AMERICAN HEALTH CONSULTANTS®

ED NURSING™

Vol. 3, No. 5

Inside

Special Report: Pain Management in the ED

March 2000

American Health Consultants® is
A Medical Economics Company

Out of compliance with standards? You must assess and treat pain quicker

Surveyors will require consistency in your ED

Special Report: Pain Management in the ED

Are you assessing, documenting, and managing pain for every patient you see in your ED? If not, you aren't in compliance with new standards for pain management developed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

"You need to get a copy of the standards and carefully review them, because your ED will be assessed on them during your next Joint Commission survey," says **Paula Tanabe**, RN, PhD, CCRN, advanced practice nurse for the ED at Northwestern Memorial Hospital in Chicago. **(See key points of standards, p. 56. For information on obtaining a copy of the new standards, see Sources, p. 55.)**

Darlene Matsuoka, RN, BSN, CEN, CCRN, clinical nurse educator for the ED at Harborview Medical Center in Seattle, says, "The standards ensure that

EXECUTIVE SUMMARY

New standards for pain management have been developed by the Joint Commission on Accreditation of Healthcare Organizations and will be scored for compliance in 2001. At mid-year 2000, surveyors will assess your ED's ability to comply with the standards and put into place a plan for full or phased-in implementation. The new standards require that the presence of pain is assessed, documented, and treated more quickly than before.

- According to a recent study, 78% of all ED patients came with a chief complaint of pain, but only 47% of these patients received an analgesic. Only 11% of patients with extremity pain received ice.
- There is a common misconception that medicating patients with abdominal pain will lead to an inaccurate diagnosis.
- Give patients a single dose of pain medication.

the presence of pain is assessed, acknowledged, and treated more quickly than before."

Because there is a wider selection of interventions and treatments, ED nurses should evaluate the choices of pain management, question the use of conventional drugs, and consider alternatives, says Matsuoka. "The new standards will help solidify this proactive approach," she adds. The standards also require that EDs formally examine successes and failures of pain assessment and management, and identify opportunities for improvement.

The new standards are included in the 2000 JCAHO standards manuals and will be scored for compliance beginning in 2001. At mid-year 2000, JCAHO will assess the ability of accredited organizations to comply with the standards and put into place a plan for full or phased-in implementation.

Study: Pain is undermanaged in ED

According to a recent study of 203 ED patients, 78% came with a chief complaint of pain.[1] But only 47% of those patients received an analgesic, and only 11% of patients with extremity pain received ice, reports Tanabe, the study's principal investigator. "All these patients had stated they would not refuse an analgesic."

About 25 patients were afraid to be given opioids for pain relief because of concerns about addiction, but of these patients, only seven actually refused analgesics, she adds.

Always investigate the reasons why patients refuse pain medications, Tanabe recommends. "Correct misunderstandings or offer alternative medications or nonpharmaceutical approaches."

Here are some ways your ED can comply with the new Joint Commission standards:

• **Educate yourself.**

Take advantage of your facility's pain management resources, advises **Patricia Spurlock**, RN, clinic administrator at Neurological Associates of Des Moines (IA) and formerly service line director of emergency services at Mercy Medical Center, also based in Des Moines.

"Many hospitals today have pain clinicians, because there has been a focus on the inpatient side for management of acute pain and chronic pain for many years," she says.

The pediatric units and pediatricians are excellent resources, as well as clinical pharmacists, says Spurlock.

Additionally, you can obtain consensus statements on pain management published by The American Pain Society and The American Academy of Pain Medicine, both based in Glenview, IL. **(For information on how to obtain copies, see Resources, p. 56. For key points from the American Pain Society guidelines, see p. 57.)**

• **Address misconceptions about pain medications.**

You should be comfortable giving larger doses for relief and not fear that the patient will become addicted, stresses Matsuoka. "The rationale of 'We need to monitor the pain so we cannot treat it' does not obviate the need for patient comfort during the evaluation."

Physicians traditionally were taught that medicating patients who had abdominal pain was not only dangerous, but that it would lead to an inaccurate diagnosis, says Tanabe. In fact, research shows that analgesics do not alter the diagnosis and might lead to a more accurate one, Tanabe adds.[2-4]

• **Prompt physicians to give pain medication.**

Recommended Reading

- Wilson J, Pendleton J. Oligoanalgesia in the emergency department. *Am J Emerg Med* 1989; 7:620-623.
- Selbst S, Clark M. Analgesic use in the emergency department. *Ann Emerg Med* 1990; 19:1,010-1,013.
- Friedland L, Kulick R. Emergency department analgesic use in pediatric trauma victims with fractures. *Ann Emerg Med* 1994; 23:203-207.
- Lewis L, Lasater L, Brooks C. Are emergency physicians too stingy with analgesics? *South Med J* 1994; 87:7-9.
- Ducharme J, Barber C. A prospective blinded study on emergency pain assessment and therapy. *J Emerg Med* 1995; 13:571-575.
- Salomone J, Price S, Watson W. A prospective evaluation of acute emergency department pain management. *Am J Pain Manage* 1995; 5:80-83.

COMING IN FUTURE MONTHS

- Program to treat needlestick injuries
- Guidelines for EMS pediatric care
- Tips to support grieving relatives
- New antidote for ethylene glycol poisoning

Physicians tend to focus on diagnostic studies and treatments and sometimes overlook pain relief, stresses Spurlock. "When summarizing the patient's presenting symptoms and objective data, ask the physician what they would like to give the patient for pain."

Prompting the physician to consider pain relief as a component of the first line of treatment decreases delays, Spurlock notes. "The physiological response of untreated pain research is valuable data to share with physicians, and it may impact their practice patterns," she recommends. **(See Recommended Reading, p. 54.)**

Include alternatives

• **Offer nonpharmaceutical therapies.**

Distraction, music, ice, and positioning are all effective for various types of pain, says Tanabe.

"Nurses must first educate themselves about these therapies to increase their comfort level, then educate their peers," she advises. **(For information on a new publication available from American Health Consultants, publisher of *ED Nursing,* see p. 63.)** "You need to practice effective pain assessment and management on a daily basis, and that includes alternatives."

• **Give pain medication before patients are discharged.**

Pain management should be a top priority, even with patients who are discharged home, says Spurlock. "The time interval it takes a patient to travel to a pharmacy and fill a prescription can be more comfortable if one dose of pain medication is administered before discharge or better yet, upon arrival," she recommends.

Special Report: Pain Management in the ED

Patients with acute onset of back pain, simple fractures that have had application of a cast or splint, and children with otitis media who have been brought to the ED due to crying, would benefit from this approach, says Spurlock. "A more global approach to the decision making would be to consider administration of medications in any patient being discharged with a prescription for pain management."

• **Make pain a fifth vital sign.**

The new standards refer to pain intensity ratings as the "fifth vital sign," notes **Emory Petrack**, MD, MPH, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland. "Consistent assessment of pain is key."

This consistency requires assessing for the presence and intensity of pain in every patient who presents to the ED, Tanabe explains. "This can easily be done by adding a column to the documentation tool for pain next to heart rate, temperature, blood pressure, and respiratory rate. It should become as routine an assessment as the other vital signs." **(See protocols for EMLA cream in the ED and renal colic pain, inserted in this issue.)**

Ask yourself: "Is every patient in your ED assessed for pain?" advises Petrack. "For example, a patient who presents with a fall and a radial fracture will generally have their pain managed if a reduction is required. However, if the patient is not in obvious pain initially, he or she may not have their pain assessed and managed."

Ideally, the formal pain assessment should be performed using a specific pain scale, notes Petrack. "The pain will then need to be managed and reassessed during the ED stay," he says. **(See story on pain assessment scales, p. 59, and Wong-Baker Faces Pain Rating Scale, p. 60.)**

• **Assess pain at triage.**

Protocols should instruct nurses to ask all patients about pain at triage, advises Spurlock. "Exclusion criteria could be established, such as those who present with behavioral symptoms or infants who appear content."

SOURCES

For more information about compliance with the new pain management standards, contact:

- **Darlene Matsuoka**, RN, BSN, CEN, CCRN, Harborview Medical Center, Emergency Department, Mail Stop 359875, 325 Ninth Ave., Seattle, WA 98104. Telephone: (206) 731-2646. Fax: (206) 731-8671. E-mail: dmatsuok@u.washington.edu.
- **Emory Petrack**, MD, MPH, Division of Pediatric Emergency Medicine, Rainbow Babies and Children's Hospital, 11100 Euclid Ave., Mail Stop MATH6097, Cleveland, OH 44106-6019. Telephone: (216) 844-8716. Fax: (216) 844-8233. E-mail: emp4@po.cwru.edu or Emory.Petrack@uhhs.com.
- **Patricia Spurlock**, RN, Neurological Associates of Des Moines, 1601 N.W. 114th St., Suite 338, Des Moines, IA 50325. Telephone: (515) 223-1917. Fax: (515) 223-0284. E-mail: DJT-Neuro@aol.com.
- **Paula Tanabe**, RN, PhD, CCRN, Northwestern Memorial Hospital, Emergency Department, Feinberg Mezzanine, Suite 714, 251 E. Huron, Chicago, IL 60611. Telephone: (312) 926-6999, ask for pager No. 57696. Fax: (312) 926-6288. E-mail: ptanabe@nmh.org.

(See story on benefits of using pain management protocols, p. 57.)

At Mercy's ED, patients are asked at triage if they are currently experiencing pain. "If the response is yes, we ask them to rate the severity of pain on a scale of 0-10, with 10 being the most severe pain. If the answer is no, a score of zero is entered," Spurlock explains.

Using pain scores as triage criteria is also an excellent screening tool, recommends Spurlock. "This is valuable during times when treatment rooms are at a premium and triaging the acutely ill is necessary. The Joint Commission will be interested in seeing that the information is used to improve care and impact the comfort of patients."

References

1. Tanabe P, Buschmann M. A prospective study of ED pain management practices and the patient's perspective. *J Emerg Nurs* 1999; 25:171-177.
2. LoVeccio F. The use of analgesics in patients with acute abdominal pain. *J Emerg Med* 1997; 15:775-779.
3. Zoltie N. Analgesia in the acute abdomen. *Ann R Coll Surg Engl* 1986; 68:209-210.
4. Pace S. IV morphine for early pain relief in patients with acute abdominal pain. *Acad Emerg Med* 1996; 3:1,086-1,092. ■

Here are key points of new standards

According to new pain management standards developed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, your ED will be called upon to:

Special Report: Pain Management in the ED

- Recognize the right of patients to appropriate assessment and management of pain.
- Assess the existence and, if existing, the nature and intensity of pain in all patients.
- Record the results of the assessment in a way that facilitates regular reassessment and follow-up.
- Determine and ensure staff competency in pain assessment and management.
- Address pain assessment and management in the orientation of all new staff.
- Establish policies and procedures that support the appropriate prescription or ordering of effective pain medications.
- Educate patients and their families about effective pain management.
- Address patient needs for symptom management in the discharge planning process. ■

RESOURCES

The pain management standards are available on the Joint Commission's Web site, www.jcaho.org. Click on "For Health Care Organizations and Professionals." On the next page, click on "Standards" in the top bar. This will take you to the standards page that includes a link to the pain management standards.

The *2000 Standards Manual for Hospitals*, which includes the new pain management standards, is available for $95 plus $9.95 for shipping and handling. A videotape resource, *Complying with the New Pain Management Standards,* is available for $295 plus $17.95 for shipping and handling. To purchase, contact:

- **Joint Commission on Accreditation of Healthcare Organizations**, Customer Service, One Renaissance Blvd., Oakbrook Terrace, IL 60181-4924. Telephone: (630) 792-5800 between 8 a.m. and 5 p.m. Central Time on weekdays. Fax: (800) 676-3299. E-mail: ebryant@jcaho.org.

Single copies of pain management guidelines, *Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer,* are available for free from the American Pain Society. To request a copy, contact the American Pain Society, 4700 W. Lake Ave., Glenview, IL 60025. Telephone: (847) 375-4715. Fax: (847) 375-4777. E-mail: info@ampainsoc.org. Web: www.ampainsoc.org.

Single copies of consensus statements on the *Basic Principles of Ethics for the Practice of Pain Medicine, The Necessity of Early Evaluation of the Chronic Pain Patient*, and the *Use of Opioids for Treatment of Chronic Pain* are available at no charge. Single copies of brochures on *Acute Pain and Cancer Pain*, *A Brief Guide to Pain Medicine,* and *A Patient's Guide to Pain Medicines* are also available at no charge. Packs of 50 are available for $20 plus $3 shipping and handling charge per order. For more information, contact:

- **American Academy of Pain Medicine**, 4700 W. Lake Ave., Glenview, IL 60025. Telephone: (847) 375-4731. Fax: (847) 375-6331. E-mail: aapm@amctec.com. Web: www.painmed.org.

Use protocols to comply with new standards

In most EDs, there is tremendous variability as to how patients presenting with painful conditions are assessed and managed, stresses **Emory Petrack**, MD, MPH, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland. However, that inconsistency will have to change if your ED wants to comply with new standards published by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO), he warns.

"A major goal of the new standards is to ensure that a patient's pain is appropriately and consistently addressed throughout the hospital," Petrack says.

Patricia Spurlock, RN, clinic administrator at Neurological Associates of Des Moines (IA) and formerly service line director of emergency services at Mercy Medical Center, also in Des Moines, says, "They will want to see how each organization meets the intent of the new standards."

By using protocols to include the assessment on the patient record and then using a numeric scale to measure the outcome, the intent is being met, Spurlock explains.

Here are benefits of using protocols to manage pain:

• **Pain of every patient is assessed.**

Most of your patients have pain, so you should assess pain universally, recommends Spurlock. "Assessment of pain should be completed at the same time vital signs are obtained."

By incorporating pain assessment in the standards of care, all patients are assessed for pain upon arrival, explains Spurlock. The management of the pain then will be driven by the patient's response.

Through standardization of care, all ED nurses assess all patients, which provides a consistent approach to comply with JCAHO standards, Spurlock says. "If pain assessment is left to the individual nurse's discretion, it reverts to the nurse's perception, rather than the patient's self-report of pain."

• **"Invisible" pain is treated.**

In the past, a nurse might ask if a patient had pain, but did nothing to intervene unless it was severe, impacted the management of the patient's other needs, or affected compliance with treatment, notes **Darlene Matsuoka**, RN, BSN, CEN, CCRN, clinical nurse educator for the ED at Harborview Medical Center in Seattle. "A patient with serious orthopedic fractures might get adequate pain medication, but another patient with contusions might not," she says. "To be treated for pain, an injury would need to be 'visible.'"

Protocols can avoid nontreatment of pain by asking all patients to characterize and quantify pain, Matsuoka advises. "Even if the pain does not have a visible component, such as abdominal pain or headache, treatment is rarely excluded."

• **Pain management is standardized with other departments.**

Develop pain protocols using a multidisciplinary approach to allow all providers, nurses, and physicians to work in a united manner, says **Paula Tanabe**, RN, PhD, CCRN, advanced practice nurse for the ED at Northwestern Memorial Hospital and former clinical nurse specialist at Northwest Community Hospital in Chicago. Northwest Community Hospital was one of four EDs featured in JCAHO training tapes for surveyors on the new standards. **(See protocols for ED EMLA cream and ED renal colic, inserted in this issue.)**

Special Report: Pain Management in the ED

• **A baseline of the patient's pain is established.**

At Mercy Medical Center's ED, a documentation tool was developed that is used primarily for the administration of conscious sedation, notes Spurlock. **(See protocol for conscious sedation/deep sedation/pain management, p. 58.)**

"While the management will change with each diagnosis and patient, the value is to establish a baseline to measure progress toward relief of pain," she says. "Uniform standards establish the framework that

(Continued on page 59)

5 ways to track quality improvement

Guidelines from the Glenview, IL-based American Pain Society recommend quality improvement programs include these five key elements:

1. Ensure that a report of unrelieved pain raises a "red flag" that attracts clinician's attention.
2. Make information about analgesics convenient where orders are written.
3. Promise patients responsive analgesic care and urging them to communicate pain.
4. Implement policies and safeguards for the use of modern analgesic technologies.
5. Coordinate and assess implementation of those measures. ■

MERCY
WHERE THE EXPERTS ARE™
400 University • Des Moines, Iowa 50314

☐ **Conscious Sedation**
☐ **Deep Sedation**
☐ **Pain Management**

Diagnosis: ______________________

Procedure: ______________________

Physician: ______________________

Consent obtained? ☐ Yes ☐ No ☐ NA

Last food: ____________ Last Fluids: ____________

Begin: ____________ End: ____________

SAFETY

Siderails up .... ☐ Yes ☐ No ☐ NA

Call light in reach of patient ...... ☐ Yes ☐ No ☐ NA

Patient I.D. band .... ☐ Yes ☐ No ☐ NA

Allergy band .... ☐ Yes ☐ No ☐ NA

Restraints .... ☐ Yes ☐ No ☐ NA

PRE-PROCEDURE

IV Therapy ☐ NA

Site ______________

Gauge ______________

Fluid ______________

Rate ______________

Time ______________

☐ Dressing

Oxygen ☐ NA

☐ N/C ______________

☐ Mask ______________

☐ NRB ______________

Time applied: ______________

Time dc'd: ______________

Time								
Drug								
Amount								
Route								
Level of Consciousness	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious	Awake Oriented Arouses easily Confused Drowsy Lethargic Unconscious
B.P.								
Pulse/Rhythm								
Resp. Rate								
SPO2								
Resp. Quality	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted	Regular Easy Deep Shallow Irregular Labored Assisted
Skin Condition	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis	Warm Dry Cool Moist Pink Flushed Pale Cyanosis
Pain Scale								
Pt. Description								
Comments								

DISCHARGE ☐ Yes ☐ No

Written discharge instructions given .... ☐ Yes ☐ No

Adult escort to drive patient home .... ☐ Yes ☐ No

Able to tolerate liquids .... ☐ Yes ☐ No

Able to dress/walk unassisted
(unless physically impaired) .... ☐ Yes ☐ No

Nurse Signature: ______________________ ______________________ Date: ____________

Source: Mercy Medical Center, Des Moines, IA.

measuring pain is a component of patient assessment in all patients."

This creates a numeric baseline that is used to measure the outcome of pain treatments, as well as progression of pain during the ED visit, notes Spurlock. "In addition, the triage nurse uses the severity of pain as one criteria for placing a patient directly into a treatment room. Our criteria is a pain score of 7 or above."

• **Nursing pain management is addressed.**

Independent nursing functions should be included, such as the application of ice, immobilization, oxygen for patients with chest pain, and antipyretics, says Spurlock. "Some emergency physicians may approve the addition of medications such as opioids in the protocols, while other groups may not."

• **Patient satisfaction is increased.**

After pain management improvement initiatives were implemented at Mercy's ED, patients responded with positive comments, reports Spurlock. "Perhaps of greater significance is the absence of patient complaints related to their pain not being taken care of."

A statement informing patients that they should expect their pain to be addressed is included in the patient brochure that is handed out at the triage desk and in the waiting room, says Spurlock. ■

Use these tools to assess pain

A patient's self-report of pain is the single most reliable indicator of pain and will demonstrate compliance with new pain standards from the Oakbrook, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO), according to ED sources.

"The use of a pain score demonstrates that the patient was assessed for pain, and the objective data documents the patient's response," says **Patricia Spurlock**, RN, clinic administrator at Neurological Associates of Des Moines (IA) and former service line director of emergency services at Mercy Medical Center, also in Des Moines.

Special Report: Pain Management in the ED

Get into the habit of using a variety of objective pain scales, advises **Paula Tanabe**, RN, PhD, CCRN, advanced practice nurse for the ED at Northwestern Memorial Hospital in Chicago. "Scales should be used for all patients experiencing pain, because this quantifies the pain," she says. "Someone with a pain score of 8 will be approached with different medications and treated differently than a patient with a score of 2 or 3."

The new standards from JCAHO require that staff take developmental concerns into account. Different pain scales are used for young children, the elderly, or developmentally delayed individuals, notes **Emory Petrack**, MD, MPH, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland.

By using scales, you can routinely measure with quality improvement initiatives how often pain is assessed and treated, says Tanabe. "Once nurses start objectively scoring pain, you will see increases in the amounts of analgesics administered."

Description of scales

Here are several types of pain scales and which patients they should be used for:

• **Numeric scales.**

For adult patients, use a 0-10 numerical pain rating scale, recommends **Darlene Matsuoka**, RN, BSN, CEN, CCRN, clinical nurse educator for the ED at Harborview Medical Center in Seattle. "We first used it in the ED assessing chest pain, and now use it to assess the presence of any pain."

The numeric pain scale is most commonly used and most accurately portrays the adult patient's pain, says Spurlock. "By asking the patient to rate their pain on a scale of 0 to 10, with 10 being the most severe pain, the patient will provide their perception."

In an audit done by the ED, 31% of triaged patients who did not arrive by ambulance fell within those parameters; all were triaged to a room for treatment, Spurlock reports.[1] "The presenting complaints included fractures, kidney stones, back pain, migraine headaches, and vomiting."

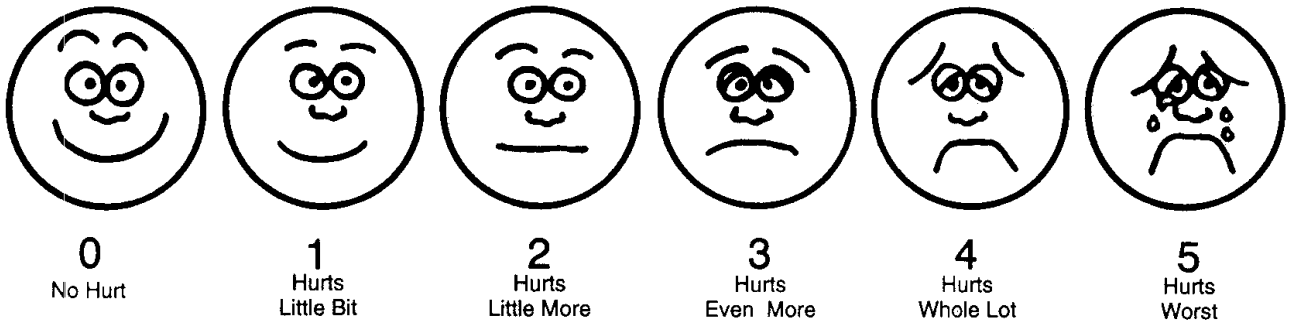
• **The Wong-Baker Faces Scale.**

Children ages 5 and older can rate their pain using the Wong/Baker Faces Pain Rating Scale, says Spurlock. **(See scale, p. 60.)** "This is a version of a numeric scale which is used for pediatric patients, as well as for those who have communication barriers. Much research has been done to validate this tool."

Descriptives are a good adjunct to those numeric scales, says Spurlock. "Using the patient's perception of pain rather than the nurse's perception is critical. Some patients may be very stoic, while others have a low tolerance of pain. Cultural differences and age also impact the nurses perceptions."

• **Verbal descriptor scale.**

While most adults can use the 0-10 numeric rating scale, many cannot, notes Tanabe. "For adults who are unable to rate their pain on the 0-10 scale, the verbal



Source: From Wong DL, Hockenberry-Eaton M, Wilson D, et al. *Whaley and Wong's Nursing Care of Infants and Children.* 5th ed. St. Louis: Mosby; 1999. Reprinted with permission.

descriptor is a nice alternative that most patients can use," she explains. "The elderly, in particular, do much better with the verbal descriptor scale."

Patients are shown the following words on a card: no pain, mild, discomforting, distressing, horrible, and excruciating. "The nurse should then document from 0-5. None equals 0, mild equals 1, etc.," Tanabe explains.

• **Oucher scale.**

This scale is most appropriate for children ages 5-7. "If the child can count to 100, he or she can use the numerical scale," says Matsuoka. "If not, the child should use the Wong/Baker Faces Pain Rating Scale."

• **FLACC (face-legs-activity-cry-consolability) behavioral scale.**

This scale can be used for children 0-5 years of age or children who cannot self-report pain. Each of the 5 categories is scored from 0-2, with the following criteria observed and rated:

— **Face:** smiling or relaxed, occasional grimace, clenched jaw and quivering chin.

— **Legs:** relaxed, squirming, kicking.

— **Activity:** lying quietly; squirming and shifting back and forth; arched, rigid, or jerking.

— **Cry:** not crying, moans or whimpers, crying steadily, screams, or sobs.

— **Consolability:** content, relaxed; reassured by occasional touching, hugging, distractible; difficult to console or comfort. After all categories are rated, scores are added and the total score from 0-10 is determined.

Reference

1. Spurlock P. An emergency nurse's pain management initiative: Mercy Hospital's experience. *J Emerg Nurs* 1999; 25:383-385. ■

Borglund ST, Hayes JS, Eckes JM. Florida's bicycle helmet law and a bicycle safety educational program: Did they help? J Emerg Nurs *1999; 25:496-500.*

After a mandatory law was passed in Florida for helmet use in bicycle riders under 18, helmet used increased, but remains too low, according to a study from Broward General Medical Center in Fort Lauderdale, FL. Researchers studied the effectiveness of Florida's mandatory helmet law and a community bicycle safety program and found that helmet use rose from 5.6% to 20.8%. Children aged 10 to 12 years, who were targeted most heavily in the bicycle safety programs, had the greatest increase in helmet use (27%).

"Although this increase was significant, the fact remains that nearly 80% of the children admitted with injuries from bicycle crashes were not helmeted," say the researchers. "The number of nonhelmeted children remains much too high."

The type and extent of head injuries sustained in bicycle crashes also was evaluated, with injury severity scores higher for nonhelmeted children.

A community bicycle safety campaign promoting

helmet use also contributed to increased helmet use, according to the study. The program was developed and implemented by ED nurses a year before the helmet law was enacted. In the ED, bicycle crash victims were given helmet safety packets, and a video about bicycle safety and helmet use was shown before discharge. If children indicated that they would wear a helmet if they could afford them, they were given helmets at no cost. Education programs increasing community awareness of the importance of bicycle helmet use among children, their parents, and other concerned adults remain an important adjunct to bicycle helmet laws, according to the researchers: "Nurses caring for bicycle crash victims and their families need to continue their efforts at the workplace and in the community to promote the use of bicycle helmets." ▼

Grossman SA, Richards CF, Anglin D, et al. Caring for the patient with mental retardation in the emergency department. Ann Emerg Med *2000; 35:69-76.*

Many ED clinicians are uncomfortable interacting with patients with mental retardation, which has implications for assessment and management of those patients in the ED, according to this research from Brigham and Women's Hospital in Boston and University of Southern California Medical Center in Los Angeles.

Because of de-institutionalization of patients with mental retardation, EDs are increasingly managing those patients; therefore, the comfort level should be increased to improve care, say the researchers. Here are key points of the guidelines for management of patients with mental retardation recommended by the researchers:

• In the ED, a concerted effort should be made to evaluate the patient in a quiet area with as few distractions as possible.

• When health care providers enter the room of patients with mental retardation, they should specifically introduce themselves to both the patients and their family or caregivers.

• During the physical examination, the patient should be assessed for signs of abuse, as these patients are at increased risk for abuse because of their dependency on their caregivers and the stressful demands placed on their caregivers. Also, patients may be incapable of comprehending, verbalizing, or even reporting abuse.

• Because patients with mental retardation already may have some baseline abnormalities in their neurologic function, indications for lumbar puncture and computed tomography might be subtle.

Invasive examinations, tests, and procedures, when performed on some apprehensive or anxious patients with mental retardation, might not be safe for the patient or the practitioner. Therefore, some form of sedation is often indicated. Examples include vaginal examinations, lumbar punctures, computed tomography scans, chest tube placement, peritoneal lavage, and dislocation or fracture reductions. ▼

Hovanessian HC. New-generation anticoagulants: The low molecular weight heparins. Ann Emerg Med *1999; 34:768-779.*

Low molecular weight heparins (LMWHs) are efficacious, safe, cost-effective, and easier to administer and monitor than standard heparin, according to this study from University Medical Center in Fresno, CA, and St. John's Health Center in Santa Monica, CA. These new agents will be used in the ED instead of unfractionated heparin for unstable angina, non-Q-wave myocardial infarction, or thromboembolic disease. **(For more information on LMWHs, see *ED Nursing*, July 1999, p. 113.)**

In the ED, LMWHs soon will become indispensable tools, say the researchers. Currently, enoxaparin (Lovenox) and dalteparin (Fragmin, in combination with aspirin) are indicated for use in selected acute ischemic coronary syndromes — clinical situations that are managed on a daily basis in the ED, the study notes.

LMWHs are also efficacious in the treatment of venous thromboembolic disease, with evidence more compelling in the case of deep-vein thrombosis (DVT) than pulmonary embolism. Enoxaparin has recently gained Food and Drug Association approval for treatment of established DVT, as well as pulmonary embolism, note the researchers.

"As such, familiarity with this class of drugs is of paramount importance because treatment for venous thromboembolic disease is frequently initiated in the ED," the researchers say. The ease of administration of LMWHs, with once-daily dosing and no stringent requirements for monitoring, their relatively infrequent rate of complications, and their potential cost-effectiveness make those agents an attractive alternative to unfractionated heparin use. ■

Use NIH Stroke Scale to assess patients

There is a valuable tool for assessment of stroke and transient ischemic attack (TIA) patients you might not be using in your ED, warns **Susan Unipan Rodriguez**, BSN, CNRN, nurse coordinator for the

EXECUTIVE SUMMARY

According to experts in stroke management, you should use the National Institutes of Health Stroke Scale to perform a thorough awake neurological exam on all stroke and transient ischemic attack patients.

- The 42-point scale can quantify most stroke symptoms as mild, moderate, or severe, with 0 being normal and 42 most severe.
- The stroke scale has 11 items and takes approximately seven minutes to perform.
- Stroke scale scores are excellent predictors of outcomes and can help identify candidates for thrombolysis.

National Institutes of Health/National Institute for Neurological Disorder and Stroke (NINDS), Stroke Branch/Stroke Diagnostics and Therapeutics, based in Bethesda, MD.

Using the National Institutes of Health (NIH) Stroke Scale takes approximately seven minutes to perform and should be standard practice for all patients with suspected TIA or stroke, says Rodriguez. **(See stroke scale, guidelines, and learning packet, inserted in this issue.)**

The 42-point scale can quantify most stroke symptoms. It gives you an idea of whether the stroke is mild, moderate, or severe, with 0 being normal and 42 most severe, says Rodriguez. "It's a great tool to utilize, and gives you a thorough neurological exam on these patients."

Neurologic status addressed

The Glasgow Coma Scale is usually the only tool used in the ED to assess neurological symptoms, but that scale doesn't tell you anything about a stroke patient, Rodriguez says. "The NIH Stroke Scale tests level of consciousness in a different way than the Glasgow Coma Scale, such as the following of commands. It gives you a thorough idea of the patient's neurological status."

The NIH Stroke Scale quantifies visual and speech disturbances, severity and location of weakness, and neglect, all of which are not usually measured in the ED, says Rodriguez. "These are symptoms that really impact how these patients do over the long term, which might not be picked up initially."

The stroke scale is an excellent predictor of patient outcomes, stresses **Judith Ann Spilker**, RN, BSN, cerebrovascular research coordinator in the Department of Emergency Medicine at University Hospital, University of Cincinnati Medical Center and consultant for the National Stroke Association, based in Englewood, CO.

The stroke scale score is an effective way to predict what will happen to stroke patients, Spilker says. "When a patient comes to the ED, we know at the baseline what their likelihood of getting better is," she says. "It also allows you to tell if the patient is getting better or worse."

Looking at the big picture

Documentation of a patient's neurological deficits is currently performed differently by each specialty and department, and the stroke scale can provide consistency, Spilker advises. "You want to look at the big picture of disease management from the ED until the time of discharge from the hospital, and this standardizes the assessment," she says.

Health care for stroke patients is compartmentalized between the ED, hospital, and rehabilitation, notes Spilker. "In order to connect all these three, we have to have this in common."

There are 11 items to complete, and the scale is lengthy, Spilker acknowledges. "But the more proficient you become, the faster it is to administer," she says. If you partner with more experienced people, it will be easier, Spilker advises.

Using the NIH scale should be part of your standard assessment of stroke patients, Spilker argues. "Before we had treatments for stroke, there wasn't much incentive to doing this. But there is enough ammunition now to justify this change."

The rationale is growing stronger for ED nurses

SOURCES

For more information about the National Institutes of Health Stroke Scale, contact:

- **Susan Unipan Rodriguez**, BSN, CNRN, National Institutes of Health/NINDS, Stroke Branch — Stroke Diagnostics and Therapeutics, 10 Center Drive, Building 10, Room 3B10, Bethesda, MD 20892. Telephone: (301) 402-7365. E-mail: rodriqs@ninds.nih.gov.
- **Judith Ann Spilker**, RN, Department of Emergency Medicine, University of Cincinnati College of Medicine, 231 Bethesda Ave., Cincinnati, OH 45267-0769. Telephone: (513) 558-8106. Fax: (513) 558-6299. E-mail: spilkeja@ucmail.uc.edu.

to do this assessment, Spilker stresses. "You need to accept that performing a full awake neurological exam is part of your job."

The scale must be fully completed, Spilker recommends. "If you only do one or two items, you are not getting a complete picture," she says. "Making it shorter is like doing two or three leads out of a 12-lead EKG."

Stroke scale scores can help you decide which patients should be treated with thrombolysis, says Spilker. "There are always exceptions, but generally speaking, small scores do well, and big scores do poorly," she explains. "As the number gets higher, your risk of hemorrhage increases." ■

Bring disabled nurses back to work in the ED

Work with your occupational health department to bring ED nurses back to work who cannot lift or are restricted in activities, but are able to walk and talk, recommends **Susan Sheehy**, RN, MSN, MS, CEN, FAAN, director of nursing for emergency services at Brigham and Women's Hospital in Boston.

Disabled nurses can be of enormous assistance in the ED by helping to link communications between patients and providers, especially when the ED is very busy, says Sheehy. "These nurses can help with numerous other things that you have good intentions of doing, but for which you simply run out of time."

ED nurses with disabilities can do the following tasks, she suggests:

- return patients' calls;
- call patients who left without being seen to ensure that patient received the help they needed;
- assist with family members;
- help interpret diagnostic tests and results;
- help locate lost objects;
- perform telephone follow-ups on lab culture reports;
- accompany a family member if your ED permits family presence during resuscitation;
- arrange follow-up appointments;
- visit patients who were admitted to the hospital from the ED;
- send sympathy notes.

"It's a great way to have extra help available and a great way for a nurse who would be sitting home because of an activity restriction to return to work and be able to interact with patients," says Sheehy. ■

New newsletter targets alternative medicine nursing

Holistic Nursing Update is the first source of holistic healing education specifically designed to meet the needs of nurses. This eight-page monthly newsletter offers the practical knowledge nurses need to incorporate complementary and alternative practices into daily patient care.

Each issue covers complementary healing therapies and modalities including acupuncture, therapeutic touch, guided imagery, exercise, herbal medicine, dietary supplements, massage, and aromatherapy. *Holistic Nursing Update* also addresses the challenge involved in integrating the holistic philosophy into existing health care organizations. Approximately 12 CE contact hours are available. For more information, contact: **American Health Consultants**, Customer Service, P.O. Box

Subscriber Information
Customer Service: (800) 688-2421 or Fax (800) 284-3291.
World Wide Web: http://www.ahcpub.com.
E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $299. With approximately 16 CE contact hours, $349. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $239 per year; 10 or more additional copies, $179 per year. 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 $48 each. (GST registration number R128870672.)

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

ED Nursing™ is approved for approximately 18 nursing contact hours. This offering is sponsored by 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.

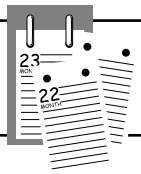
Editor: Staci Bonner.
Group Publisher: Brenda Mooney.
Managing Editor: Joy Daughtery Dickinson, (joy.dickinson@medec.com).
Production Editor: Nancy McCreary

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson at (912) 377-8044.

740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Web site: www.ahcpub.com. ■

CALENDAR



• **April 3-4, 2000:** Injuries to Children — From Minor to Major and Multiple Trauma: Cambridge, MA. Sponsored by the Children's Hospital, Boston. Contact: Harvard Medical School, Department of Continuing Education, P.O. Box 825, Boston, MA 02117-0824. Telephone: (617) 432-1525. E-mail: hms-cme@warren.med.harvard.edu.

• **April 14, 2000:** A Crash Course in Emergency Nursing: New York City. Sponsored by the New York-Presbyterian Hospital, New York Weill Cornell Center, Department of Nursing Education, and School of Continuing Education for Nurses. Contact: Steve Weinman, 525 E. 68th St., Box 174, New York, NY 10021. Telephone: (212) 746-2914.

• **May 1-3, 2000:** 26th Annual New England Regional Symposium, Portland, ME. Sponsor: Maine Emergency Nurses Association. Contact: Carol Minnis, Maine General Medical Center, 149 North St., Waterville, ME 04901. Telephone: (207) 872-1300.

• **May 4-5, 2000:** ENA By the Bay 2000, Ocean City, MD. Sponsored by the Maryland Emergency Nurses Association. For more information, contact: Carla Stemmer, 8 Warren Lodge Court, 1A, Cockeysville, MD 21030. Telephone: (410) 683-3477. E-mail: carlaedrn@aol.com.

• **May 5-6, 2000:** Setting the Pace 2000, Niagra Falls, NY. Sponsored by the New York State Emergency Nurses Association. For more information, contact Debby Uhlman, 71 Woodgate Road, Tonawanda, NY 14150. Telephone: (716) 837-4380. E-mail: gucci@gateway.net.

• **June 12-13, 2000:** A Course in Trauma Nursing, New York City. Sponsored by the New York-Presbyterian Hospital, New York Weill Cornell Center, Department of Nursing Education and School of Continuing Education for Nurses. For more information, contact: Steve Weinman, 525 E. 68th St., Box 174, New York, NY 10021. Telephone: (212) 746-2914.

• **Aug. 3-4, 2000:** Course in Advanced Trauma Nursing, New York City. Sponsored by the New York-Presbyterian Hospital, New York Weill Cornell Center, Department of Nursing Education, and School of Continuing Education for Nurses. For more information, contact: Steve Weinman, 525 E. 68th St., Box 174, New York, NY 10021. Telephone: (212) 746-2914. ■

CE objectives

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

1. Identify clinical, regulatory, or social issues relating to ED nursing. (See *Out of compliance with standards? You must assess and treat pain quicker, Use these tools to assess pain,* and *Journal Reviews* in this issue.)
2. Describe how those issues affect nursing service delivery.
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Use NIH Stroke Scale to assess patients.*)