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Psychiatric patients are flooding EDs: Ensure safety with these solutions

Problem has reached crisis level in emergency departments nationwide

(Editor's note: This is the first of a two-part series on psychiatric patients in the ED. This month, we cover ways to improve care, ensure safety, and maintain throughput. Next month, we give strategies for reducing risks of chemical and physical restraints.)

Patients with psychiatric emergencies are being held in hallways for hours or even days, wreaking havoc on throughput. Delusional patients are assaulting nursing staff. Nurses are unable to care for sick and injured patients because they are required to observe a violent schizophrenic in restraints.

Sound familiar? These dangerous scenarios are commonplace in many EDs, as the number of psychiatric patients skyrockets, report emergency nurses interviewed by *ED Nursing*. According to a recent report from the Hyattsville, MD-based National Center for Health Statistics, 2.05 million ED patients had a chief complaint of psychological or mental disorders in 2002, nearly double the 1.1 million psychiatric patients treated in EDs in 1994.[1]

At Northwest Community Hospital in Arlington Heights, IL, a significant surge in this patient population was first noticed two years ago, with 3,579 psychiatric patients seeking care at the ED in 2003, which was more than a 12% increase over the 3,136 psychiatric patients seen in 2001, reports **Rosemary Kucewicz**, RN, BSN, ED manager. "In the beginning, we thought it was just us," she says. "Now

EXECUTIVE SUMMARY

Psychiatric patients are dramatically increasing in EDs, severely impeding patient flow, and putting staff and patients in danger, according to ED nurses nationwide.

- Track numbers of psychiatric patients to show the need for additional resources or practice changes.
- Move patients being held in the ED to inpatient hallways when certain volumes are reached.
- Use standing orders so medications can be given without delay.

we know all parts of the country are struggling with this." As hospitals close inpatient units and beds in state facilities decrease, more and sicker psychiatric patients are seeking care in EDs, she says.

At St. Rose Dominican Hospital's ED in Henderson, NV, psychiatric patients have increased by approximately 30%-40% in the past few years, estimates **Pamela S. Rowse**, RN, quality/risk consultant and former assistant nurse manager for the ED and hospital representative for the Southern Nevada Coalition for Mental Health.

Reductions in state funding have "created a monster," Rowse says. "If you are an average 25-bed ED holding anywhere from five to 10 psychiatric patients at a given time, that is consuming 20%-40% of your bed capacity, not to mention nursing resources and ancillary services," she says. "This compounds our already critical capacity problem a hundredfold."

The influx of psychiatric patients is having an adverse impact on the care other patients receive, reported 60% of 340 ED physicians surveyed by the Dallas-based American College of Emergency Physicians (ACEP) in 2004.[2]

In Rowse's conversations with nurses about this problem, they repeatedly convey this message: "We can't give them what they need."

"These patients need acute psychiatric intervention, not sitting around in special gowns eating — and watching TV," she says. "This can endanger not only us, but the rest of our patients." **(See steps taken by the ED to ensure safety, p. 111.)**

To dramatically improve care of psychiatric patients in the ED, do the following:

• Track psychiatric patients.

"Though I am quite positive that over the past several years we have had quite a large increase in psychiatric patients, the sad truth is that we have no statistics to back it up," says **Annia Taylor**, RN, BSN, ED nurse at Durham (NC) Regional Hospital.

The health care system doesn't track numbers or percentages of patients presenting to the ED with various complaints, she explains.

The ED is in the process of rewriting its psychiatric protocols and revamping the way these patients are cared for, reports Taylor. "It is obvious to us that problems will ensue if we do not," she says. "However, as we have tried to change things, not having statistics to back up the need for these changes has been a problem when dealing with upper management and getting the needed support."

At triage, an additional information sheet with a basic psychiatric history is now completed. "We hope to be able to make a record of these triage sheets and collect data on numbers of patients, as well as look at other trends and characteristics such as the numbers of suicidal patients," says Taylor.

At St. Rose Dominican, charge nurses complete productivity sheets listing numbers of psychiatric patients and their length of stay for every shift, with monthly data reported electronically to the Southern Nevada Mental Health Coalition.

"This tracks not only numbers but 'repeaters,'" reports Rowse. Recidivism is rampant in the mental health diagnostic group, she says. "Tracking of the 'frequent flyers' will boost our case with the state legislature to show that there are insufficient outpatient services for this patient population," Rowse says.

• Maintain patient throughput.

According to the ACEP survey, psychiatric patients routinely are being held in EDs twice as long as other patients.[2] If even a single patient is held for three days in the ED, that means that 72 hours of nursing care

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

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Editor: **Staci Kusterbeck**.
Vice President/Group Publisher: **Brenda Mooney**.
Senior Managing Editor: **Joy Daughtery Dickinson**, (joy.dickinson@thomson.com).
Senior Production Editor: **Nancy McCreary**.

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SOURCES

For more information on caring for psychiatric patients in the ED, contact:

- **Rosemary Kucewicz**, RN, BSN, Manager, Emergency Department, Northwest Community Hospital, 800 W. Central Arlington Heights, IL 60187. Telephone: (847) 618-4010. E-mail: rkucewicz@nch.org.
- **Pamela S. Rowse**, RN, Quality/Risk Consultant, Emergency Department, St. Rose Dominican Hospital — Rose de Lima Campus, 102 E. Lake Mead Drive, Henderson, NV 89015. Telephone: (702) 616-5548. Fax: (702) 898-6381. E-mail: wownurse@aol.com.
- **Annia Taylor**, RN, BSN, Emergency Department, Durham Regional Hospital, 3643 Roxboro Road, Durham, NC 27704. E-mail: annia taylor@yahoo.com.

and resources are taken up, says Rowse.

This patient isn't the same as the one on the medical/surgical floors, she says. "We're talking about an individual that has the potential for violence and self-destruction," she says. "Patients can bolt at any time and possibly injure or kill themselves as well as others."

Patients must have sitters to ensure safety, with some requiring 1:1 observation to help reduce the time that they are in restraints, in addition to ongoing nursing care requiring frequent medication administration and assessments, says Rowse.

"When you are using all these resources on psychiatric holds, what is left for the other ill and injured patients?" says Rowse. To improve patient flow, the ED implemented a "capacity alert" system, activated by specific volume and acuity triggers.

"Code Lavender" is the first stage and calls for early interventions by all hospital departments to free inpatient beds. If this action isn't enough to break up the bottleneck, a "Code Purple" is implemented, which results in elective surgeries being rescheduled and ED "hold" patients moved to hallways upstairs on the inpatient units.

• Take steps to discourage elopement.

The needs of the psychiatric patient are easily overlooked in a busy ED, notes Taylor. "These patients often sit in the ED for many hours before admission or transfer to a mental health facility," she says. "It is during these long wait times that patients are at highest risk for elopement."

Many depressed and potentially suicidal psychiatric patients have left the ED without treatment, which presents a possible liability risk for the hospital, says Taylor.

She recommends having a trained sitter or nursing assistant remain with the patient, or providing patients with materials such as books, music, and movies to pass the time. Taylor points to a study that showed ED psychiatric patients who were kept occupied during the long wait were more satisfied and perceived their wait time as being less.[3]

• Implement "psychiatric hold orders."

"One of the things that we have learned in our trials and tribulations is that most of these patients escalate because they haven't taken their psychiatric medications, either because they can't afford them or because they have poor outpatient support services," says Rowse.

Standardized psychiatric hold orders allow for immediate administration of medications and medical management of patients. The orders address nicotine patches, prevention of deep venous thrombosis from immobilization, and dietary needs. "We discovered that the better our baseline management is, the less likely restraints will be needed," she says.

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Take these steps to keep staff and patients safe

In light of increasing numbers of psychiatric patients at St. Rose Dominican Hospital in Henderson, NV, the following steps were taken to ensure safety of ED patients and staff:

— A hotline links the ED with the police department for immediate response. After obtaining approval from the local police department for the phone line to come directly into their dispatch, the only cost involved was for installation of a dedicated phone line, which was done in-house.

— ED charge nurses, a nurse educator, and security officers attended a four-day training session on defusing potentially violent situations, given by the Brookfield, WI-based Crisis Prevention Institute at a cost of

$1,100 per person. Upon their return, these individuals then trained the entire ED staff.

— Two-way radios were purchased for $250 apiece that connect directly with security. The radios are positioned in the middle of the nursing station and easily accessible by unit secretaries, physicians, nurses, and volunteers.

— A "Code Gray" policy is being implemented for immediate response by security and engineering staff for an out-of-control individual.

— A training packet was created for ED staff to improve care of psychiatric patients with policies on suicide precautions, assessment, and contracting with patients for safety. The policy includes detailed instructions for sitters observing high-risk patients, such as never taking your eyes off the patient and reporting increased agitation to the ED nurse in charge of the patient's care.

— Psychiatric patients are kept in an isolated area whenever possible, with certified nursing assistants acting as mandatory sitters and reporting directly to the patient's ED nurse. The sitters also perform tasks such as taking patients' vital signs and assisting with bathing and personal hygiene. All efforts are made to ensure that items that could cause danger to anyone are not allowed within the patient's reach.

— Patients are unclothed, including removal of shoes and socks, and put into special colored gowns for easy recognition. ■

Want to stop IV drug errors? Use these proven strategies

A nurse pulls out a 10,000 units per cc concentration of heparin for a cardiac patient — double the correct dosage.

Did this patient get twice the dose of heparin, resulting in bleeding complications? No, because the dosage was double-checked by a second ED nurse, so the error never occurred, reports **Sharon A. Graunke**, RN, MS, CEN, TNS, ED clinical nurse specialist at Elmhurst (IL) Memorial Hospital.

This near-miss underscores the importance of having effective systems in place to prevent errors with intravenous (IV) medications, she notes. "IV medications are a little riskier because the dosage needs to be calculated, whereas pills are usually unit dose," she explains. "Also, IV meds get into the system faster."

To prevent IV drug errors in your ED, take these steps:

• Check calculations for all admitted patients.

EXECUTIVE SUMMARY

Errors with intravenous (IV) drugs may occur in the ED due to mistakes in dosage calculations, and they potentially can cause great harm to patients.

- Verify that calculations and programming for IV pumps are correct before admitted patients are discharged.
- If you suspect an order may be incorrect, do not give the medication until it is verified.
- Double-check insulin and heparin boluses before administering.

At Harris Methodist Hurst/Euless/Bedford (TX) Hospital, a charge nurse now double-checks IV pump settings and calculations for every admitted patient before they leave the ED, reports **Linda Russell**, RN, ED manager.

"At the same time, the charge nurse takes the opportunity to verify patient identification bracelets, documentation of weight in kilograms, correct labeling of all chart documents, and complete documentation," she adds.

• Use an automated medication dispensing system.

"This cuts down on grabbing the wrong medication," says **Karen Donnahie**, RN, ED nurse at St. Mary's Hospital in Grand Junction, CO. "However, potentially lethal medications such as potassium aren't even kept in the unit and must be ordered from pharmacy."

• Intervene if you believe an order is incorrect.

If you suspect an order is wrong, the first thing to do is look it up or call the pharmacist for clarification, says Donnahie. If you still are unsure or if the order is blatantly wrong, question the physician about the order, but never give a medication you are uncomfortable with, she advises.

"None of us is perfect," Donnahie says. "If the order is unchanged and remains unclear or unsafe, the nurse can and should refuse to give the medication."

When a resident ordered 1.2 million units of penicillin to be given IV, Donnahie caught the error. "The antibiotic he ordered was an opaque, thick suspension that is indicated for deep intramuscular injection only," she says. Injecting this intravascularly can result in severe neurovascular damage, including transvese myelitis with permanent paralysis, gangrene that may require amputation, or edema requiring fasciotomy, she adds.

As an ED nurse, you must know why, what, and how much of a medication is being given, she stresses. "I think nursing knowledge is the biggest medication-error

SOURCES

For more information on preventing intravenous drug errors, contact:

- **Karen Donnahie**, RN, Emergency Department, St. Mary's Hospital, 2635 N. Seventh St., P.O. Box 1628, Grand Junction, CO 81502-1628. Telephone: (970) 244-2818. E-mail: ksd2go @hotmail.com.
- **Sharon A. Graunke**, RN, MS, CEN, TNS, Clinical Nurse Specialist, Emergency Department, Elmhurst Memorial Hospital, 200 Berteau Ave., Elmhurst, IL 60126. Telephone: (630) 833-1400 ext. 35564. E-mail: Sgraunk@emhc.org.
- **Linda Russell**, RN, Emergency Department, Harris Methodist Hurst/Euless/Bedford Hospital, 1600 Hospital Parkway, Bedford, TX 76022. Telephone: (817) 685-4729. E-mail: LindaRussell @texashealth.org.

prevention tool we have," she says. "New medications seem to come out daily, and it is difficult to keep on top of each of them; but as professionals, it is up to us to know about the medications we are giving."

To increase your knowledge, Donnahie recommends asking ED physicians why they chose one drug over another, asking about the risk and benefits of a particular medication for a particular illness, and giving inservices on classes of drugs for nurses.

• Use standard concentrations.

Standard concentrations cut down on errors because IV drips are always mixed the same way, such as 50,000 units heparin in 500 cc IV fluid, says Graunke. "We can make up charts based on one concentration instead of having to reconfigure if, for example, someone else mixes up 25,000 units in 500 cc fluid."

Since drip rates are constant, you don't have to worry that someone's calculations are wrong, she says, adding that multiple concentrations of medications have been removed from the ED's automated medication dispenser. "For example, we only have morphine 2 mg syringes instead of both 2 mg and 10 mg," she says.

• Have a second nurse double-check all insulin and heparin boluses.

At Elmhurst Memorial, the procedure is as follows: Insulin and heparin boluses have an order written. The primary nurse draws up the medications, and a second nurse reviews her calculations.

"They look at the bottle she drew up from, the amount in the syringe, and the order that was written to make sure they match," says Graunke. The primary nurse then goes into the room, checks the patient's identification band, and explains what medication she is giving and why.

If another nurse has drawn up a medication, ask to see the vial so you can do your own calculation, she advises. "Otherwise I usually have them give the medication," she says. "Also, if someone hands you a medication, you should always check to make sure they have pulled the correct one. Don't just assume it is correct."

• Repeat verbal orders.

In the ED, there are a lot of verbal orders given with multiple hands on the medications, especially for IV drugs during a code, says Graunke. "One of the ways I try to avoid errors is to repeat the order back to the physician and again to the recorder as I am double-checking the medication that I am ready to give," she says. ■

Are your ED staff at risk for needlestick injury?

OSHA citations have increased dramatically

Are potential violations of the Emergency Medical Treatment and Labor Act high on your "worry list?" Here's another high-risk area that you should add to your list: Occupational Safety & Health Administration (OSHA) citations for violations of the Bloodborne Pathogens Standard (BPS). This standard requires you to take steps to protect health care workers from needle stick injuries.

Citations of health care facilities, including EDs, for BPS violations have increased dramatically in the last few years, according to **Jane Perry**, director of communications for the University of Virginia's International Healthcare Worker Safety Center, based

EXECUTIVE SUMMARY

Citations for violations of the Bloodborne Pathogens Standard have significantly increased, and many EDs have not yet achieved 100% compliance.

- Devices frequently resulting in high-risk injuries to ED staff include butterfly needles and intravenous catheter stylets.
- Ensure newly implemented devices are compatible with existing supplies.
- Encourage nurses to report problems or concerns about sharps safety devices.

SOURCES/RESOURCES

For more information on preventing needlestick injuries in the ED, contact:

- **Jane Perry**, Director of Communications, International Health Care Worker Safety Center, P.O. Box 800764, University of Virginia, Charlottesville, VA 22908-0764. Telephone: (434) 982-3763. Fax: (434) 982-0821. E-mail: janeperry@virginia.edu.
- **Stacey Westphal**, RN, MS, CEN, Clinical Educator, Emergency Services, Cape Canaveral Hospital, 701 W. Cocoa Beach Causeway, Cocoa Beach, FL 32931. Telephone: (321) 868-7651. E-mail: Stacey.Westphal@health-first.org.

- **The National Institute for Occupational Safety and Health (NIOSH)** web site (www.cdc.gov/niosh/topics/bbp) has a variety of free resources pertaining to prevention of needlestick injuries under the headings "Preventing Needlesticks and Sharps Injuries" and "Safer Needle Device Listings."

- **The International Health Care Worker Safety** Center web site (www.healthsystem.virginia.edu/internet/epinet) offers an updated list of safety devices organized by product type. Click on "Safety Device List and Other Products Designed to Prevent Blood and Body Fluid Exposures." It also offers a checklist to use when implementing safety devices. Click on "Checklist for Sharps Injury Prevention (PDF file)."

in Charlottesville, VA. Penalties can be as high as $70,000.

According to the Washington, DC-based National Institute for Occupational Safety and Health, an estimated 600,000 to 800,000 needlestick injuries occur annually in hospitals, with nursing staff most frequently injured.

Many EDs still are using unsafe devices and practices, and some now face stiff fines as a result, says Perry. From OSHA's point of view, health care facilities have had more than enough time to implement safety devices, says Perry. "So there are really no more excuses for noncompliance," she says. "Safety devices are not optional."

To avoid violations, you must do the following:

• Use safety devices whenever possible.

The rule of thumb is that all needles and sharp devices used on patients should have a safety feature to protect the user from injury, Perry says. "If safety devices aren't being used for particular procedures, find out why," she says. "OSHA has made it clear, in recent citations, that the goal is 100% compliance." **(See list of one ED's alleged violations on p. 115.)**

Perry points to a study on percutaneous injuries in EDs that showed that 86% of injuries were from conventional devices.[1] "My guess is that many EDs still utilize at least some conventional sharp devices," she says.

• Make implementation of safety butterfly needles and safety intravenous (IV) catheters a priority.

Data from a network of hospitals that use the Exposure Prevention Information Network (EPInet) surveillance program to track sharps injuries show that the most frequent source of high-risk injuries for ED staff — those from blood-filled, hollow-bore needles — are butterfly needles and IV catheter stylets, says Perry. "These should be considered a top priority when EDs are implementing safety devices."[1]

• Give nurses thorough training in the correct use of safety devices.

"This is one of the most crucial steps in the whole process of implementing safety devices, and it's important to have the participation of the whole staff," says Perry. She suggests the following:

— Once a new device is implemented, make sure that nurses don't hoard the old devices.

— Allow enough training time so that all ED staff are comfortable using the device and have made any necessary adjustments in technique.

— Make sure the product representative is willing to troubleshoot or give additional training if problems or questions arise once the device is implemented.

• Use devices consistently.

Even when safer devices are available, nurses may be tempted to improvise in order to save a few seconds, warns **Stacey Westphal**, RN, MS, CEN, clinical educator for emergency services at Cape Canaveral Hospital in Cocoa Beach, FL.

Busy ED nurses may not take the few extra seconds to activate the protective feature on a safety device, especially if they haven't had enough training on it, says Perry. "And a used safety device with the protective feature not activated is just as dangerous as a conventional device," she underscores. She recommends looking for safety devices or equipment that are "passive," with the safety feature automatically activating after use or requiring as few steps as possible to activate.

When you do implement a safety device, get rid of the conventional alternatives, advises Perry. "If a nurse has a choice between a device she has used for years and one that she is less familiar with, she will most likely pick the one she is more comfortable with in an emergency situation," she explains.

• Ask nurses for input.

After new blood drawing needles were implemented, ED nurses reported a problem with blood splashing, and a decision was made to discontinue use of the device, says Westphal. "Staff do have the power to take a device out of circulation if they identify a problem with safety," she says.

When there's a problem with a safety device, it's important to find out if it's due to the device itself, or to lack of training or improper use, advises Perry. "For most device categories, there are a number of safety alternatives available, so it is important to evaluate at least several different brands to find the one staff are most comfortable with," she says.

• Encourage nurses to use personal protective equipment including goggles.

Blood or bodily fluids splashed over a distance are a more common occurrence in the ED compared to other clinical areas, says Perry. For eye protection to be effective, it has to have a seal above the eyes to prevent blood or body fluids from dripping down into the eyes, she notes.

"It also needs a side shield," she recommends. "And it has to be comfortable, or it will be less likely to be used consistently by staff."

Reference

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One ED was fined $9K for these unsafe practices

Here are some of the alleged violations of the Bloodborne Pathogens Standard that occurred at Montefiore Medical Center in Bronx, NY, which resulted in several citations and $9,000 in fines, according to Occupational Safety & Health Administration inspection No. 305769994:

— Doctors performed wound irrigation procedures without using a splash shield to control splashing, spraying, or generation of droplets of blood and other potentially infectious materials.

— Contaminated reusable sharps were placed on open-topped flat trays that were not labeled or color-coded and were not placed in appropriate containers until properly reprocessed.

— The employer did not ensure that nurses and doctors used personal protective equipment such as protective gowns and shoe coverings to prevent blood from reaching the employees' work clothes during wound irrigation procedures, treatment of people with lacerations, miscarriages, and other procedures.

— The employer did not ensure that appropriate personal protective equipment such as shoe coverings was readily accessible in the ED or other work areas where gross contamination by blood or other potentially infectious materials may be found. ■

Stroke treatment to widen time window to 8 hours

How many times have you carefully assessed a stroke patient in your ED to determine time of symptom onset, only to find out that this individual is not eligible to receive thrombolytics? New treatment options on the horizon will give you other potentially lifesaving interventions for these patients.

Catheter-based treatments for acute ischemic stroke, such as local thromboplasty and angioplasty, have been shown in small studies to be safe, feasible, and efficacious, says **Lauren Brandt**, RN, MSN, CNRN, clinical director of the Neurosciences, Brain, & Spine Center at Brackenridge Hospital in Austin, TX.[1,2]

When researchers tracked long-term outcomes of 16 stroke patients who were ineligible for thrombolytics and underwent catheter-based treatments, they found the patients had significantly improved.[1]

"Although there need to be additional large scale studies done to confirm this, it opens up another option to the patient experiencing an ischemic stroke," says Brandt.

Currently, the only treatment approved by the Food and Drug Administration (FDA) for acute ischemic stroke is the administration of intravenous (IV) tPA within three hours of symptom onset, but only 2%-4%

EXECUTIVE SUMMARY

New catheter-based treatments for patients with acute ischemic stroke have shown promising results in clinical trials and are expected to receive regulatory approval in 18-24 months.

- Currently, fewer than 5% of stroke patients are eligible to receive thrombolytics.
- New treatment options may extend the time window from three hours to eight hours.
- The number of ED patients who can receive lifesaving treatment will increase significantly.

SOURCES

For more information about the use of catheter-based treatments for stroke patients, contact:

- **Dawn K. Beland,** RN, MSN, CCRN, CS, CNRN, Stroke Center Coordinator, The Stroke Center at Hartford Hospital, 80 Seymour St., Hartford, CT 06102-5037. Telephone: (860) 545-2183. Fax: (860) 545-1976. E-mail: dbeland@harthosp.org.
- **Lauren Brandt**, RN, MSN, CNRN, Clinical Director, Neurosciences, Brain & Spine Center, Brackenridge Hospital, 601 E. 15th St., Austin, TX 78701. Telephone: (512) 324-7782. Fax: (512) 324-7051. E-mail: lbrandt@seton.org.

of patients are eligible for this intervention. "Many limitations, including the patient's delay in reaching the ED and potential risk of bleeding, make patients ineligible for this life-saving drug," says **Dawn K. Beland**, RN, MSN, CCRN, CS, CNRN, stroke center coordinator at the Stroke Center at Hartford (CT) Hospital.

Time limitations for treatment is the primary reason why less than 5% of ischemic stroke patients are being treated with standard IV thrombolysis, according to Brandt. As the catheter-based treatment options become available, the number of patients who can receive life-saving treatment in the ED will increase dramatically, she predicts.

As an ED nurse, you play a pivotal role not only in recognizing stroke symptoms, but also in determining whether this patient is treated or not, emphasizes Brandt. "The ED nurse is in a unique position to impact care of the stroke patient population," she says.

You must be knowledgeable of what other options are available and what the criteria for those options are, says Brandt. "As these options are continually being refined and changed, review or update of protocols will be necessary," she adds.

New options on the way

For patients with a middle cerebral artery occlusion noted on computed tomography angiogram, promising results are being seen from device trials or catheter-based treatments, says Beland.

Beland's ED participated in the Mechanical Embolus Removal in Cerebral Ischemia (MERCI) trial. The MERCI device (developed by Mountain View, CA-based Concentric Medical) is a helical-shaped coil that ensnares the clot, removing it through a catheter in the femoral artery. A proximal balloon catheter situated in the femoral artery is inflated as the clot is being removed to prevent normal blood flow from fragmenting the snared clot.

All patients who were treated with the device originated in the ED, since treatment needs to be done within eight hours of symptom onset, says Beland. "The sooner the cerebral vessels are opened, the smaller the stroke will be, hopefully translating to decreased dependency and death," she says.

Results for 114 patients treated in 20 centers showed a 53.2% success rate for reopening of the occluded blood vessel.[3]

Since the MERCI device can be offered up to eight hours from symptom onset with less risk for bleeding, more patients were eligible for this treatment than for thrombolytics.

"One drawback to this device is that it requires highly specialized physicians and imaging techniques in order to use it effectively, making it less than accessible to small, rural communities," notes Beland. "This is one of many reasons why smaller hospitals are partnering with larger regional stroke centers for rapid transport and care of acute ischemic stroke patients."

Overall, the success rate of IV tPA administration has been reported to be between 15%-33% while the preliminary results of the MERCI trial have shown a 56% success rate for clot retrieval, reports Beland. "As we wait for the FDA ruling on this new device, a second trial is under way, named Multi-MERCI," she says.

The Multi-MERCI trial is using the same device with and without additional procedures such as IA tPA, angioplasty, or stenting if needed. "Employing a variety of options is often necessary in patients with significant cerebrovascular disease," says Beland.

The current study is expected to take less than a year to complete, with several months for data analysis, and it then can go through the FDA approval process. "So if everything goes well, we're looking at 18 to 24 months before the device becomes only the second FDA-approved treatment for acute ischemic stroke," says Beland. "We are very excited about this."

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Cut door-to-doctor delays by 60 minutes

It's more important than a comfortable waiting room with VCRs and fish tanks, or even an attentive triage nurse. In fact, it's often the single most important factor impacting patient satisfaction: door-to-doctor times.

"After all, the patient didn't come to see the nurse or registration folks; they came to see the doctor," says **Mary Kate Dilts-Skaggs**, RN, MSN, director of nursing, emergency and outpatient services at Southern Ohio Medical Center in Portsmouth.

In 1997, the 22-bed ED's patient satisfaction scores were dismally low, only in the ninth percentile, and door-to-doctor time averaged about 95 minutes. After several changes were implemented, average door-to-doctor time was cut to 36 minutes by the end of 2003, and satisfaction scores soared to the 97th percentile.

To dramatically cut door-to-doctor times, use the following effective strategies implemented at EDs:

• Use a multidisciplinary team approach.

To achieve their dramatic results, Southern Ohio's ED nurses worked closely with physicians and registration clerks to identify and implement changes. "Having all the right players at the table when decisions are being made is a critical element," says Dilts-Skaggs.

• Add a triage technician.

An ED nurse suggested adding a triage technician position for high-volume periods when a triage nurse alone might not be sufficient, and the idea was implemented. The technicians take vital signs while nurses interview the patient, and the technicians can escort patients to beds so the nurses don't have to walk away from the triage area.

"We started with eight hours, but we now have a tech out there close to 24 hours," says Dilts-Skaggs.

• Create a space for triage, nursing, and registration to work simultaneously.

The triage area was expanded to include space for nurses and registration staff to work alongside each other. This arrangement enables the patient to walk in, be seated at triage, be assessed by a nurse, and be registered — all in one place.

"If we can't do bedside registration because the beds in the back are all full, we no longer move the patients back and forth like a yo-yo," says Dilts-Skaggs. "Instead, the staff do the moving."

• Immediately bring back patients when a room is available.

Bringing back patients immediately allows the ED to triage and start the assessment at the same time, says **Vicki Sanchez**, RN, ED manager at Pomerado Hospital in Poway, CA. "Many times, the physician is actually at the patient's bedside while the nurses are doing their assessments." This way, the patient does not have to repeat the same information again and again, she adds.

• Have staff carry in-house phones.

Portable phones with a four-digit extension are carried by the triage nurse, charge nurse, and ED physicians and are used to notify physicians of new patients and incoming ambulances, says Sanchez. "When physicians are in a patient room, the dictation room or anywhere in the facility, we can notify them of another patient. Frequently, the physician is able to come to the room and listen to the report from the paramedics."

• Order tests at triage.

When all beds are full, physicians always perform a brief assessment at triage.

"No patient goes back to the waiting room without the physician having seen that patient for a quick initial assessment," says Sanchez. By doing that assessment, the patient care process begins, she adds. "Tests can be ordered, and sometimes results are back before the patient is in a room."

Patients feel they have been seen quickly, at least initially, says Sanchez. "This seems to make the wait a little less stressful for the patient and the families."

Currently, after triage and registration, the admitting clerk puts in the orders that the physician has placed. "But in the very near future, when we are on-line with computer charting, the triage nurse will be able to do a quick registration of the patient while doing the initial assessment," says Sanchez. "She will be able to enter the orders all at the same time."

• Use a tracking board to keep others informed.

A Dry Erase board is positioned outside of the physician's work area with each patient's last name, time of arrival, primary physician, and a space for the ED physician to update the plan for the patient, says Sanchez. Once the physician has seen the patient, he or she initials the board, which signals that the patient has been seen and the physician has taken responsibility, she explains.

The tracking board is posted outside the physician

EXECUTIVE SUMMARY

Reducing door-to-doctor times can have a dramatic impact on your patient satisfaction scores.

- Create a triage technician position to assist nurses during high-volume periods.
- Expand the triage area so patients can be registered at the same time.
- Use overhead pages and in-house phones to notify staff of incoming ambulances.

SOURCES

For more information about reducing door-to-doctor times, contact:

- **Mary Kate Dilts-Skaggs**, RN, MSN, Director of Nursing, Emergency and Outpatient Services, Southern Ohio Medical Center, 1805 27th St., Portsmouth, OH 45662. Telephone: (740) 356-8430. Fax: (740) 356-6387. E-mail: diltsmk@somc.org.
- **Vicki Sanchez**, RN, ED Manager, Pomerado Hospital, 15615 Pomerado Road, Poway, CA 92064. Telephone: (858) 613-4328. E-mail: Vicki.Sanchez@pph.org.

dictation room next to the medication room and is completely out of sight for visitors, adds Sanchez.

• Notify staff of incoming ambulances.

All incoming ambulances are announced via an interdepartmental overhead page system with the estimated time of arrival, and they are announced again upon the patient's arrival with the assigned room number. "This notifies the primary nurse, the charge nurse, admitting clerk, and the physician at the same time," says Sanchez.

"Our current door-to-doc times are 26-28 minutes," she reports. "With the combination of these processes, we have trimmed off an average of 15-20 minutes." ■

Wisconsin ED cuts $50,000 a year off its staffing costs

Have you ever wished that you could instantly adjust your staffing based on the current census in the ED? An "off-with-benefits" program at St. Vincent Hospital's ED in Green Bay, WI, saves approximately $50,000 per year by doing exactly that, reports **Paula Hafeman**, RN, MSN, director of the emergency center.

Nurses take turns going home early or coming in late if the ED's census is down, she explains. "They can use paid time off if they choose, or can just take the time off with benefits still accruing for that time."

During each shift in the ED, team leaders determine if the policy will go into effect according to minimum staffing levels for time of day, based on average census. "For example if there are only two or three patients in the ED at 6 a.m., we would ask one or two nurses to come in at 9 instead of 7," says Hafeman. "Nurses are very cost-conscious and usually volunteer to go home if it is quiet."

The off-with-benefits program is used about four hours a day on average, says Hafeman. "But it is usually a half hour here and there, which does add up to an impressive cost savings," she says.

Productivity measures are shared with nurses via the ED's monthly newsletter and staff meetings, adds Hafeman. "The off-with-benefits program improves productivity, which in turn improves job security and decreases salary costs," she says. The ED is expected to maintain 98% productivity to replace nursing staff at the current level.

The ED measures productivity based on the number

of patients in each acuity level. Each level is assigned a relative value unit, which is multiplied by the number of patients in each level.

"Our year-to-date productivity is 102%, which demonstrates what a great job the staff is doing managing the workload," says Hafeman.

[Editor's note: For more information, contact Paula Hafeman, RN, MSN, Director, Cancer and Emergency Center, St. Vincent Hospital, 835 S. Van Buren St., Green Bay, WI 54307-3508. Telephone: (920) 433-8428. E-mail: phafeman@stvgb.org.] ■

Use site to improve care of trauma patients

Is your ED practicing according to current guidelines for trauma patients? Do you need images for use during trauma inservices? The www.trauma.org web site has become an invaluable resource for many emergency nurses.

"The site has a section dedicated to trauma nursing, and we will be expanding content with discussions regarding trauma tertiary surveys performed by nurses and nurse practitioners," says **Karim Brohi**, FRCS, FRCA the site's director and a trauma surgeon at Royal London Hospital in London.

You'll find information on trauma care guidelines, images to download for use in presentations, articles on trauma care topics, and course listings. One of the most popular features is the interactive trauma moulage scenarios, which nurses use to test their knowledge of initial assessment, pre-hospital care, cervical spine clearance, pediatric, neurotrauma, and trauma team leader decision scenarios.

"Nurses are very welcome on the trauma-list e-mail discussion forum where they listen and participate in discussions," says Brohi. ■

Vital Signs

Site: www.trauma.org

To subscribe to the trauma e-mail discussion, go to www.trauma.org/traumalist.html and enter your e-mail and password.

JOURNAL REVIEW

Kane BG, Degutis LC, Sayward HK, et al. **Compliance with the Centers for Disease Control and Prevention recommendations for the diagnosis and treatment of sexually transmitted diseases.** *Acad Emerg Med* 2004; 11:371-377.

EDs are not adhering to recommended guidelines when caring for patients with sexually transmitted diseases (STDs), according to this study from Yale University School of Medicine in New Haven, CT.

Researchers conducted retrospective chart review of 203 patient visits for STDs, and compared documentation of the history, physical examination, diagnostic testing, prescribed antibiotics, and discharge instructions with current recommendations from the Centers for Disease Control and Prevention (CDC). Here are key findings:

- All patients should have had gonorrheal and chlamydial cultures sent, but only about three-fourths of patients received this required testing.
- Recommended antibiotic regimens for gonorrhea and chlamydia were correctly prescribed for less than one-third of patients.
- Safe-sex instructions were documented for 50% of patients with urethritis, 18% of cervicitis patients, and 15% of patients with pelvic inflammatory disease.
- Compliance with the recommended discharge instructions for pelvic inflammatory disease only was 3%.

"The study revealed that the overall compliance with the CDC recommendations for the diagnosis and treatment of STDs measured by documentation is extremely poor," wrote the researchers, who noted that the most concerning finding was failure to comply with the recommended antibiotics.

They recommended a formal feedback and practitioner accountability system, implementation of continuing quality improvement measures, and systems changes including computer-assisted decision support and automated data entry. ■

COMING IN FUTURE MONTHS

- Update on new flu guidelines
- Effective strategies to make verbal orders safer
- You can avoid problems with bedside registration
- Dramatically improve care of patients with alcohol withdrawal
- Comply with Joint Commission's 2005 National Patient Safety Goals

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 **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided 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 *Are your ED staff at risk for needlestick injury?* and *Stroke treatment to widen time window to 8 hours.)*
- **Describe** how those issues affect nursing service delivery. (See *Psychiatric patients are flooding EDs: Ensure safety with these solutions.*)
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Want to stop IV drug errors? Use these proven strategies.)*

5. Which of the following is a liability risk when caring for patients with psychiatric injuries in the ED, according to Annia Taylor, RN, BSN?
A. Placing psychiatric patients in an isolated room.
B. Tracking numbers of psychiatric patients.
C. Potentially suicidal patients leaving the ED without being seen.
D. Placing psychiatric patients in special colored gowns.

6. Which is an effective strategy to prevent errors with intravenous medications, according to Karen Donnahie, RN?
A. Relying on floor nurses to verify that IV pumps are correctly programmed for patients admitted from the ED.
B. Storing potassium in the ED instead of the pharmacy.
C. Having multiple concentrations available.
D. Challenging any order that you suspect is incorrect.

7. Which is true regarding prevention of needlestick injuries, according to Jane Perry?
A. Citations will not be given as long as safety devices are used for some procedures.
B. All needles and sharp devices used on patients should have a safety feature to protect the user from injury whenever possible.
C. Conventional butterfly needles still are acceptable for use in the ED.
D. It's best to allow nurses to continue using conventional devices even after sharps safety devices are being implemented.

8. Which is accurate regarding new catheter-based treatments for acute ischemic stroke patients?
A. The treatment window may be extended up to eight hours.
B. The treatment window will remain at three hours, but there is less risk of bleeding.
C. There is increased risk of bleeding.
D. Fewer patients are eligible for treatment.

Answers: 5. C; 6. D; 7. B; 8. A.