD 20878. Phone: (301) 417-0770.

the live virus vaccine," he says. "Maybe if they worked all day with cancer patients or severely immunocompromised patients, that would be an issue, but I don't see a concern in the ED."

That advice is seconded by **Jeffrey Stoddard**, MD, FAAP, senior director of medical affairs with MedImmune. The drug label approved by the FDA includes a caution regarding the theoretical transmission of the virus after FluMist vaccination, but there is no contraindication for health care workers, he says.

"Nationally, only about 36% of health care workers get vaccinated against the flu, and that's a national disgrace," he says. "With respect to emergency room personnel, there is nothing in the label that would preclude use. There is some language that states a preference for the inactivated vaccine for those health care workers in close contact with immunocompromised patients, but the mention is made there only in regard to very close contact like household contact."

There has been no documented case of the virus being transmitted to anyone by someone vaccinated with FluMist, Stoddard says. The risk is "purely hypothetical," he says. It would be a mistake for ED staff to avoid the flu vaccination, especially this year, he says. By mid-December, the flu had spread to 24 states, and the CDC reported that the weekly percentages of patient visits for influenzalike illnesses jumped from 0.9% to 5.1% from Oct. 4 through Dec. 6. (For more information, go to www.cdc.gov/flu/.)

"ED managers are going to see some very sick people in very large numbers," he says. "Whether you use the intranasal vaccine or the shot, your personnel need to be vaccinated, or they're going to be hit by the flu just when you need them the most."

No benefit to FluMist?

Despite his lack of concern about the intranasal vaccine, Wilcox says that the old-fashioned flu shot may be the better way to go. He advocates the standard flu shot because it is less expensive, typically about $20 compared to about $60 for FluMist.

"There's really no benefit to getting the FluMist vaccine unless you're severely phobic about shots," he says. "It's more expensive, and I don't think that's a good way to spend our health care dollars. If the nasal vaccine makes the difference between someone on your staff getting vaccinated for the flu and not getting anything, then FluMist is fine. But I don't think that many people have trouble with the flu shot."

Wilcox says ED managers should strongly encourage their staff to be vaccinated against the flu, not only for their own good, but to ensure full staffing for the department when the flu hits your community hard. The sooner they get vaccinated, the better, he says, because it typically takes about two weeks to build immunity.

Reference

1. Centers for Disease Control and Prevention. Advisory committee on Immunization Practices. Using live, attenuated influenza vaccine for prevention and control of influenza. *MMWR* 2003; 52 (RR13):1-8. ■

Cross-training your staff necessitates caution

It sounds like a good idea, and consultants are throwing it around all the time: Cross-train your staff so you get more out of the same people. But how exactly do you cross-train the staff?

Very carefully, says **Emory Petrack**, MD, FAAP, FACEP, president of Petrack Consulting in Shaker Heights, OH. Cross-training won't solve all of your problems, but it can help ease many common difficulties faced in the ED, such as overcrowding, short staffing, and tight budgets, he says. But do it wrong, and you may end up with seriously disgruntled staff and lower productivity than you started out with. Do it right, and you could see great improvements, Petrack says.

Petrack has been involved with cross-training ED staff many times, and he says the most dramatic improvements came from cross-training pediatric emergency nurses and adult emergency nurses.

He has seen EDs cross-train secretaries and medical assistants, and he has seen cross-training of transport staff and emergency technicians. **(For an example of how clerical staff were cross-trained for ED support, see related article, p. 8.)**

The first step in cross-training ED staff is simply acknowledging that you need to do it, Petrack says. There usually is an automatic resistance to cross-training because people don't like to be told they will have additional duties, and managers often are reluctant to

broach the topic, he says. "As much as people don't want to hear it, EDs are under tremendous financial constraints now, and cross-training can be appropriate," Petrack explains. "To have one area where people are sort of sitting around and another where people are going crazy because they're so busy just doesn't make sense. It's important to acknowledge that as a reality."

Once you decide that cross-training staff is appropriate, Petrack says you must go about it with a carefully organized plan. He offers these tips:

• **Clarify to staff the need for cross-training.** Establish a partnership of understanding about the financial constraints the hospital and the department are under, and why those difficulties directly affect the staff. Promote the idea that you're all in this together and the cross-training is a necessary step, as opposed to it being something onerous handed down from administration.

"This is where I've seen some difficulty," Petrack says. "When people start talking about cross-training, staff get very anxious. They're being asked to put themselves very much outside their comfort zones, knowledge base, and even their professional expertise."

• **Avoid sending the message that staff aren't working hard already.** Any time you suggest cross-training, there is the danger of sending the message that "we think you have too much free time on your hands." That may be true, actually; but it's not the way to bring up the idea of cross-training, Petrack says. Use data to show that though the staff are busy much of the time — and stress that you appreciate that hard work — there are some times when they're not that busy.

"Most staff in the ED know that there are some busy times and some not-so-busy times," he adds. "Just be careful how you say that."

• **Listen to the staff's concerns, and respond to them.** Even if you succeed in getting the staff on board with your cross-training plan, they will have concerns about how it is implemented. Encourage staff to air their misgivings, and then structure the plan to accommodate those concerns.

"With nurses, pediatric nurses think of themselves as only pediatric nurses, and they're not so comfortable with adults, and vice versa," he says. "You have to respect that. Some, however, are comfortable with both roles, and those are the ones you might want to target for leadership positions when rolling this out. They can model the behavior you want, and their confidence can be an example for others."

Petrack says it is crucial to respect the staff's concerns. It is normal for staff to resist the idea at first, but how you respond can determine the future of your cross-training.

"How that resistance is handled will absolutely determine the ultimate success of the program. If that resistance is handled in a respectful way in which staff are heard and concerns are addressed as much as they can be, the plan is likely to be accepted," he says. "But if the administration just plows ahead without creating a sense of security with appropriate training and support, it's probably going to fail."

• **Reassure staff that you won't ask them to go beyond their abilities.** Contrary to common belief, resistance to cross-training staff is not based on a reluctance to work harder. It's based on the fear that they will be asked to do things they're not capable of, Petrack says.

• **Provide appropriate training before the plan is implemented.** Don't just do it on the fly. Cross-training plans can be doomed to failure if you just tell staff to go over to the other department and "someone will show you what to do," Petrack says.

You must implement formal training for any skills that are new or substantially different, and at a minimum, you should provide orientation to the new area. Even if a nurse from one department is capable of handling the clinical duties in another, don't throw that nurse into your ED without providing orientation to the everyday procedures and where supplies are located, he adds. Partnering is one solution, Petrack says. In some instances, it can be useful to have a pediatric nurse partner with a nurse in the adult ED to overcome any trepidation. After the pediatric nurse becomes comfortable, the partnering probably won't be necessary.

Remember that some necessary skills are not clinical. An adult ED nurse, for instance, might need pointers on how to talk with children and parents.

• **Document that staff have been trained and achieved the skills necessary.** To ensure that training is provided to each person and that staff are comfortable with their new roles, Petrack advises using a short didactic test.

• **Limit the cross-training roles to the necessary hours.** Just because you need to cross-train staff doesn't mean you have to make those staff available at all times. If one department is slammed only during the evening hours, for instance, you may want to make your cross-trained staff available to that department

Source

For more information, contact:

- **Emory Petrack**, MD, FAAP, FACEP, President, Petrack Consulting, 16781 Chagrin Blvd., No. 249, Shaker Heights, OH 44120. Phone: (216) 371-8755. E-mail: epetrack@petrackconsulting.com. Web: www.petrackconsulting.com.

only during those hours.

Limiting the hours in which they might be assigned makes people more comfortable, Petrack says.

• **Confirm that staff members have the time. Don't just add to their workload.** If you have clerical staff members who are busy all the time, you can't insist that they take on patient care duties just because that's what you need. You can end up losing your secretarial staff, and that will cause a different set of problems, with phones ringing all the time and labs not sent off. Don't trade one problem for another.

• **Don't use cross-training as a substitute for proper staffing.** Cross-training can help you make the most of your current staff, but it won't help you avoid hiring the necessary staff. If volume surges aren't the problem and you really need more pediatric emergency nurses, cross-training your adult nurses only will be a temporary fix.

"Look to see if redistribution of staff would be a better answer," Petrack says. "If one area is always more busy, it might be better to move staff permanently instead of cross-training them." ■

Success: Clerical staff are cross-trained as ED techs

An ED in Lebanon, NJ, has been cross-training clerical staff to work as technicians for the past 10 years and reports that the system is a major help in reducing the workload for nurses and other staff.

"It improves efficiency and makes things work more smoothly overall in the ED," says **Kathy Cook**, LNA, unit services coordinator for emergency services at Dartmouth-Hitchcock Medical Center.

Cook started out in a clerical role in the ED and was cross-trained for patient care. "When we're not there, the nurses really miss us," she says.

Cook then became coordinator for the program. Before the program, the ED employed staff in purely clerical roles but had a need for more clinical help. The decision was made to cross-train the clerical staff for patient care. "It was not so much that we were short staffed, but we had a need for specific types of help," she says. "We needed to make the nurse's job better but also to make the secretary's job more exciting, more satisfying than just spending the day at a desk."

Training was necessary, so all of the clerical staff were asked to attend courses for a certification as licensed nursing assistants (LNAs). The hospital provided the courses on-site and free of charge. Hospital educators taught the courses at a negligible cost, Cook says.

The ED ended up with 10 clerical staff who were cross-trained for patient care duties and has maintained that staffing. The ED typically has three support techs on duty from 7 a.m. to 3 a.m., and two the rest of the time. Once they are LNA-certified, they are capable of tasks such as taking vital signs and cleaning wounds. Each year, the ED tries to improve the support staff's skills so they can do a little more. Most recently, they were trained in phlebotomy.

"The clerical work is still done by the same people. The job now has two components: clerical and floor tech," she says. "It's been very successful for the ED, and we don't have much turnover in our support staff."

Cook describes the support staff position as a challenging role, but she says the employees enjoy it more than purely clerical work. And the ED staff are very appreciative, she says.

"It's not just that you're asking them to do more work. It's more fulfilling," she says. ■

Source

For more information, contact:

- **Kathy Cook**, LNA, Unit Services Coordinator for Emergency Services, Emergency Department, Dartmouth-Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756. Phone: (603) 650-5000.

EMTALA Q & A

[Editor's note: This column addresses reader questions about the Emergency Medical Treatment and 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 OK to have someone very quickly screen incoming patients at the door to catch those who clearly do not have an emergency condition — such as the woman who just wants a pregnancy test — and send them away to a public clinic or more appropriate provider? Even if it is technically compliant with EMTALA, would this be a risky way to clear our overcrowded ED?

Answer: If done correctly, this strategy can be

entirely compliant with EMTALA and an effective way to relieve the burden of clearly nonemergent patients, says **Daniel J. Sullivan,** MD, JD, FACEP, president of the Sullivan Group, a consulting company in Oak Brook, IL, that specializes in EMTALA interpretation.

Sullivan spoke on the topic recently at the meeting of the American Society for Healthcare Risk Management (ASHRM) in Nashville, TN.

The rule does not require a medical screening examination (MSE) for people who clearly do not have an emergency condition and who are not requesting emergency care. As far as EMTALA is concerned, Sullivan says the key is who does this quick screen at the door.

The final EMTALA rule specifies that some medical decisions must be made by a "qualified medical professional," so not just anyone can make the decision to turn the patient away. **(For more on the final EMTALA rule, see *EDM,* October 2003, p. 109.)**

Spell out who is qualified to screen

Hospitals are free to make their own determination of exactly who is qualified, but the EMTALA rule is clear that such decisions should be made by someone with substantial medical training. That means that you might not be able to use just any nurse, but a registered nurse often will qualify, Sullivan says.

The triage nurses may not be considered qualified medical personnel unless your hospital policies spell that out, he says.

"The hospital board must determine what makes someone qualified medical personnel and implement bylaws designating those triage nurses as such," adds Sullivan.

Once you determine who can make that call, screening at the door can be an effective way to reduce overcrowding, he explains.

"You can determine with a few questions that the patient has no emergency condition and is not requesting emergency care," he says. "You can tell them 'We don't do routine blood pressure checks,' and give them a list of public clinics."

Of course, the reason why the patient wants a blood pressure check can be germane, Sullivan says. You don't want to turn away a patient who is feeling lightheaded and might be suffering from severe hypertension. But if the patient simply wants a routine blood pressure check, that is a different situation.

The goal of the screening at that point is to weed out those who *clearly* have no emergency condition and don't even think they do, he says.

The Centers for Medicare and Medicaid Services (CMS) stated in the final EMTALA rule that the law is triggered when the patient has an emergency condition or is requesting emergency care, so there can be some disagreement when screening at the door.

If the screener determines there is no emergency condition but the patient insists he needs emergency care, the more prudent course may be to let that patient through and into the ED to be triaged normally, points out Sullivan.

Though ED managers may be reluctant to screen patients at the door like an exclusive nightclub, he says you would not be pushing the limits of EMTALA by doing so.

A velvet rope and bouncer at the door might be too much, but otherwise, CMS expects you to perform this type of screening, Sullivan continues.

"CMS says it's OK and even encourages it as a way to address overcrowding," he says.

That interpretation is borne out by more guidance issued recently by CMS after the final rule was released. **(CMS issued a guidance memo to state survey agency directors, helping surveyors interpret some gray areas. For more on that memo, see related article, p. 10.)**

Explaining the final EMTALA rule to surveyors, the memo stated, "The rule clarifies that when an individual comes to the dedicated ED for nonemergency services, and from the nature of his or her request, it is clear that the individual is not making a request or having a request made on his or her behalf for examination or treatment for an [emergency medical condition], the hospital is not obligated to conduct a comprehensive MSE. An example is an individual who presents to the dedicated ED for a minor medical complaint such as suture removal."

The memo noted that the preamble to the regulation "contemplates that a registered nurse could conduct a relatively basic MSE in this instance and direct the patient to another location other than the dedicated ED for the suture removal.

"Implicit in this guidance is the notion that it is permissible for a registered nurse to conduct the MSE, as long as the nurse is considered to be qualified medical personnel by the hospital and is acting within the scope of his/her license," it added. ■

Source

For more information, contact:

- **Daniel J. Sullivan**, MD, JD, FACEP, The Sullivan Group, 2000 Spring Road, Suite 200 Oak Brook, IL 60523. Phone: (630) 990-9700. Web: www.thesullivangroup.com.

CMS issues guidance on interpreting EMTALA

Anticipating that its surveyors may have as much difficulty as ED managers in interpreting the final Emergency Medical Treatment and Labor Act (EMTALA) rule, the Centers for Medicare & Medicaid Services (CMS) recently issued a guidance memo that clarified some definitions and outlined three ways in which your EMTALA obligation comes to a halt.

The guidance memo noted that more official "interpretative guidelines" are under development; but in the meantime, **Thomas E. Hamilton**, director of the survey and certification group for CMS, offered some pointers. For example, he delineated three ways in which the ED's EMTALA obligation can end.

EMTALA no longer applies if a physician or other qualified medical personnel makes any of these three decisions:

1. No emergency exists.

2. An emergency exists that requires transfer to another facility, or the patient requests transfer to another facility.

3. An emergency exists, and the patient is admitted to the hospital for further stabilizing treatment.

Admitted decision must be documented

The guidance memo also explained that "a patient is considered to be admitted when the decision is made to admit the individual to receive inpatient hospital services with the expectation that the patient will remain in the hospital at least overnight. Typically, we would expect that this would be documented in the patient's chart and medical record as the time that the admitting physician signed and dated the admission order."

The memo also helped clarify when a patient is considered stable: "To be considered stable, a patient's emergency medical condition must be resolved, even though the underlying medical condition may persist. For example, an individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. A physician completes a medical screening examination [MSE] and diagnoses the individual as having an asthma attack, which is an emergency medical condition [EMC]."

After stabilizing treatment is provided, such as medication and oxygen, to alleviate the acute respiratory symptoms, the ED's EMTALA obligation may end.

"In this scenario, the EMC was resolved, but the underlying medical condition of asthma still exists. After stabilizing the patient, the hospital no longer has an EMTALA obligation," the memo explained.

Off-campus facility should call EMS

The memo offered this further advice:

• **People (including visitors) presenting themselves at an area of a hospital on the hospital's main campus other than a dedicated ED must receive a MSE only if they request, or have a request made on their behalf, for examination or treatment for what may be an EMC.** "Where there is no verbal request, a request will nevertheless be considered to exist if a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment," the memo said.

• **If a request were made for emergency care in a hospital department off the hospital's main campus other than a dedicated ED, EMTALA would not apply.** "The off-campus facility should call the local emergency medical service [EMS] to take the individual to an emergency department [not necessarily the emergency department of the hospital that operates the off-campus department, but rather the closest emergency department] and should provide whatever assistance is within its capability," the memo stated. Therefore, an off-campus location that does not meet the definition of a dedicated ED is not required to be staffed to handle potential EMCs."

For the full guidance memo, go to www.cms.hhs.gov/medicaid/survey-cert/letters.asp and choose item 10, "Emergency Medical Treatment and Labor Act (EMTALA) Interim Guidance (S&C 04-10)." ■

Audio program prepares your ED for return of SARS

Is your facility ready for a resurgence?

Leading epidemiologists say a global return of severe acute respiratory syndrome (SARS) — which wreaked havoc on the health care systems that had to deal with it — almost is inevitable.

What would happen today if a patient with suspected or probable SARS were admitted to your hospital? To help you prepare for the threat, Thomson American Health Consultants offers a compact disc recording of the audio conference: **The Resurgence of SARS: Why Your Hospital May Not Be as Prepared as You Think.**

The program's first speaker is **Allison McGeer**, MD, director of infection control at Mount Sinai and Princess Margaret Hospitals in Toronto. A veteran epidemiologist, McGeer dealt firsthand with SARS patients and occupationally infected workers during the prolonged outbreak in Toronto. McGeer outlines the lessons she learned dealing with this novel emerging pathogen on the front lines. Her insight provides guidance on preparing your facility now for what may come.

If or when SARS returns, hospital EDs certainly will be on those front lines. A career ED clinician, **Susan E. Shapiro**, PhD, RN, CEN, supplies listeners with valuable tips and procedures, in addition to addressing and clarifying recently updated Centers for Disease Control and Prevention (CDC) recommendations for SARS.

Shapiro is a postdoctoral fellow in risk assessment and intervention research with individuals and families at Oregon Health & Science University School of Nursing in Portland. An ED nurse and nurse manager before recently completing a doctoral program, she is the Emergency Nurses Association's representative to the CDC's SARS task force.

This program will serve as an invaluable resource for your entire staff. Your fee of $199 includes presentation material, additional reading, and 1 hour of CE, CME, or critical care credit.

For more information, call customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com. When ordering, please reference effort code **85541.** ■

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 the semester's activity, 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*

For information on the CE/CME program, contact customer services at (800) 688-2421. For CE/CME instructions, **see box, below left.**

19. According to Diane M. Sixsmith, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens, why is customer service so important in reducing malpractice claims involving the ED?
    A. People are more likely to sue when they feel the staff didn't care about them.
    B. Most state laws cite customer service as a cause of action.
    C. It is easier to prove poor customer service than to prove poor clinical care.
    D. Good customer service is required by medical ethics.

20. According to Andrew S. Kaufman, JD, a partner with Kaufman, Borgeest, & Ryan in New York City, a prominent law firm defending health care malpractice claims, 90% of ED malpractice claims involve which patients?
    A. Admitted patients
    B. Discharged patients
    C. Cardiology patients
    D. Pediatric patients

21. What is the mortality rate for aortic dissection after symptom onset?
    A. 10% per hour
    B. 5% per hour
    C. 3% per hour
    D. 1% per hour

22. When St. Joseph's/Candler started using pagers for patients waiting in the ED, what was the effect on patient satisfaction?
    A. There was no effect.
    B. Patient satisfaction decreased at the next quarterly measurement.
    C. Patient satisfaction increased at the next quarterly measurement.
    D. Patient satisfaction increased, but not until eight months had passed.

COMING IN FUTURE MONTHS

- EMTALA's stance on dispatching ambulances
- Chest pain accreditation: Worth pursuing?
- Keep your ED running smoothly during renovation
- In-house billing analyst generates revenue

23. According to Jeffrey Stoddard, MD, FAAP, senior director of medical affairs with MedImmune Vaccines, what are the contraindications for ED staff using the live virus flu vaccine?
    A. There is no contraindication; ED staff may use the live virus flu vaccine.
    B. The live virus flu vaccine is contraindicated for all ED staff.
    C. The live virus flu vaccine is contraindicated only for ED staff older than 50.
    D. The live virus flu vaccine is contraindicated for ED staff only for this first year of availability.

24. According to the final EMTALA rule, who may screen patients at the door to turn away those who clearly do not have an emergency medical condition and who are not requesting emergency care?
    A. Any ED staff
    B. Only an emergency physician
    C. Any nurse
    D. Any "qualified medical personnel"

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

CE/CME objectives

- Discuss and apply new information about various approaches to ED management. (See *"ED is hotbed for lawsuits; take simple steps to address riskiest conditions"* and *"Chest pain treatment options increase liability"* in this issue.)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *"EMTALA Q&A"* and *"CMS issues guidance on interpreting EMTALA."*)
- Share acquired knowledge of these developments and advances with employees. (See *"Cross-training your staff necessitates caution"* and *"Success: Clerical staff are cross-trained as ED techs."*)
- Implement managerial procedures suggested by your peers in the publication. (See *"Take tip from restaurants to ease waits, ED advises"* and *"Flu season severe: FluMist may pose little risk."*) ■