ED NURSING®

THOMSON
AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

OCTOBER 2004
VOL. 7, NO. 12

Will your ED comply with safety goals? Don't wait until it's too late

Failure to comply with goals will mean serious consequences for your ED

It's the one thing surveyors will be looking for in every corner of your ED during your next survey with the Joint Commission on the Accreditation of Healthcare Organizations: Proof that patients in your ED receive safe care. The Joint Commission's new National Patient Safety Goals for 2005 include new requirements that will affect the ED dramatically. Your ED must be in complete compliance as of Jan. 1, 2005.

"Compliance is critical because if an organization is found to be out of compliance, they are cited not only with a special recommendation, but may also be cited with a recommendation at a standard," says **Ann Kobs**, president of Wheaton, IL-based Ann Kobs & Associates, a consulting firm specializing in Joint Commission compliance.

It's a "double whammy," she adds. "Failure to resolve a requirement for improvement ultimately can lead to loss of accreditation," Kobs says.

In addition, as of July 15, compliance with the patient safety goals has become public knowledge as this information now is posted on the Joint Commission's Quality Reports web site (www.jcaho.org/quality+check/index.htm). "A negative remark could be construed poorly by the community and possibly result in the public losing confidence in the organization," she warns.

Insurers are jumping on the bandwagon, too, Kobs says. "They are beginning to base reimbursement on outcomes," she says. "The hospitals that have

EXECUTIVE SUMMARY

The new National Patient Safety Goals for 2005 from the Joint Commission on the Accreditation of Healthcare Organizations will affect your practice dramatically. The new requirements are effective Jan. 1, 2005.

- You'll need to define what constitutes a "critical test result" for your ED and identify look-alike, sound-alike medications.
- Use two patient identifiers whenever clinical tests, treatments, or procedures are performed.
- Create a faxed admission report to improve communication with floor nurses.

the highest volume *and* the best outcomes will get the reimbursement."

You'll need to show evidence of compliance with every goal for many surveys to come, adds Kobs. "This will be a forever thing, because the public is demanding it," she says.

Here are key changes in the 2005 goals that impact the ED, with strategies for each:

• Use two patient identifiers when taking specimens for clinical testing or providing any other treatments or procedures.

Because up to 70% of admissions come through the ED, it is the original point of contact where the needs of the patient are assessed, an initial diagnosis is made, and a patient is assigned to an appropriate service, Kobs says.

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), $199. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. 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 $61 each. (GST registration number R128870672.)

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

ED Nursing® (ISSN# 1096-4304) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending 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 Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours. This program (program # 0704-1) has been approved by an AACN Certification Corp.-approved provider (Provider #10852) under established AACN Certification Corp. guidelines for 18 contact hours, CERP Category A. This activity is authorized for nursing contact hours for 36 months following the date of publication.

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

Statement of Financial Disclosure
Ms. Ball (board member) discloses that she is a consultant and a stockholder for Steris Corp. and is on the speaker's bureau for the Association of periOperative Registered Nurses (AORN). **Ms. Holleran** (chairman of the Editorial Advisory Board), and board members **Ms. Bradley**, **Dr. Mellick**, **Ms. Matsuoka**, **Ms. Dill, Ms. Eckle, Ms. Kosnik, Ms. Meehan, and Ms. Weintraub** (board members) have no relationships to disclose.

THOMSON
AMERICAN HEALTH CONSULTANTS

"In order to accomplish that mission, the patient must be appropriately identified," says Kobs. You must reliably identify the individual as the person for whom the service or treatment is intended, and also match the service or treatment to that individual, she explains. Therefore, the two patient-specific identifiers must be directly associated with the individual, and the same two identifiers must be directly associated with the medication, blood products, or specimen tube, such as on an attached label.

When clinical testing is needed, you must ensure that you have the correct patient, that the correct specimen has been drawn, in the correct receptacle, and that it is appropriately transported in the right amount of time, says Kobs. "It is amazing, the number of steps where mistakes can be made," she adds.

In addition, the patient safety goals require that two identifiers are used to ensure that the correct procedures and treatments are done for the correct patient, says Kobs.

• Measure, assess, and take action as needed to improve the timeliness of reporting of critical test results.

First, define what constitutes a "critical test result" for your ED, says Kobs. This may include "stat" tests, "panic value" reports, and other diagnostic tests including imaging studies, electrocardiograms, laboratory results that require urgent response, and test results reported verbally or by telephone.

If you don't define "critical test results" for your ED, surveyors will consider all verbal or telephone reports of diagnostic tests to be "critical," warns Kobs. "For the ED, this probably would be almost all of the test results, including care of patients who seem to use the ED as their local family provider and manage to drop by for the malady of the week," she says.

For this reason, your ED should put together a list of your "critical" tests now, since January 2005 isn't far off, says Kobs.

In addition, you must take steps to decrease delays in reporting of laboratory and diagnostic tests, imaging studies, electrocardiograms, and ultrasounds, says Kobs. "In order to improve, you will need to know what your actual turnaround time is now," she says. "If you do not have this information, it would be wise to gather it starting today."

• You must improve communication and documentation.

To meet this goal, ED nurses at Gwinnett Medical Center in Lawrenceville, GA, created a faxed admission report to show floor nurses what was done in the ED, including diagnosis, medications given, vital signs before transfer, lab results, and special needs such as non-English-speaking or paraplegic. "When giving a

SOURCES

For more information about the 2005 National Patient Safety Goals, contact:

- **Ann Kobs**, President, Ann Kobs & Associates, 1946 Briarcliffe Blvd., Wheaton, IL 60187. Telephone: (630) 456-4169. E-mail: aejbbk @aol.com. Web: www.annkobs.com.
- **Sandy Vecellio**, RN, BSN, Gwinnett Medical Center, 1000 Medical Center Blvd., Lawrenceville, GA 30046. Telephone: (678) 442-3243. Fax: (678) 442-4531. E-mail: SVecellio@ghsnet.org.

verbal report, you may forget to tell the nurse certain things, or the floor nurse may later say 'I didn't hear that in the report,'" says **Sandy Vecellio**, RN, BSN, ED clinician. "The form gives you specific questions to be sure they are answered; whereas, in a verbal report, you may forget to ask them."

The form also gives the floor nurse a paper document to refer back to, says Vecellio. "We fax this report to all of the floors, wait 15 minutes, and then call to see if they have any questions," she says.

• Identify and annually review look-alike/sound-alike drugs, and take action to prevent errors involving these drugs.

This requirement is extremely important for the ED, because staff use a greater variety of medications with increased drug interactions than other units, says Kobs. "So there is a more intense need for them to be savvy about all look-alikes and sound-alikes," she underscores.

Work with pharmacists to identify these, Kobs recommends. "Clinical pharmacists can be invaluable team members and resources," she says.

• Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.

No one likes to believe that there are patient falls in the ED, says Kobs. "However with an aging population, drug abuse, and unfamiliar surroundings, falls aren't so uncommon," she says. The goal specifically requires that you assess the potential risks associated with the patient's medication regimen, she notes.

Kobs suggests the following:

— Mark gurneys with "fall risk" tags.

— Work with pharmacy to jointly identify which medications place patients at risk for disorientation and possible falls.

—- Don't think only in terms of medications given in the ED, but also what medications patients may have taken beforehand. **(See related story, below about new Joint Commission requirements for medications.)**

The biggest practice change for ED nurses will be remembering to document the periodic reassessment of the risk for falling, says Kobs. "A simple form with check boxes at chosen intervals would be a simple solution," she recommends. ■

Use creative strategies for JCAHO's medication goal

What's the toughest new requirement for EDs in the 2005 National Patient Safety Goals from the Joint Commission on Accreditation of Healthcare Organizations? For many ED nurses, that's an easy question: They point without hesitation to the goal requiring that medications are reconciled across the continuum of care.

"We have been working on all the goals and are achieving all but this one," says **Kathleen Carlson**, RN, MSN, CEN, operations manager for the ED at Sentara CarePlex Hospital in Hampton, VA. "We are struggling to find the best way to achieve this in the ED, as the patient is in the department for such a short time compared to the inpatient stay."

This goal must be planned and attempted during 2005, with full implementation by January 2006. "So the development of appropriate implementation strategies needs to begin now," says **Bonnie Atencio**, MS, RN, clinical educator for the ED at Mercy San Juan Medical Center in Carmichael, CA.

To comply, you must develop a process for obtaining

EXECUTIVE SUMMARY

One of the new National Patient Safety Goals for 2005 requires you to reconcile a patient's medications across the continuum of care. This may be more difficult in the ED, because patients may be unresponsive.

- If possible, obtain and document a complete list of the patient's current medications.
- Instruct patients to bring a medication list with them to the ED for future visits.
- Communicate medication information with others caring for the patient, whether other hospital units or receiving facilities.

SOURCES/RESOURCE

For more information about reconciling medications across the continuum of care, contact:

- **Bonnie Atencio**, MS, RN, Clinical Educator, Emergency Department, Mercy San Juan Medical Center, 6501 Coyle Ave., Carmichael, CA 95608. Telephone: (916) 536-3140. Fax: (916) 863-6802. E-mail: batencio@chw.edu.
- **Kathleen Carlson**, RN, MSN, CEN, Operations Manager, Emergency Department, Sentara CarePlex Hospital, 3000 Coliseum Drive, Hampton, VA 23666. Telephone: (757) 736-1031. E-mail: kkcarls@aol.com.
- **Kathleen Catalano**, Director of Regulatory Compliance, PHNS, 15851 Dallas Parkway, Suite 925, Addison, TX 75001. Telephone: (972) 701-8042, ext. 216. Fax: (972) 385-2445. E-mail: kathleen.catalano@phns.com.

To obtain a pocket card for patients to record their medications, go to **www.madisonpatientsafety.org.** Choose "Medication Safety Brochure with Wallet Card" on the right navigational bar, and click on "Accompanying Pocket Card to Record Medications."

and documenting a complete list of the patient's current medications, including prescription drugs, over-the-counter drugs and herbal preparations, upon the patient's admission from the ED. "This must be done with the involvement of the patient," she adds.

The process must include a comparison of the medications given in the ED with the other medications the patient is currently taking. "This is what we need to develop," says Atencio. "ED nurses are currently asking for a complete list of medications from the patient. If the patient has been a patient in our facility, or if the patient has a complete list of their medications, we then can compare," she says.

The goal is to check for potentially harmful drug interactions and to see what medications the patient has tried in the past that have not worked, to avoid ordering these same drugs again, says **Kathleen Catalano**, director of regulatory compliance at Dallas-based PHNS, a privately held company that provides information technology, medical records, transcription, coding, and business office outsourcing services to the health care industry, she adds.

In addition, a complete list of the patient's medications must be communicated to the next provider of service when your ED refers or transfers a patient to another setting, service, practitioner, or level of care, either within or outside your organization.

The obstacles for the ED are many, according to Catalano. Patients may be comatose or unresponsive, and family and friends may have no idea what the patient is taking, says Catalano.

In addition, patients rarely come to the ED with a complete list of medications, or they may have an outdated list and are unsure as to the dosage changes, says Atencio. "The new requirements state that we will need to develop a way of obtaining this information that is more accurate and reliable," she says.

Electronic systems would be one way to accomplish this, but only if the patient had been seen in your ED previously, says Catalano. "But if the patient had been seen and the systems were electronic, with a push of a button, you'd have the patient's past medical record," she says.

To comply with the medication goal, you must take the following steps:

• Obtain as much current medication information as possible before the patient is admitted.

"The floor to which the patient is being transferred then would be responsible for filling in the gaps," says Catalano. These gaps might include over-the-counter drugs or herbal supplements used by the patient, or new information obtained by a family member about the patient's current medications.

"Maybe the patient says their medications are all in the kitchen cabinet, but they can only remember they take a heart medication and a family member had to go home to see what the items were," she adds.

Even if the patient isn't being admitted, it's still good practice to obtain medication information if possible, says Catalano. "The patient's ED record will be maintained with the patient's other medical records, so this information would be available if needed at a later date," she explains.

• Document a complete list of the patient's current medications.

"The challenge will be for those patients who are unaware of, or unable to provide us with a complete accounting of their medications," says Atencio.

She suggests the following to address this problem:

— Instruct patients to keep track of their medications on one list. "The ED is an excellent place to educate patients about this," says Atencio.

— Start a community education program in collaboration with ED physicians about the importance of having medication information readily available.

— Use a pocket tool for patients to list their medications. **(See resource box, above left.)**

If a patient is unresponsive and no information is

available, document this as follows, advises Catalano: "Patient unresponsive and unable to provide information regarding current medications, over-the-counter drugs, or herbal preparations." ■

Fast treatment of alcohol withdrawal can save lives

Imagine a middle-aged woman who seems a bit nervous and whose hands are shaking slightly. Would you suspect alcohol withdrawal syndrome in this patient? If not detected quickly, the patient's symptoms could quickly become life-threatening.

Alcohol withdrawal has the potential of causing severe morbidity and mortality, warns **Victoria Leavitt**, RN, regional nurse educator for emergency services for Franciscan Health System, a three-hospital system in Washington's Puget Sound area.

Subtle or early symptoms may escape detection, which causes patients to be overlooked in a busy ED, she says. "The fine sheen of perspiration, hand tremor, and general jitteriness may be lost in the crush of patients at triage," she says. "Most EDs are overcrowded and understaffed. It is not surprising that some people will fall in the cracks."

The longer you wait to give medication, the more serious the signs and symptoms become, explains **Suzanne White**, MD, FACEP, FACMT, associate professor of emergency medicine at Wayne State University School of Medicine in Detroit and an ED physician and medical toxicologist at Detroit Medical Center. "If patients are not treated quickly, it may progress to full-blown delirium tremens, which quickly can cause death," she says.

If the patient is exhibiting confusion, seizures, fever, tachycardia, tachypnea, hypertension, diaphoresis, or altered mental status, then there is a chance that the patient may die — even *with* treatment, says Leavitt. If you overlook a patient and an adverse outcome results, there is also the possibility of a malpractice lawsuit, she adds. "Left untreated, alcohol withdrawal can be life-threatening," says Leavitt, who adds that delirium tremens carries a death rate of up to 35% if left untreated.[1]

"If [alcohol withdrawal] goes unrecognized by the nurse, it is just as if she did not recognize a potential myocardial infarction and would constitute a 'missed' triage," she says.

To dramatically improve care of alcohol withdrawal patients, do the following:

• Don't make assumptions.

If a patient fits your expectation of a person likely to drink excessively — such as poor, male, and unemployed — he may be more quickly diagnosed than a woman with a fractured hip with no immediately visible symptoms, says Leavitt.

Remember that alcoholism cuts across gender, social, and age lines, says Leavitt. "I have taken care of 25-year-old male patients who are having withdrawal symptoms as well as women in their 60s," she says.

• Catch it early.

Many conditions often seen in EDs look a lot like alcohol withdrawal, including drug overdoses, infection of the brain, hypoglycemia, or patients who are postictal, says White. "It's a great masquerader," she says.

If you fail to recognize the emerging symptoms of alcohol withdrawal, the patient may be treated for the wrong condition, Leavitt warns. Look for the following signs and symptoms: abnormal vital signs, tachycardia, high blood pressure, elevated temperature, slightly enlarged pupils, and abnormal perspiration.

"These patients will look seem to have a lot of adrenaline in their system," says White. "One of the hallmarks is the tremor of the hand, eye, or tongue."

If the patient is in full-blown delirium tremens, expect to see an altered mental status, such as confusion or delirium. "The important thing is to catch them before they get to that point, when the patient comes in and reports feeling anxious," she says.

• Ask the right questions at triage.

Alcohol and substance abuse screening should be a standard part of triage, says Leavitt. "Normalize the questions by being matter of fact," she recommends. "Avoid a show of surprise when someone tells you, for example, that they drink a pint of whiskey a day."

Whether screening occurs at triage or at the bedside, the goal is to diagnose the patient early, so medication can be given to prevent escalation of symptoms, says White.

If a patient gets admitted from the ED for an unrelated

EXECUTIVE SUMMARY

Patients with alcohol withdrawal syndrome often are overlooked in the ED because early symptoms may be subtle, but treatment delays can be life-threatening.

- Early administration of benzodiazepines can prevent patients from progressing to delirium tremens, which has a 35% death rate if untreated.
- Common signs and symptoms of withdrawal include perspiration, tremors, and tachycardia.
- All ED patients should be screened for alcohol and substance abuse.

SOURCES/RESOURCE

For more information on caring for patients with alcohol withdrawal syndrome, contact:

- **Victoria Leavitt**, RN, Regional Nurse Educator, Emergency Services, Franciscan Health System, St. Francis Hospital, 34515 Ninth Ave. S., Federal Way, WA 98003-6799. Telephone: (253) 942-4139. E-mail: VictoriaLeavitt@chiwest.com.
- **Suzanne R. White**, MD, Clinician Educator, Emergency Medicine, Harper Professional Building, Detroit Medical Center, 4160 John R. St. Suite 616, Detroit, MI 48201. Telephone: (313) 745-5335. Fax: (313) 745-5493.

To obtain a faxed or e-mailed copy of the Revised Clinical Institute Withdrawal Assessment for Alcohol scale at no charge, contact:

- **Karen Benson**, Executive Assistant to Dr. Edward M. Sellers, President and CEO, Ventana Clinical Research Corp., 340 College St., Suite 400, Toronto, Ontario M5T 3A9. Telephone: (416) 963-9338, Ext 440. Fax: (416) 963-9732. E-mail: k.benson@ventana-crc.com.

problem such as an accidental fall and their alcoholism is unknown, that patient may go into alcohol withdrawal on the inpatient floors, White says. "This is a very common scenario," she adds.

• Administer medication early.

Early use of benzodiazepines is key, and you should treat in response to the patient's symptoms, advises Leavitt. "If the patient is still tremulous after 50 mg diazepam, then they have not had enough diazepam," she says. "Patients should be as symptom-free as possible."

There is no ceiling on the amount of benzodiazepines that may be given in these circumstances, and alcohol withdrawal syndrome is not an "all-or-none" phenomenon, says Leavitt. Symptoms may range from mild jitteriness to delirium tremens, she says.

Use an objective scoring system to assess severity of withdrawal, as this system will allow you to titrate the therapy to the individual patient, says White. "We no longer recommend fixed doses, such as 5 mg diazepam every 10 minutes," she says. "That is no longer considered the best way to approach this problem."

White recommends using the Revised Clinical Institute Withdrawal Assessment for Alcohol scale, which monitors the level of agitation or anxiety, orientation status, and whether the patient is vomiting, perspiring, or having hallucinations. **(See box, left, to obtain scale.)** "When used properly, this allows for less medication to be used in a shorter treatment period, with a better outcome," says White.

Reference

1. Accessed at http://www.emedicine.com/emerg/topic123.htm. ■

Are pediatric trauma carts missing essential supplies?

It's the worst pediatric trauma case you've ever seen in your ED: A child has life-threatening injuries from a motor vehicle accident. You rush to gather supplies and notice that the appropriate-sized chest tube is missing.

Don't let this unthinkable scenario occur in your ED. "If you are going to care for any pediatric patients, you need the right size equipment or you will have problems," warns **Kaaren Fanta**, RN, MSN, CPNP, trauma nurse practitioner at Cincinnati Children's Hospital.

If the right equipment is not readily available, results can be devastating, says **Pamela Smith**, RN, BSN, clinical nurse leader for children's emergency services at Medical University of South Carolina in Charleston. "Imagine trying to intubate an infant without an infant-sized tube or laryngoscope," she says.

Still, many EDs are lacking appropriate supplies for pediatric trauma patients, especially those that see these cases only rarely, says Smith. Even small community EDs must be ready to stabilize a child until transport arrives, which would necessitate having appropriately sized airway supplies and vascular access devices, she adds.

"They could get away with putting a needle in the chest for a pneumothorax if they don't want to go to the expense of carrying the smaller chest tubes, or they could decrease the amount of sizes they carry," she says. "Obviously, this will not work for a hemothorax."

There is a tendency to believe that "pediatric trauma won't happen in our ED," says **Kelly Arashin**, RN, ADN, CEN, charge nurse and trauma coordinator at Hilton Head (SC) Regional Medical Center. "Unfortunately, it does happen, and often it turns out that when

EXECUTIVE SUMMARY

Your ED may lack rarely used pediatric trauma supplies such as child-sized chest tubes, central lines, and intraosseous needles. This omission can have devastating consequences.

- At a minimum, have airway equipment and the ability to do vascular and/or intraosseous cannulation.
- Store supplies by size in packets or color-coded boxes.
- Refer to the color-coded Broselow Pediatric Emergency Tape to determine the correct size equipment.

it does, some EDs are not prepared," she warns.

Pediatric patients are not "little adults," says Arashin. "Children have anatomical features unique to their population, which pediatric supplies are designed for," she says. "Not having appropriate equipment or supplies can have disastrous consequences."

You can significantly improve care of pediatric trauma patients by following these tips:

• Make weight-specific packets of equipment.

For example, for a child weighing 10 kg, you would pull a packet containing all the appropriately sized equipment in one place, including face mask, Ambubag, endotracheal tube, and suction catheters, suggests Fanta.

"Keeping supplies stocked and replenished after each use will ensure the proper equipment is ready to use when needed," adds Arashin.

• Assess supplies on your pediatric trauma cart.

According to Fanta, your pediatric trauma cart should contain the following items in pediatric sizes: endotracheal tubes, face mask/resuscitation bags, laryngoscopes, oral airways, suction catheters (down to 6 FR) intravenous catheters (down to 24 gauge), interosseous needles, chest tubes, cervical spine collars, and blood pressure cuffs.

Supplies that are rarely used in EDs and therefore, might be overlooked include smaller sized chest tubes and central lines, says Smith. "We often use pediatric-sized triple lumens or pediatric jugular kits for central line access," she says. "The other thing missing would probably be intraosseous needles."

At an absolute minimum, EDs should have airway equipment and the ability to do vascular and/or intraosseous cannulation, says Smith, adding that laryngeal mask airways can be used in infants. "Obviously, appropriate airway size equipment is the most important thing," says Fanta. "If you cannot manage the airway, the patient will deteriorate."

• Use color-coded tape as a resource.

On the color-coded Broselow Pediatric Emergency Tape, the right-sized equipment is listed for each color, and this is a good rule of thumb to go by, says Smith. **(For information on ordering the tape, see resource box, below.)** The tape lists the right size for endotracheal tubes, stylet, suction catheter, laryngoscope, bag valve mask, oral airway, laryngeal mask airways, urinary catheter, end-tidal carbon dioxide detectors, nasogastric tube, intravenous catheter, interosseous lines, chest tubes, and blood pressure cuffs.

"For those who do not do pediatrics frequently and are unsure of the correct size equipment to use, this is a great tool," she says. **(See resource box, below, to obtain the tape.)**

SOURCES/RESOURCE

For more information about pediatric trauma supplies, contact:

- **Kelly Arashin**, RN, CEN, Trauma Coordinator, Hilton Head Regional Medical Center, 25 Hospital Center Blvd., Hilton Head Island, SC 29926. Telephone: (843) 689-6122, ext. 8281. E-mail: KelRN24@aol.com.
- **Kaaren Fanta**, RN, MSN, CPNP, Trauma Nurse Practitioner, Cincinnati Children's Hospital, 3333 Burnet Ave., Cincinnati, OH 45229. Telephone: (513) 636-0575. Fax: (513) 636-3827. E-mail: kaaren.fanta@chmcc.org.
- **Pamela Smith**, RN, BSN, Clinical Nurse Leader, Children's Emergency Services, Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29425. Telephone: (843) 792-1299. E-mail: smithpb@musc.edu.

The Broselow Pediatric Emergency Tape's 2002 Edition reflects the latest guidelines from the American Heart Association. A reference at each color bar on the tape informs you of equipment sizes to perform emergency resuscitation on a child. A reference at each weight zone on the tape shows pre-calculated medication dosages and infusion rates. The cost is $120 for a package of five tapes, plus shipping cost, which varies depending on location. To order, contact:

- **Armstrong Medical Industries**, 575 Knightsbridge Parkway, P.O. Box 700 Lincolnshire, IL 60069-0700. Telephone: (800) 323-4220 or (847) 913-0101. Fax: (847) 913-0138. E-mail: csr@armstrongmedical.com.

You can use the tape as a reference whether you stock supplies in a cart or a bag, says Smith. "Whether you use a cart or a bag depends on the amount of storage room you have for a cart vs. a bag and how secure the unit can keep the bag," she adds.

There were problems with missing supplies due to physicians using the bag for teaching purposes, she explains. "We can lock each individual drawer of the cart and don't have to restock the entire thing," says Smith.

• Use color-coded plastic boxes.

The Broselow/Hinkle ColorCode Cart with fully stocked Broselow/Hinkle Pediatric Emergency System gives you a mobile work station with everything you need for a pediatric emergency, says Smith. However, if you can't afford the cost of the this, which is approximately $2400, another option is to use colored plastic boxes with all of the appropriate size equipment in them for each color on the tape, suggests Smith. They can be stored in the bottom of the resuscitation cart so they are easily accessible, she says. "The carts are very expensive for a unit on a tight budget, and this is one alternative to actually purchasing the cart," she says. ■

Redirect nonurgent patients and comply with EMTALA

ED gives expedited MSE to 260 patients a month

Would you like to improve patient flow by decreasing the number of nonurgent patients waiting for care in your already crowded ED waiting room? At University of Colorado Hospital in Denver, physicians and specially trained ED nurses perform an expedited medical screening examination (MSE) after triage but before registration, and they report dramatic results.

EXECUTIVE SUMMARY

An expedited medical screening examination (MSE) by nurses or physicians can redirect nonurgent patients while complying with the Emergency Medical Treatment and Labor Act (EMTALA).

- There is the potential for bad publicity and liability risks.
- The practice does not violate EMTALA because no insurance or financial discussion occurs until after the screening.
- Only specially trained ED nurses may perform the expedited MSE.

"We screen and refer approximately 8% of our ED volume, about 260 patients per month," reports **Kathleen Oman**, RN, PhD, CNS, ED clinical nurse specialist and research nurse scientist.

Although the benefits of a less crowded waiting room speak for themselves, there also are potential problems related to expedited MSEs, she cautions. "There is the concern of bad public relations if the community, rightly or not, interprets us as denying care to the uninsured, and there are liability risks if a mistake is made," she notes.

Since the expedited MSEs were implemented, the ED has had to contend with an onslaught of bad publicity, such as frequent articles in the local newspaper with a negative slant, reporting on cases such as a man who drove a long distance to the ED seeking care for trauma to his jaw and after screening, was informed that he did not have an emergency. "In retrospect, we wished we would have anticipated this reaction and done some proactive work, such as sending out press releases explaining that we are trying to control wait times and overcrowding and educating patients about appropriate places to seek care," says Oman.

In addition, EDs are probably worried about possible violations of the Emergency Medical Treatment and Labor Act (EMTALA), says Oman. "We've had EMTALA violations alleged against us by both patients and other EDs, but investigations have supported our screening and decision-making process," she says.

Here are key steps in the MSE process:

• The exam is given to patients triaged at Level 4 or 5.

If the patient is triaged as a Level 4, the nurse places the patient in a room for the physician to do the MSE. If the patient is a Level 5, a specially trained nurse completes the MSE. Triage nurses receive a three-hour training on the protocols, EMTALA issues, and customer service in order to perform the MSE, says Oman.

Training includes an overview of EMTALA and an explanation of why this is not violating federal regulations, says Oman. "Nurses are instructed that there is no discussion of insurance or finances/charges before screening exam," she says.

Many times, triage nurses are not allowed to perform the MSE as they have not completed the training, notes **Amy Diesburg-Stanwood**, RN, an ED triage nurse at the facility. "In that case, if a physician is not able to perform the MSE, the patient stays in the ED and does not receive an expedited screening exam." About 20 nurses have completed the voluntary training so far, comprising one-third of the ED nursing staff.

The nurse and physician complete an MSE form that is more detailed than the standard triage form. "It includes physical findings that the nurse and physician

SOURCES/RESOURCE

For more information on expedited medical screening examinations, contact:

- **Amy Diesburg-Stanwood**, RN, Emergency Department, University of Colorado Hospital, 4200 E. Ninth Ave., Denver, CO 80262. E-mail: Amy.Diesburg-Stanwood@uch.edu.
- **Kathleen Oman**, RN, PhD, CNS, Clinical Nurse Specialist, Emergency Department, University of Colorado Hospital, 4200 E. Ninth Ave., Denver, CO 80262. Telephone: (303) 372-5634. E-mail: kathy.oman@uch.edu.

A patient education brochure, "What You Should Know about the Emergency Department," explains the problem of ED overcrowding and why some emergency patients experience long waits for care. Copies of the brochure can be downloaded at no charge on the American College of Emergency Physicians web site (www.acep.org). Click on "Health Information," "Brochures & Handouts," "What You Should Know about the Emergency Department — Four-color/Two-page version."

need to look for," says Diesburg-Stanwood. "This ensures that key findings, such as compromised circulation, are not missed."

• Patients are asked for a deposit.

If patients are assessed not to have an emergency medical condition, a registration clerk asks for a deposit to continue care in the ED. "The copay depends on the insurance status of the patient and can range from $3 to $260," says Oman. Patients without insurance are asked for a $260 copay.

If no deposit is made, the patient is given community referrals such as primary care clinics, women's health clinics, and dental resources. "Everyone has a choice, and care is not refused to anyone," says Diesburg-Stanwood. "If the patient pays their copay, they go back to the waiting room and wait behind the emergent patients."

• Many patients choose to seek care elsewhere.

Most patients given the expedited MSE do not have emergency medical conditions, notes Oman. "Our preliminary data showed that 38% of patients sought care elsewhere," she adds.

Patient with a mole

Recently, Diesburg-Stanwood triaged a Level 5 patient who presented with a mole on his back. "I pulled out the MSE form, assessed his mole, and explained to the man that he did not have an emergent condition, and he agreed," she says.

Diesburg-Stanwood explained that if the patient had an emergent condition he would be seen regardless of his ability to pay, but nonemergent conditions required a copay that is applied toward the ED visit. "He made the decision to leave after I educated him on follow-up options in the community and important changes to his condition that might change the status, such as signs of infection," she says.

Without the expedited MSE, people with emergencies would wait longer, says Diesburg-Stanwood. "It also gives the patient an understanding of what the appropriate use of the ED is, so that a patient with abdominal pain is not waiting behind a patient with a mole who does not need care today," she says. ■

Smart pumps can prevent dangerous drug errors

If there were a way you could substantially reduce the risk of infusion pump errors in your ED, would you do so? Surprisingly, although new technology is available that can prevent adverse outcomes from misprogrammed infusion pumps; only a small number of EDs are using this technology.

Cost is one of the biggest obstacles, says **Hedy Cohen**, RN, BSN, MS, vice president of the Huntingdon Valley, PA-based Institute for Safe Medication Practices. The initial investment is estimated by the Washington, DC-based Health Care Advisory Board at $1 million for a facility.[1] Also, you must take time to decide which pump to buy, address programming issues such as building the drug library based on the

EXECUTIVE SUMMARY

Infusion pump errors can be prevented with the use of smart pumps, but few EDs currently are using this technology.

- Cost of purchasing the product, in addition to the need for programming and training, are the biggest obstacles.
- The patient's weight, drug, and dosage is entered, and the correct drip rate is automatically calculated.
- If you enter a nonstandard dosage, the pump will prompt you to recheck the dosage ordered.

hospital's formulary and drug protocols, and educate staff on its use, she notes.

"You don't take it off the shelf and start using it," says Cohen.

When Spartanburg (SC) Regional Healthcare System implemented the Guardrails Safety Software Suite, a group of ED nurses attended off-site training classes held by the pump's manufacturer, San Diego-based Alaris Medical Systems, says **Becky Williams**, RN, an ED nurse at the hospital. **(See resource box on right to obtain more information on smart pumps.)** They then taught the rest of the ED staff how to use them, Williams says.

Money vs. safety

Most EDs don't have a lot of money available to purchase new technology, "but you have to consider safety when making purchasing decisions," Cohen says. Also, EDs may have contracts in place for existing pumps and may be unwilling to take a financial hit to switch to smart pumps, Cohen adds. Fewer than 5% of EDs currently use smart pumps, she estimates.

It took three decades for infusion pumps with free-flow protection to be standard in EDs, even after serious adverse outcomes and patient deaths were linked to these as early as the 1970s, says Cohen. "There was a simple solution, but it cost money, and here we are at the same crossroads again," she says. "But I don't think it will take 30 years to switch to smart pumps, because of public pressure to improve safety." Cohen expects the use of smart pumps in EDs to greatly increase in the next two to three years.

"The pumps save time and make patients safer by reducing the risk of human error," says **Amber L. Egyud**, RN, director of emergency services at Ohio Valley General Hospital in McKees Rocks, PA. "ED staff nurses find the pumps to be user-friendly and extremely efficient."

Shortly after smart pumps were implemented at Ohio Valley, a nurse incorrectly calculated the dosage of nesiritide for a congestive heart failure patient. This potentially devastating error never occurred, because the smart pump alerted the nurse that the dosage was incorrect, says Egyud. "The nurse then let the smart pump do the work, and the medication was administered at the correct drip rate," she says. "Death could have resulted because the dose was calculated by the nurse at double the amount that it should have been."

When seconds count, such as when a patient has a blood pressure of 60/40 and you need to administer intravenous dopamine immediately, the smart pump can potentially save a patient's life, says Williams. "The pump already has the drug option programmed and will calculate the amount using the patient's weight," she says.

The pumps eliminate the time spent by staff calculating drip rates, which saves about five to 10 minutes per patient, explains Egyud. "This could be life-saving when you are dealing with a critical patient who is having an acute myocardial infarction or a neurologic

SOURCES/RESOURCES

For more information about use of smart pumps in the ED, contact:

- **Hedy Cohen**, RN, BSN, MS, Vice President, Institute for Safe Medication Practices, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Telephone: (215) 947-7797. Fax: (215) 914-1492. E-mail. hcohen@ismp.org.
- **Amber L. Egyud**, RN, Director, Emergency Services, Ohio Valley General Hospital, 25 Heckel Road, McKees Rocks, PA 15136-1694. Telephone: (412) 777-6577. E-mail: aegyud@ohiovalleyhospital.org.
- **Becky Williams**, RN, Emergency Department, Spartanburg Regional Healthcare System, 101 E. Wood St., Spartanburg, SC 29303. Telephone: (864) 560-6000. Fax: (864) 560-6558. E-mail: bwilliams@srhs.com.

For information on the Guardrails Safety Software Suite for The Medley Medication Safety System, contact:

- **Alaris Medical Systems**, 10221 Wateridge Circle, San Diego, CA 92121-2772. Telephone: (858) 458-7000. Fax: (858) 458-7760. E-mail: internetebusiness@alarismed.com. Web: www.alarismed.com.

For information on the Outlook Safety Infusion System, contact:

- **B. Braun Medical**, 824 12th Ave., Bethlehem, PA 18018. Telephone: (800) 854-6851 or (610) 691-5400. E-mail: sapwebsiteinquiriesus@bbraun.com. Web: www.bbraunusa.com.

For information on Colleague CX infusion pumps with the Guardian feature, contact:

- **Baxter International**, One Baxter Parkway, Deerfield, IL 60015. Telephone: (800) 422-9837 or (847) 948-2000. Fax: (888) 229-0020 or (847) 946-2016. E-mail: onebaxter@baxter.com. Web: www.baxter.com.

injury such as a stroke or aneurysm," she says.

"If it is a high-risk medication such as [eptifibatide], a screen will come up alerting staff to monitor coagulation studies and hematocrit and hemoglobin for bleeding," says Egyud.

All the ED nurse needs to do is choose the right medication and concentration, then enter the patient's weight, says Egyud. "The smart pump does the rest."

However, that doesn't mean that your clinical judgment isn't important, stresses Cohen. "We don't want anybody to think that this pump is going to take away a nurse's cognitive thought process," she says. Think of it as a tool, like a seatbelt or airbag, Cohen says. "And as we go down the road, I think we will find it's an invaluable tool," she adds.

Reference

1. Health Care Advisory Board. *Reducing Adverse Drug Events: Costs, Benefits and Challenges of CPOE.* First Consulting Group, Washington, DC; 2003. ■

Use 'star' system to raise nursing morale in the ED

What is likely to be a more powerful morale booster than a pat on the back from your manager? A sincere compliment from a colleague.

At Lafayette (LA) General Medical Center, a "stars" reward program allows any staff member to compliment another for a job well done with a written note, called a stargram, with copies given to the staff member and his or her manager. This generates a point for the receiving staff member, who is given a reward after five "stargram" points are received.

"This allows the staff to recognize each other vs. just recognition by management," says **Vernon Craig Meche**, RN, BSN, CEN, an ED nurse at the facility.

Five stargram points earns a gift

At a staff meeting, nurses who have received five stargram points are presented with items such as a basket of sweet treats, with no gift costing more than $50 due to a policy prohibiting employees from receiving gifts of more than $50 value.

ED nurses receive points for actions such as picking up extra time when needed, staying after the end of a shift to help with a patient, or receiving a compliment on the patient satisfaction survey. The stargrams also are given for "extras" such as wheeling a patient out to the parking lot in bad weather, paying for a patient's ride home, or watching a patient's children while they are undergoing procedures.

"Any going above or beyond the call of duty may be judged as a point toward a reward," says Meche. "This keeps all staff working toward practicing quality nursing."

[Editor's note: For more information, contact Vernon Craig Meche, RN, BSN, CEN, Emergency Department, Lafayette General Medical Center, 1214 Coolidge, Lafayette, LA 70505. Telephone: (337) 289-7183. Fax: (337) 289-7172. E-mail: cmeche@lgmc.com.] ■

COMING IN FUTURE MONTHS

- Dramatically improve care of trauma patients
- Reduce impact of flu outbreaks on diversion
- Novel ways to cut delays in lab test results
- Solutions for your toughest patient safety problems

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 *Will your ED comply with safety goals? Don't wait until it's too late* and *Use creative strategies for JCAHO's new medication goal.*)
- **Describe** how those issues affect nursing service delivery. (See *Smart pumps can prevent dangerous drug errors.*)
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Fast treatment of alcohol withdrawal can save lives.*)

13. To comply with the Joint Commission's National Patient Safety Goal regarding fall prevention, which is recommended?
A. Assess the patient's risk of falling only at triage.
B. Work with pharmacists to identify medications placing patients at risk for falls.
C. Identify only those medications taken in the ED.
D. Only patients considered at high risk for falls need to be assessed.

14. Which is a requirement of the patient safety goals regarding patient medications being reconciled across the continuum of care?
A. Floor nurses are responsible for obtaining all medication information.
B. ED nurses must document only medications given in the ED.
C. If the patient is transferred, the transferring facility bears no responsibility for conveying medication information.
D. You must obtain and communicate a complete current medication list, whether the patient is admitted or transferred.

15. Which is recommended when caring for patients with alcohol withdrawal syndrome?
A. Use of an objective scoring system to assess severity.
B. No treatment should be given except for patients in delirium tremens.
C. Subtle symptoms such as anxiety and perspiration call for a wait-and-see approach.
D. Fixed doses of benzodiazepines should be given.

16. Which is a benefit of smart pumps?
A. No training is needed.
B. The cost involved is minimal.
C. Medications can be given more quickly.
D. Nurses don't need to select the medication or concentration.

Answers: 13. B; 14. D; 15. A; 16. C.