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IN THIS ISSUE

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Perform abdominal assessment, or risk missing life-threatening trauma injury

Don't allow 'invisible' injuries to escape detection in your ED

When a trauma patient comes to your ED, are head and extremity injuries the first thing on your radar screen?

"Nurses often look for obvious trauma and forget to assess the abdomen — sort of like the saying 'out of sight, out of mind,'" says **Kelly Arashin**, RN, CEN, night charge nurse and trauma coordinator for the ED at Hilton Head (SC) Regional Medical Center. "To rule out injuries, don't forget what's going on inside."

Abdominal injury is a leading cause of death for adult and pediatric trauma victims, according to a new clinical policy from the Dallas-based American College of Emergency Physicians.[1]

"A leading cause of preventable trauma deaths is abdominal trauma, which is why a timely and accurate assessment is so important, particularly in the face of multiple injuries," says **Tim Murphy**, RN, MSN, APN,C, nursing director of the trauma program at Robert Wood Johnson University Hospital in New Brunswick, NJ.

Assessing trauma patients from head to toe, including the abdomen, will give you potentially life-saving baseline information, underscores Arashin. "What if the patient has a soft belly when he first arrives, then starts complaining of pain an hour later, and now he has a board-like abdomen and no bowel sounds — or vice versa?" she asks. To assess abdominal trauma, do the following:

1. Assess for bowel sounds and rigidity. These could indicate bleeding into

EXECUTIVE SUMMARY

You must assess trauma patients for life-threatening abdominal injuries, which is a leading cause of preventable trauma deaths.

- A good assessment will give you potentially life-saving baseline information.
- Focused abdominal sonograph for trauma is a quick and accurate way to assess for intra-abdominal bleeding.
- Only abdominal computed tomography scan can detect a retroperitoneal injury.

the abdomen from vital organs, or intestinal injuries, says Arashin.

2. Look for abrasions or contusions. "If there are contusions, you have to rule out any internal injuries, such as ruptured organs or bleeding from the liver or spleen," she says.

3. Place a Foley catheter to assess for bleeding. Blood in urine from a catheter specimen can indicate kidney or bladder injury, Arashin advises.

4. Check for occult blood in stool. Blood in stool may indicate intestinal and colon injuries from lower abdominal trauma, such as from use of a lap belt, she says.

To improve care of abdominal trauma patients, use the following current recommendations for diagnostic tests:

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• Focused abdominal sonograph for trauma (FAST).

The FAST is a noninvasive procedure and can be done at the patient's bedside within minutes, says **Steve Rasmussen**, RN, of Virginia Commonwealth University Medical Center in Richmond. The ED uses a Hitachi EUB-525 ultrasound system, manufactured by Twinsburg, OH-based Hitachi Medical Systems.

"It's portable, and there is relatively little training needed when compared to reading [computed tomography] scans," he says. The test is used to determine whether patients can be observed in the ED, admitted, or transported to a larger facility, he explains. Here are the steps that occur at Virginia Commonwealth:

— If the FAST is negative, the patient is observed in the ED or admitted with serial exams to ensure the patient remains asymptomatic. An elective CT may be ordered.

— If the FAST is positive and the patient is stable, he/she goes to CT.

"The CT will demonstrate damage to solid organs, presence of fluid, and damage to surrounding bony structure," says Rasmussen.

— If the FAST is positive and the patient is unstable, the patient usually goes to the OR for an angiogram. Whether the patient goes to the OR depends on the amount of fluid and the solid organ involved, says Rasmussen. For example, a liver injury would require OR intervention, unless the laceration was a grade 4 or 5, in which case an angiogram would be obtained for possible cauterization of the bleed, he explains.

However, FAST shows only the presence of fluid, without differentiating the type of fluid, says Rasmussen. "This could mean blood or free fluid such as ascites, urine from a ruptured bladder, or fluid in the pelvis of a female patient during her cycle," he notes.

FAST can help evaluate the trauma patient for fluid around the pericardium, around the liver or spleen, and the urinary bladder, says Murphy.

At Akron (OH) General Medical Center, a FAST scan of the abdomen is done within five minutes of the patient's arrival with a SonoSite ultrasound machine (manufactured by Bothell, WA-based SonoSite), says **Bill Woods**, RN, BSN, an ED nurse at the facility.

"This gives a very quick and accurate look at the abdomen for any gross amount of intra-abdominal bleeding," he reports. "If positive, a diagnostic peritoneal lavage may be performed, or the trauma surgeon may choose to go directly to the OR for exploratory surgery."

ED nurses ensure that the equipment is ready to go the instant the patient arrives, says Woods. This includes making sure the machine is properly charged, checking the paper to make sure it is full for printed images, checking that ultrasound gel is filled and with the

SOURCES

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machine, and possibly turning the lights off for improved visibility, says Woods. "We also use the SonoSite in a full arrest situation to check for cardiac activity, as even heart valve movement can be visualized at times," he says.

• Diagnostic peritoneal lavage (DPL).

"DPL is the old gold standard, but the FAST is now becoming the new gold standard for rapid assessment of intra-abdominal bleeding," says Rasmussen.

Robert Wood Johnson University Hospital uses DPL much less often than in the past, reports Murphy. "While it will show that there is bleeding in the peritoneum, it is nonspecific in the sense that it does not tell you what is bleeding," he says.

However, DPL still may be a useful exam in the hemodynamically unstable patient, Murphy adds.

• Abdominal CT scan.

Currently, abdominal CT is the "gold standard" diagnostic test for hemodynamically stable trauma patients at risk for blunt abdominal trauma, says Murphy.

Unlike the FAST scan, a CT scan requires oral and injectable contrast, notes Rasmussen. "If you have a patient with a kidney injury, it can further complicate your situation," he explains. "Injectable contrast can be toxic to renal patients, but contrast is still given, since the renal artery is generally where the injury occurs." Also, CT is a poor indicator of diaphragmatic injuries, and these may be missed, he says.

With the new scanners, a quick, high-resolution image can be obtained to assess injury severity, says Murphy. Recently, he treated a 30-year-old male unrestrained driver after a motor vehicle collision. The man sustained multiple injuries of the chest and abdomen, including a flail chest, splenic laceration, and liver injury.

The use of abdominal CT allowed the patient, who was hemodynamically stable, to be treated without surgery, says Murphy. "The patient was managed on a ventilator for the flail chest for several days, but an abdominal operation was avoided and probably led to a reduced length of stay," he says.

The patient was subsequently discharged to a rehabilitation facility and has had a good outcome, reports Murphy. "Since a DPL and FAST exam are nonspecific, they would have most likely been positive and led to an operation," says Murphy. "Since we were able to assess the severity of internal injury, the decision could be made to treat the patient nonoperatively."

The CT scan provides a high-resolution image that allows you to noninvasively determine what organs are injured and assess the severity with a reasonable amount of reliability, notes Murphy. "The other tests will tell us that there is a problem in the peritoneum, but not where or how bad,' he explains. "They also don't tell us anything about the retroperitoneum."

Only the CT scan is useful in detecting a retroperitoneal injury, says Murphy. "Both the FAST and the DPL could lead to a missed diagnosis," he adds.

Reference

1. American College of Emergency Physicians. Clinical policy: Critical issues in the evaluation of adult patients presenting to the emergency department with acute blunt abdominal trauma. *Ann Emerg Med* 2004; 43:278-290. ■

Education is the key for switch to 5-level triage

Be sure your 'go live' day isn't a disaster

(Editor's note: This is the second of a two-part series on switching to a five-level triage system. This month, we'll cover effective strategies to avoid problems during the transition. Last month, we covered how to choose the right five-level system for your ED.)

When you picture the day your ED makes the switch to five-level triage, do you have visions

EXECUTIVE SUMMARY

Effective education of nursing staff is key for your five-level triage system switch to be successful.

- Have a small group of experienced nurses train others.
- During the training period, have one nurse act as a resource person at triage.
- Allow nurses to sit and observe the use of the new system.

of confused nurses, mistriaged patients, and a chaotic waiting room? Unless you take the correct steps to prepare nursing staff, these gloom-and-doom scenarios will occur.

For most EDs, switching to five-level triage no longer is a question of if, but when. A task force formed jointly by the Des Plaines, IL-based Emergency Nurses Association (ENA) and the Dallas-based American College of Emergency Physicians (ACEP) recently recommended that EDs switch to five-level triage, but did not endorse a specific system. It is not yet known if the task force will ultimately recommend a specific system. To ensure a smooth transition during your ED's switch to five-level triage, follow these steps:

• Choose a core group of nurses to train others.

At St. Joseph's Hospital and Medical Center in Phoenix, eight experienced ED nurses were given materials on the five-level Emergency Severity Index (ESI) and charged with becoming experts on the new triage system.

"We created a core triage group that learned the new system and only worked triage for three months," says **Kim Flanders**, RN, BSN, CEN, clinical nurse manager for emergency services.

During this period, the eight nurses were taken out of the regular ED schedule to train the second "ring" of ED nurses. "We have just completed the training of this group. Our intent is to continue training in this method until all staff have been provided hands-on training in the new system," she reports.

From the second group, more experienced nurses will again be asked to train another group of nurses, and so on.

"I will again be taken out of the count to mentor this group, but only for two weeks this time," says **Susan Jackson**, RN, one of the eight ED nurses who trained the first group. "By the time I get to the next group, some of the nurses I am training now will be ready to take on the role of the training nurse, and so on."

This way, all new nurses hired throughout the year will be trained, and recently trained nurses will have enough time to become comfortable with the new system before they begin to triage patients, she adds.

• Show nurses the benefits in a concrete way.

Jackson and the nursing educator held three-hour classes on the ESI, with nurses asked to rate the acuity of 15 sample patients and compare their assigned triage levels using a three-level triage system with the group.

"I asked them to go around the room and call out what acuity they got for each question," says Jackson. "This exercise was very powerful, because it showed the huge variance you can get even in a small group [with the three-level system]."

Next, the nurses were asked to give the acuity levels of another 15 sample patients, but this time, the nurses used the ESI system as a guide. "In each and every class, everyone was 100% in agreement with the answers," reports Jackson.

• Have an additional nurse at triage during the training period.

After the first group of nurses was trained, Jackson exclusively worked triage for a month, acting as a full-time troubleshooter and resource person at triage. "They each got one eight-hour day with me. During that time, I worked alongside them as their own personal educator," she says. "Being right there on the spot, I could answer questions as they came up."

As these nurses gained enough experience, they were able to function as a "first nurse" at triage, to back up a second nurse who was learning the process, explains Jackson. "If nurses were working triage and trying to learn the system at the same time, it would become too difficult," she says.

Jackson is going to hold the triage course on a quarterly basis, each time being taken off the schedule for

SOURCES

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two weeks to train nurses. "Our manager has made this a compulsory course, so by running it every four months, we should catch all the new staff," she says.

• Have nurses observe for a period of time.

Before nurses actually use the five-level system, Jackson recommends having them sit and watch the process for a few days.

"I found it difficult to teach them why I was asking certain questions and how I came to the decisions I did about the ESI level," she says. "I found that if nurses just watched and listened, they could soon pick it up."

The benefits of five-level triage already are becoming obvious, says Jackson. "We have decreased our waiting times significantly," she reports. "We're finding that our sicker patients are now being more satisfactorily recognized and therefore being seen quicker." ■

What can you legally tell patients about delays?

Avoid EMTALA violations: 6 tips

Are you ever tempted to tell a patient with a sore throat who comes to your ED on a busy Saturday night that he'll most likely be there in the morning, still waiting to be seen? What about if a woman with a headache asks you if she'll make it home in time to pick up the kids at school — and you take one look at the crowded waiting room and know the answer is "no"?

Getting specific about wait times can result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA), warns **Shelley Cohen**, RN, CEN, educator for Hohenwald, TN-based Health Resources Unlimited, a consulting company specializing in nursing education.

Cohen recommends that you check all policies related to EMTALA with your risk manager and/or legal counsel.

"If it can be in any way construed, even if you did not intend so, that they left because you implied that they would have to wait awhile, you are a setup for an EMTALA citation," warns Cohen. "That is the bottom line."

However, a shrug or "I don't know" response won't do any wonders for your patient satisfaction scores. At Harris Methodist Hospital in Bedford, TX, a question on satisfaction surveys asks patients, "Did you get clear, complete explanations about delays?" says **Linda Russell**, RN, ED manager. "The scores showed the patients were not told why there are delays," Russell says. "This is an area that needs improvement, according to our satisfaction scores."

To keep patients informed without violating EMTALA, do the following:

• Use scripted replies.

Cohen recommends having scripted messages on hand to refer to. "You don't have to recite them verbatim — you can and should impart your own personality," she says. **(See sample scripted replies on p. 78.)**

The important thing is that all ED nurses are consistent in the information conveyed to patients, explains Cohen. "You may use different words to describe it, but the message should be the same 24 hours a day, seven days a week," she says.

• Make it personal.

"Say something specific about why the patient came," advises Cohen. For example, you might tell a worried mother, "I understand it is difficult to wait when you have a sick child by your side."

If patients really press you for an answer about delays, find out why, advises Cohen. "Ask, 'Is there another problem we should know about?'" she says. "This is how you find out if there is a baby sitter issue or employer concern."

This information allows you to respond, "Any time you are concerned enough to come to the ED, we always recommend that you stay until your care is completed," says Cohen.

• Explain why you can't predict wait times.

Cohen suggests telling patients, "As you know, because this is an ED, we never know who or what will come through our doors. You can imagine how difficult it is then, to predict how long anybody will have to wait."

• Tell patients what you can do for them while they are waiting.

When patients ask about delays, it's a perfect time to explain standing orders or protocols for laboratory tests, medications, or X-rays, suggests Cohen. You can tell patients: "While you are waiting, we do have

EXECUTIVE SUMMARY

Don't say anything that could be interpreted as encouraging a patient to leave, to avoid violations of the Emergency Medical Treatment and Active Labor Act.

- Be empathetic, but explain why you can't predict wait times.
- Tell patients about standing orders while they are waiting.
- Use scripted replies to ensure a consistent message is given.

What to say when patients ask 'How long?'

Below are sample responses recommended by **Shelley Cohen**, RN, CEN, a member of the Emergency Nurses Association's task force on the Emergency Medical Treatment and Labor Act:

- "We realize it is important for people to know how long they will have to wait to be seen. Being an emergency room makes it difficult to predict waiting times. Please let me know what I can do for you while you are waiting."
- "I understand it is frustrating to wait with a sick child and not know how long it will be before the doctor sees her/him. Would you like me to recheck her/his temperature one hour after she has had the medicine I just gave her?"
- "Although I do not know how long the wait will be, I can tell you that we always have a registered nurse here at triage. So if you should become concerned at any time while you are waiting, we are here to help you."
- "What I do know is, our doctor will see you as soon as possible. While you are waiting, I will be more than happy to recheck your blood pressure and get you a new ice pack. My name is Shelley, and I am the triage nurse." ■

orders from the ED physician to give you medication for your child's fever. I can give you that now," or "A technician will be coming to get you for an X-ray to help speed up the process, so when the doctor does see you, your X-ray already will have been taken."

• Consider EMTALA implications before posting wait time signs.

Some EDs actually post current wait times in their waiting room, but this is a potentially risky practice, says Cohen. "Some have color signals, such as 'When this color is red, the wait time is more than 30 minutes," she says.

It's OK to have a policy to tell patients if the wait time exceeds a certain amount of time, says Cohen. "But if your patients can construe from that information that they may not want to hang around, then you have a problem," she says.

For instance, if you post a sign that says the waiting time is shorter than 60 minutes and you suddenly receive several trauma patients, the sign will be inaccurate and patients may complain, adds Cohen.

Still, some EDs have posted wait times for years and have never had a problem, acknowledges Cohen. "But if you are considering doing this, you've got to involve risk management and hospital legal counsel," she advises.

• Never say anything that could be construed as discouraging patients from waiting.

Avoid mentioning the possibility of the patient leaving unless they bring it up first, says Cohen. For instance, don't tell patients, "If you need to leave, please let me know," unless the patient already has made it clear that he or she might be unable to wait, she explains. "If you tell a patient, "It's going to be a long while before the doctor gets to you," that could be interpreted as encouraging them to leave," she stresses. ■

SOURCES

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Just-surveyed EDs report on new JCAHO process

Have you pictured accreditation surveyors interviewing your newest, least well-spoken nurse about your restraint policy, as part of the new Shared Visions, New Pathways survey process that began in January 2004? Or have you envisioned patient tracers being done for an ED patient where everything that could go wrong, did?

If so, you have plenty of company. "We were anxious about the new process, even though we've done a lot of preparation," acknowledges **Barb Baughman**, RN, director of emergency services at Harford Memorial Hospital in Havre de Grace, MD, which was surveyed in January 2004 by the Joint Commission on Accreditation of Healthcare Organizations. "We didn't know what to expect."

To improve the way you prepare, consider the following reports from just-surveyed EDs:

EXECUTIVE SUMMARY

As part of the new survey process of the Joint Commission on Accreditation of Healthcare Organizations, direct questions will be asked of ED nurses during patient tracers, with an overall emphasis on patient safety.

- Surveyors are looking for consistent answers.
- Be ready to address the 2004 National Patient Safety Goals throughout the survey.
- For a quick reference during surveys, post the ED's core measures data on a bulletin board.

• Make sure every staff member is ready to talk about the 2004 National Patient Safety Goals.

"They touched on every single one of the goals, time and time again," reports **Karol Edwards**, RN, nursing director of the ED at Upper Chesapeake Medical Center in Bel Air, MD. "One way or another, surveyors constantly found a way to bring them up in the conversation."

This should be a top priority as you prepare nurses for survey, emphasizes Edwards. The safety goals were posted on bulletin boards throughout the ED and printed on pocket-sized guides for all nurses, she says. "We talked about them in all of our staff meetings, they were highlighted in mock surveys, and we drilled the nurses on an individual basis," says Edwards.

When you post the safety goals, include an explanation for each about its specific application in the ED, recommends Baughman. **(For more information on this topic, see "New safety goals listed for 2004 JCAHO surveys," *ED Nursing*, September 2003, p. 134.)**

• Surveyors will want to talk to staff nurses.

You won't have a lot of control over whom surveyors talk to, since surveyors will ask to speak with nurses who cared for specific patients, as opposed to formally scheduled appointments with managers, emphasizes Baughman. "In the past, the staff would sort of disappear when the surveyors arrived," she says.

Although Baughman acknowledges supplementing her nursing staff during the survey, she knows that won't be an option when unannounced surveys begin in 2006. "I did put on more experienced nurses instead of new grads for that week, but we won't be able to do that soon," she says. "The moral is, you need continuous education so everyone is always prepared."

However, surveyors are taking a more educational role and often made suggestions to improve compliance, says Baughman. "I felt very relaxed with them," she says. "You didn't feel they were there to try and make you fail."

To prepare nurses for possible questions about core measures, Baughman posted bulletin boards to show the ED's core measure data, including aspirin-on-arrival and door-to-drug times for myocardial infarction, and diuretic administration and brain natriuretic peptide levels for congestive heart failure. "The board was in the unit staff area where nurses could have referred to it for specifics if questions had been asked," she says.

• Give surveyors consistent responses.

During a patient tracer of an orthopedic patient admitted with a hip fracture, the surveyor discovered the woman had come to the ED the previous day with a knee injury and returned the following day with hip pain. "The surveyors wanted to know how we decided whether a physician assistant or physician saw a patient," says Baughman. "They also asked if the patient would be upgraded in their priority level if they came back for a return visit."

After Baughman explained that higher acuity patients are seen by physicians and lower acuity patients are seen by physician's assistants, and that patients with additional or unresolved complaints usually would be bumped up to a higher acuity, the surveyor asked to speak to a triage nurse, gave the scenario, and asked the same questions.

"Thankfully, she gave the same response," says Baughman. "The surveyors were looking for consistent answers. No matter what unit they go to, they want everybody to be saying the same thing."

• Surveyors may ask patients about their ED stay.

The surveyor asked a dialysis patient about his time in the ED, including how quickly he was triaged, how quickly a physician saw him, and how he was treated, says Edwards.

• Be ready to discuss all the details of a patient's care.

While tracing an intensive care unit patient with chest pain who came to the ED by ambulance, the surveyor specifically asked to talk to a *less* experienced nurse. "They wanted a new nurse who was only there for a year or two, but I didn't have any on that day," says Edwards. "They didn't want to talk to me at all."

The surveyor wound up talking to an experienced ED nurse and fired away detailed questions for more than an hour, says Edwards. "It was one question after another to that staff nurse," she says. "She went through the entire process, right up to getting the patient admitted."

The surveyor asked questions such as, "When the patient arrived by ambulance, what did you do? Was the electrocardiogram done within 10 minutes? How did you know it was the correct patient when the medications were given? If you heard the monitor go off, what did you do?"

SOURCES

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"When the nurse said that vital signs were taken, the surveyor showed her the patient's chart and asked where they were listed," adds Edwards.

Although detailed questions do give surveyors ample leeway to branch off into other areas, this makes the survey process more focused on patient care, says Edwards. "It was not intimidating to the nurse or clinical coordinators involved," she says. "It was an opportunity to brag about the great care that we give." ■

Are you putting patients at risk during transport?

Critical care patients being held in your ED for hours at a time are probably a familiar sight. You're probably aware of the increased patient care needs these patients have, such as additional monitoring and assessment. But there is another factor putting these patients at risk: The chance of severe injury or death during transport for diagnostic tests such as computed tomography (CT) scans and magnetic resonance imaging (MRI).

"Our protocols for transporting patients for the ED to a diagnostic area are based on Murphy's law of emergency medicine: If your patients are going to crash, they will do it in the area [where] you are least prepared to handle it," says **Teri Howick**, RN, nurse educator for the ED at McKay Dee Hospital in Ogden, UT.

EXECUTIVE SUMMARY

Critically ill or injured patients transported for diagnostic tests are at increased risk for adverse outcome.

- Bring life-saving supplies on transports.
- Monitor patients during diagnostic procedures.
- Perform tests at the bedside if at all possible.

New recommendations for patient transport from the American College of Critical Care Medicine and the Society of Critical Care Medicine, both based in Des Plaines, IL, give specific practice changes ED nurses must make to avoid problems. The transportation guidelines recommend a plan to address pre-transport communication and coordination, transport personnel and equipment, patient monitoring during transport, and documentation.[1] **(See resource box on p. 81 to obtain complete guidelines.)**

To avoid adverse outcomes during patient transport, do the following:

• Require a "patient passport."

At Caritas Holy Family Hospital and Medical Center in Methuen, MA, ED nurses complete "passports" for all patients requiring transport for diagnostic testing, says **Laura Crawford**, RN, BSN, director of emergency and ambulatory nursing. The passport documents patient identifiers, allergies, whether the patient must be transported with a nurse, and the name of the nurse and physician caring for the patient.

"The transporter cannot move a patient out of the department without the passport," Crawford says.

The transporter signs the passport and documents verification of the correct patient to be transported, says Crawford. "In addition, the technician in the ancillary department uses this to identify that they have the correct patient for diagnostic testing," she says.

The following patients are required to have a nurse accompany them:

— all trauma patients traveling to CT scan;

— all patients in cervical spine immobilization;

— any patient with a triage acuity level of one or two on the ED's five-level system;

— any patient requiring cardiac monitoring.

In addition, documentation of vital signs during transport and testing is required, says Crawford.

• Have immediate access to lifesaving supplies.

When nurses transport patients from the ED, a portable monitor is used to watch vital sign trends, and two bright orange tackle boxes marked "airway box" are brought, says Howick. The first contains airway management tools, and the second is a drug box with advanced cardiac life support medications. "These are stowed under the stretcher 'just in case.'" says Howick. **(See list of contents on p. 81.)**

These supplies saved the life of a young man with a tricyclic overdose who was tachycardic, recalls Howick. "He seized on the elevator on the way to the ICU, and

Bring lifesaving items on patient transports

Here is a listing of the supplies contained in the drug and airway boxes carried by ED nurses transporting patients for diagnostic tests at McKay Dee Hospital in Ogden, UT.

• **Drug box:** one sodium bicarbonate, one 50% dextrose, two atropine, three epinephrine, two lidocaine boluses, flumazenil, naloxone, oral airways, extra defibrillator gel pads, and intravenous (IV) 1,000-cc normal saline with IV tubing and IV start kits.

• **Airway box:** lidocaine jelly; 10 cc syringes; Magill forceps; 6 French and 14 French stylets; laryngoscope handle, large and small; variety of laryngoscope blades; laryngoscope light bulbs; instrument tray; twill tape or endotracheal tube holder; adhesive tape; Luki trap; endotracheal tubes 5-10; cotton swabs; 10 French and 14 French suction catheters; vial normal saline; medical adhesive; jaw screw; arterial blood gas kit; micro arterial blood gas kit; sterile gloves; oral airways; cushion mask; nasal trumpet; size C and AA batteries; bite block; and Yankauer suction. ■

we used the airway kit to intubate him and the bicarb to stop the seizing," she says. "He was truly a save."

At Memorial Hospital in Colorado Springs, CO, the ED and all receiving areas have "difficult airway boxes" containing laryngeal mask airways, self-inflating bags, and special laryngoscopes for adults, pediatrics, and neonates ready on a moment's notice if needed during transport, says **David Lucero**, RRT/BS, clinical coordinator for transport care services.

• Use portable phones.

Patient transporters always carry a portable phone so they can be immediately be reached throughout the hospital, he says. If a patient is seizing or apneic, the transporting nurse can call the receiving unit to let them know blood needs to be ordered or a ventilator set up, or a code team can be called to respond if there is a problem, says Lucero. "In some special procedure rooms, there is not a phone available," he notes.

• Monitor patients during procedures.

While in the diagnostic area, the monitor always is placed where the nurse can see it without entering the room, says Howick. "When necessary, the nurse will don a leaded apron and stay with the patient during the procedure," she adds.

• Perform procedures at the bedside whenever possible.

Howick recalls an elderly farmer with blunt trauma to the abdomen who had stable vital signs, who was being transported by wheelchair for an ultrasound before bedside testing was done. "I was noticing the top of his head, which was getting paler, then cyanotic. I kept chatting with him, and suddenly there was no reply," she recalls. "Had I been able to see his face, I would have known he'd become unconscious. He was in cardiac arrest when we reached the X-ray department."

If at all possible, you should perform diagnostic testing at the bedside, urges Howick. "Any procedures that can be done at the bedside, are," she says. "Most X-rays and ultrasound can be brought to the patient."

Reference

1. Warren J, Fromm RE, Orr RA, et al. Guidelines for the inter- and intrahospital transport of critically ill patients. *Crit Care Med* 2004; 32:256-262. ■

SOURCES/RESOURCE

For more information about transporting patients for diagnostic testing, contact:

• **Laura Crawford**, RN, BSN, Director of Emergency and Ambulatory Nursing, Caritas Holy Family Hospital and Medical Center, 70 East St., Methuen, MA 01844. Telephone: (978) 687-0156, ext. 2128. E-mail: Laura_Crawford@cchcs.org.

• **Teri Howick**, RN, Nurse Educator, Emergency Department, McKay Dee Hospital, 4401 Harrison Blvd., Ogden, UT 84403. Telephone: (801) 387-2286. Fax: (801) 387-2244. E-mail: teri.howick @ihc.com.

• **David Lucero**, RRT/BS, Clinical Coordinator/ Transport Care Services, Memorial Hospital, 1400 E. Boulder St., Colorado Springs, CO 80909. Telephone: (719) 365-5615. E-mail: David.Lucero @memhospcs.org.

The American College of Critical Care Medicine and the Society of Critical Care Medicine developed guidelines for transport of critically ill patients. The complete guidelines can be downloaded free of charge on the Society of Critical Care Medicine's web site (www.sccm.org). Click on "Professional Resources," "Guidelines," "Table of Contents," and "Guidelines for the Inter- and Intrahospital Transport of Critically Ill Patients."

Is your ED unsafe? Make these changes now

Do you worry about unsafe staffing levels, a shortage of experienced nurses, a lack of trust between administration and staff, long work hours, and systems that don't promote safety and efficiency? If so, you have new ammunition to call for dramatic changes in your ED.

A 2004 report from the Washington, DC-based Institute of Medicine, *Keeping Patients Safe: Transforming the Work Environment of Nurses* gives specific recommendations to avoid adverse outcomes.

"Emergency nurses have been talking for years about the issues in this report and will feel supported by these recommendations that are designed to improve the workplace," says **Linda F. Yee**, RN, MSN, CEN, former chair of the Emergency Nurses Association (ENA) patient safety workgroup.

The report cites compelling research that links nursing conditions with patient safety. "It is hard to argue with the evidence found in these studies," she says.

Here are key recommendations:

• Empower direct care nursing staff to determine staffing levels, regulate the unit work flow, and develop methods to allow for variability in patient volume and acuity. "EDs should incorporate systems such as ENA's 'Guidelines for Emergency Department Nurse Staffing' to ensure appropriate staffing levels," says Yee. **(See resources box, below left, for more information.)**

• Require budgetary allowances equal to a defined percentage of nursing payroll to support education and skill development for nurses and assistive personnel. "EDs must have resources to provide routine, ongoing patient safety education for staff which includes special training in error detection, analysis, and reduction," says Yee.

• Change your ED from a punitive environment to one that encourages reporting of errors, both actual and near misses. "EDs should institute rewards and incentives for error reduction," she advises. "Staff must feel safe in reporting errors so systems can be designed to prevent errors from recurring." ■

SOURCE/RESOURCES

For more information about nursing conditions and patient safety in the ED, contact:

- **Linda F. Yee**, RN, MSN, CEN. E-mail: LindaFYee@aol.com.

A paper copy of the Institutes of Medicine report, "Keeping Patients Safe" costs $44.95 plus $4.50 shipping charge. To order, contact: The National Academies Press, 500 Fifth St. N.W., Lockbox 285, Washington, DC 20055. Telephone: (888) 624-8373 or (202) 334-3313. Fax: (202) 334-2451. E-mail: zjones@nas.edu. Web: www.nap.edu.

To order the Emergency Nurses Association's Guidelines for Emergency Department Nurse Staffing, go to www.ena.org. Click on "Marketplace" and "The ENA Staffing Best Practices Tool and Guidelines." The cost is $500 for nonmembers or $100 for members.

Shave up to 15 minutes off treatment of chest pain

Would you like to cut door-to-treatment times for patients with acute coronary syndrome and acute myocardial infarction by up to 15 minutes? Put together a "Chest Pain Tackle Box," recommends **Marilyn Swinford**, RN, director of emergency and outpatient services at Saint Joseph Hospital in Lexington, KY.

These patients require rapid intravenous (IV) line access and medications at the onset of their treatment and diagnosis pathway, she says. To speed the process, "one-stop access" to supplies is needed, she says. "The automated medication dispensing system in our ED contains essential supplies as does our supply system, but each would require separate selection and removal," says Swinford. "This takes considerable time and removes staff from the bedside to the med room."

To address this, a portable tackle box containing all necessary supplies for chest pain patients was put together. The box contains IV supplies including prep kits, IV catheters and start kit, primary IV tubing, syringes, and nitroglycerin set. Medications include reteplase, heparin for bolus and infusion, nitroglycerin infusion, D5W normal saline, aspirin, atropine, atenolol, and metoprolol. A numbered breakaway plastic lock ensures that the box has all its required contents, as long as the lock is not broken.

When a patient is admitted or transferred to the cardiac catheterization lab, ED nurses return the box to the pharmacy, exchanging it for a replacement kit so the ED is never left without a box. "Pharmacy then replenishes the medications and central distribution replenishes the IV supplies, and the patient is only charged for those items used," says Swinford.

A sticker is affixed to the box listing the expiration date of medications, the name of the pharmacist and technician who filled the box, the date checked, and the lock number.

"The staff retrieves this box upon arrival of an acute coronary patient and proceeds to remove IV and medication supplies as indicated," says Swinford. "The nurse remains at the bedside communicating with the patient while initiating care with first-line therapy."

[Editor's note: For more information, contact Marilyn Swinford, RN, Director, Emergency and Outpatient Services, Saint Joseph Hospital, Lexington, KY 40504. Telephone: (859) 313-1672. E-mail: marilyn_p_swinford @sjhlex.org.] ■

ED saves $150,000 by using fewer agency nurses

With an ever increasing nursing shortage coupled with increased patient volumes, you may believe it's impossible to cut labor costs in your ED. "Not so," says **Laura Guerrieri**, RN, MBA, director of emergency services at Gottlieb Memorial Hospital in Melrose Park, IL.

"By focusing on reducing staff turnover and placing yourself in a continual state of recruitment, it is possible to win the battle against excessive use of overtime and contract labor," she says.

She reports that the ED cut its agency staffing costs from $196,000 in 2001 to $51,000 in 2003.

Here are the changes made to achieve this goal:

• Nurses were asked what would keep them from leaving.

"A reduction in turnover reduces contract labor, overtime, and orientation costs," Guerrieri emphasizes. ED nurses were given a 30-question survey to assess what would make them satisfied, with the data analyzed and shared with administration.

Surprisingly, most nurses weren't interested in financial rewards, and instead, really wanted more control over their personal lives and schedules, says Guerrieri. To address this, a 0.9 full-time equivalent (FTE) program with full-time benefits and a flexible work schedule program were implemented. "We also added a last-minute premium program that equates to time and a half, even if you don't work 40 hours," she reports. "This is much less expensive than the cost of agency nurses."

• An extra nurse was hired.

"I would estimate that 95% of all EDs have had at least one staff member per year off for an extended period of time due to illness or have had at least one staff member per year resign," says Guerrieri.

These situations are what force the use of overtime and agency nurses, as there is no way to hire and orient an ED nurse in two or three weeks, she explains. "If you overhire by 1 FTE and create a large supplemental pool, you will not need to utilize agency nurses or extensive overtime to replace staff," she says.

[Editor's note: For more information on decreasing staffing costs in the ED, contact: Laura Guerrieri, RN, MBA, Director, Emergency Services, Gottlieb Memorial Hospital, 701 W. Melrose Park, IL 60160. Telephone: (708) 450-4988. Fax: (708) 681-1545. E-mail: laura_ guerrieri@ghr.org.] ■

COMING IN FUTURE MONTHS

- Steps to dramatically cut door-to-doctor time
- Improve care of patients with alcohol-related injuries
- Foolproof ways to avoid getting named in a lawsuit
- Stop the most dangerous type of drug errors

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE*questions*

After reading this issue of *ED Nursing*, the CE participant should be able to:

- **Identify** clinical, regulatory, or social issues relating to ED nursing. (See *What can you legally tell patients about delays?* in this issue.)
- **Describe** how those issues affect nursing service delivery. (See *Perform abdominal assessment, or risk missing life-threatening trauma injury* and *Are you putting patients at risk during transport?)*
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *ED saves $150,000 by using fewer agency nurses.)*

17. Which diagnostic test is used to assess traumatic injury in the retroperitoneal area?
A. Abdominal computed tomography scan
B. Focused abdominal sonograph for trauma
C. Diagnostic peritoneal lavage
D. Magnetic resonance imaging

18. Which is recommended regarding patients and delays to avoid violations of the Emergency Medical Treatment and Labor Act, according to Shelley Cohen, RN, CEN, ED nursing educator with Health Resources Unlimited?
A. Suggest patients leave and return when convenient.
B. Inform patients whenever the wait is more than 30 minutes.
C. Instruct patients with minor complaints to return when the wait is shorter.
D. Don't say anything to encourage patients to leave.

19. Which is recommended to increase safety of patients during transport from the ED for diagnostic tests, according to David Lucero, RRT/BS, clinical coordinator for transport care services at Memorial Hospital?
A. Monitor patients only during life-threatening emergencies.
B. Bring airway supplies only if you anticipate a problem.
C. Have nurses carry portable phones while transporting patients.
D. Avoid doing ultrasounds at the bedside.

20. Which is an effective way to improve retention and reduce staffing costs in the ED, according to Laura Guerrieri, RN, MBA, director of emergency services at Gottlieb Memorial Hospital?
A. Use increased numbers of agency nurses.
B. Rely solely on agency nurses to fill gaps in the schedule.
C. Underhire nurses by 1 FTE and utilize overtime as needed.
D. Overhire nurses by 1 FTE.

Answers: 17. A; 18. D; 19. C; 20. D.