ED NURSING®

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IN THIS ISSUE

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Are you about to be sued? Make practice changes now, avoid disaster

Staffing shortages and overcrowding put you at risk for lawsuits

Picture a packed waiting room in the height of the flu season. Could a 61-year-old woman in heart failure be mistaken for another pneumonia case? That's what a patient's family said happened in one ED when a woman with labored breathing was left to wait for several hours as her condition worsened. As a result of lack of intervention by overworked emergency nurses, the patient required resuscitation that left her paralyzed and unable to talk, the family claimed. Her family sued for malpractice and argued that inadequate nurse staffing harmed the patient irreversibly. They won a $2.76 million settlement.[1]

"Any time a case such as this receives national attention, and with the litigious nature of our country, more suits based on similar claims are bound to be filed," says **Trudy Meehan**, RN, CHE, principal of Gonzales, LA-based Meehan Consultants, a legal nurse consulting company and former ED director at East Jefferson General Hospital in Metairie, LA. "Who hasn't heard of the many states with mandatory staffing ratios? These are fuel for that fire."

ED overcrowding and the nursing shortage are dangerous for patients, and as a result, nurses are more likely to be sued, warns **Mary Ann Shea**, JD, RN, a St. Louis, MO-based nurse and attorney. "I fear that we might see an increase in lawsuits against nurses," she says. "I present lawsuit prevention seminars to nurses all over the country, and one of the most frequently expressed concerns

EXECUTIVE SUMMARY

ED nurses are facing increased liability risks due to the nursing shortage and overcrowding. One successful malpractice case specifically involved inadequate nurse staffing in the ED.

- If you realize you forgot to document something, add it to the patient's chart as a late entry.
- Remember increased requirements for critical care patients, such as specific staffing ratios and documenting intake/output.
- In addition to documenting any change in vital signs, you must document the fact that a physician was informed and his/her response.

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by nurses is short staffing and its effect on the quality of the care given."

She points to a case of a 33-year-old woman who came to an ED with complaints suggestive of myocardial infarction. "She was sent to the waiting room and was found in cardiac arrest about 50 minutes later," recalls Shea. "The ED staff attempted to defend themselves by claiming the ED was full and there was no bed for her. The case settled for $850,000."[2]

Jackie Ross, RN, BSN, CPAN, a Chagrin Falls, OH-based risk management consultant who specializes in health care, says, "I have noted that individual nurses are being named more frequently in the cases that I am reviewing."

Too often, nurses lack time to give the quality of care they feel is appropriate, says Shea. "Numerous statistics show that the number of medical errors is increasing," she says. "And as the errors increase, so does the likelihood of being sued."

To dramatically decrease your liability risks, do the following:

• Don't forget to document.

Lack of documentation is the No. 1 liability risk for ED nurses, says **Kathie Eberhart**, BSN, RN, CEN, a Santa Rosa, CA-based legal nurse consultant and ED nurse at Santa Rosa Memorial Hospital.

If you realize within an hour or two after completing a procedure that you forgot to document something, you should document a "late entry" note, she advises. If a longer time has passed, you still should chart it with the time and date, Eberhart adds, because this information is better late than never.

"If ever asked about it in a deposition, you can explain that you were too busy to document it at the time of occurrence," Eberhart says.

A late entry note within a reasonable time period is always better than no documentation at all, but this type of entry should be the exception, not the rule, Eberhart says. "You need to make the time to document, even if just writing down a set of vital signs at a certain time," she says.

Always document any change in patient status, such as vital signs, onset of chest pain, shortness of breath, level of consciousness, or cardiac rhythms, says Eberhart. It's not enough to document that a patient is reporting chest pain — you also must document that the ED physician was made aware of this change in patient status, she adds, such as, "Dr. X advised no change in orders."

"Many nurses do not do this," she says.

• Give admitted patients the same standard of care as they would receive as inpatients.

With more admitted patients being held in the ED to await an available bed, nurses often fail to follow stricter requirements for critical care patients, says Eberhart. A common omission is documentation of urine intake and output for patients with a Foley catheter, she says.

"It may not be an immediate problem, but hours later when the patient is on fluid overload, you need to know how much their intake and output was," she says.

Be aware of your state's regulations regarding nurse staffing ratios, advises Eberhart. For instance, in California, an intensive care unit (ICU) nurse cannot have more than one or two patients at a time, depending on acuity, and therefore the same ratios must apply in the ED.

This is a tremendous challenge, she acknowledges.

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"If we are holding four ICU patients, that's two nurses right there, which may be a third of our staff," she says. "If we don't have enough staff to cover the other patients, this can turn into a dangerous situation for patients. It may mean going on divert."

• Always communicate patient complaints to the physician.

When two children were brought to an ED with rashes, their mother told the nurse that one of the children had tick bites, but the nurse did not communicate this to the physician, says Shea.

"The physician diagnosed the children with measles, and this misdiagnosis resulted in the death of one of the children," she says. "The nurse was found to be negligent in this case."[3]

• Always give thorough discharge instructions.

If a patient sustains a lower extremity fracture and is casted in the ED, the discharge instructions must include the need to monitor the distal neurovascular status, says Shea.

"This must be stated in lay terms so the patient understands what to do," she says. For example, Shea says, an appropriate instruction might read, "Check toes of casted leg every four hours. Notify Dr. Smith or return to ED immediately if you experience loss of feeling, discoloration, or severe pain in your foot or toes."

If patients are not informed about the need to do this, they could develop a serious complication such as compartment syndrome and subsequently lose a leg or the function in a leg, says Shea. "The nurse could share in the liability in this case," she adds.

Many malpractice lawsuits involve claims that the patient was not aware of whom to call or how to treat a wound after discharge from the ED, notes Ross. "It is important that accurate information, including at least two contact phone numbers, is included on the discharge instructions," she says.

Also document which family members or others were present during the discharge instructions, especially if the patient received any sedation or narcotics, says Ross.

Always reassess your patient at the time of discharge and report any change in the patient's status to the physician, since otherwise an unstable patient could be sent home, advises Eberhart.

• Establish a good rapport.

Many nurses underestimate the significance of rapport, emphasizes Shea. "Being courteous and friendly, exhibiting a caring demeanor, and smiling are very simple ways to establish a relationship with the patient and family that result in their not wanting to pursue legal action against you," she says.

• Don't hesitate to question orders.

Several claims have involved nurses failing to question an order for a medical treatment or medication, says Ross.

"If the nurses are concerned about a physician's order, it is their responsibility to voice concerns," she underscores. "Nurses are professionals and will be held accountable for their actions and inactions in court."

You can prevent bad outcomes and litigation by being a patient advocate, says Eberhart. "I have caught medication orders with the wrong dose many times," she says. "Most of the time [when you question orders], the order is fine and you are wrong. But what about that time when you are not wrong?"

SOURCES

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2. Laska L. Failure to diagnose and treat MI results in death of 33-year-old woman. *Medical Malpractice Verdicts, Settlements, and Experts* 1998; 14:26.
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Dramatically improve care of your trauma patients

Be honest: Are you truly comfortable caring for trauma patients? Many ED nurses rarely see these cases, notes **Pat Manion**, RN, MS, CCRN, CEN, trauma coordinator at Genesys Regional Medical Center in Grand Blanc, MI.

"Whether the nurse works in a large urban ED or a smaller community hospital, the major trauma patient

EXECUTIVE SUMMARY

To prevent hypothermia in trauma patients, warm intravenous fluids and blood products, keep the patient covered, and give uncrossmatched blood using the rapid infuser/fluid warmer.

- Obtain a baseline temperature as quickly as possible.
- Empty the urinary drainage bag before you obtain a specimen.
- Stabilize pelvic fractures to prevent significant blood loss.

is always a challenge," she says.

Simple practice changes can be potentially life-saving to these patients, she adds. You can significantly improve care of trauma patients by taking the following steps:

• Obtain an accurate temperature as soon as possible on all trauma patients.

There is a tendency to think that "the patient is too sick to bother with this" or that other things are much more important, says **Jean M. Marso**, BSN, RN, trauma coordinator at University of Colorado Hospital in Denver.

"Hypothermia only creates more problems for trauma patients, and you need a baseline temperature to know where you are starting from," she says.

Always warm all intravenous (IV) fluids and blood products, says Marso. If warm fluids aren't enough, you may need to increase the room temperature, add a warming blanket or keep the patient covered by exposing only one part of the body at a time, she adds.

"You won't know if these measures are enough if you don't have a baseline body temperature to compare serial temperatures to," she explains.

• Before obtaining a urine specimen, empty the urinary drainage bag.

"It is easier to monitor the urine output when you start with an empty bag," says Manion. Monitoring urine output is one of the assessment parameters to determine adequate resuscitation, she explains. Intensive care units routinely monitor urine output with special urinary drainage bags, but these bags are rarely used in the ED, Manion adds.

"Starting with an empty urinary drainage bag allows almost continuous visual monitoring of urine output," she says.

• Keep patients warm.

"There are many factors that can rapidly lead to hypothermia in a trauma patient," says Manion. This is one component of the "trauma triad of death" of hypothermia, academia, and coagulopathy, she notes. Patients are at risk from wet clothing, pre-hospital environmental temperatures, removal of clothing in the trauma bay, the use of intravenous fluid that has not been warmed, and irrigation of open wounds, she says.

By applying three warm blankets horizontally — one from the neck to the lower chest, one from the lower chest to the groin, and one from the groin to the feet — you can continue the physical exam without baring the patient's entire body, says Manion.

"Keeping the patient covered is a simple way of preventing loss of body heat," she says.

• Ensure that pelvic fractures are initially stabilized.

"Open-book" pelvic fractures can potentially cause significant blood loss into the retroperitoneal space, and "closing the book" can stabilize the pelvis and decrease the amount of blood loss, Manion notes.

This closing can be accomplished in a variety of ways, including application of an external fixater, use of a pneumatic antishock garment, or commercially available pelvic orthotic devices, says Manion. "If none of these options are available to you, then wrap the pelvis snugly in a sheet and tie the patient's ankles together," she says. "Do not cross the ankles."

• Administer uncrossmatched blood using the rapid infuser/fluid warmer.

Uncrossmatched blood is refrigerated, so the patient is in danger of losing a lot of body heat when this blood is being administered, notes **Timothy Murphy**, RN, MSN, APN, C, nursing director for the trauma program

SOURCES

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at Robert Wood Johnson University Hospital in New Brunswick, NJ. "If a patient is sick enough to need uncrossmatched blood, then they are probably receiving lots of fluid," he says.

These patients are also susceptible to developing hypothermia from blood loss and receiving large amounts of cool fluid, he says. "The colder they get, the more they bleed."

New trauma nurses often wonder when to set up the Level I rapid infuser/fluid warmer because it is very time-consuming and labor-intensive, he says. This should be done whenever uncrossmatched blood is given, Murphy says.

Other warming techniques include adjustment of the thermostat in the room, a convection warmer, warming lights, or warmed humidified oxygen for ventilated patients, he adds.

• **Record intake and output.**

"Many charts that I review do not have this recorded," says Marso.

A Foley catheter usually is put in place for trauma patients, whether stable or unstable, but often no one writes down the initial output, subsequent hourly outputs, or the total output, she says.

"Certain trauma patients are at increased risk for acute respiratory distress syndrome, and the kidneys are a great window to view how the body is responding to resuscitation," Marso says. ■

Reduce the risks of verbal orders with these steps

Verbal orders can put patients in danger for serious adverse outcomes resulting from medication errors, and the ED is at especially high risk for this, says **Lisa DiMarco**, RN, BSN, MBA, administrative director for emergency services at Edward Hospital in Naperville, IL. "Unlike other departments, verbal orders are common in the ED — out of both habit and necessity."

You can radically improve the safety of verbal orders by doing the following:

• **Comply with requirements of the Joint Commission on Accreditation of Healthcare Organizations.**

According to the Joint Commission's National Patient Safety Goals, verbal or telephone orders or telephonic reports of critical test results must be verified by having the person receiving the order or test result read back the complete order or test result.

At Tallahassee (FL) Memorial HealthCare, orders are written and read back to the physician, except in dire emergencies such as resuscitation, major trauma, life- or limb-threatening events, says **Debora Lee**, RN, assistant director of the hospital's Bixler Emergency Center. "It has been emphasized to all staff to be extra vigilant with verbal orders. This is a huge patient safety issue."

In a life-threatening situation, such as a cardiac arrest, the writing step is eliminated and the order is simply repeated to ensure clarity, says DiMarco.

• **Reduce verbal orders.**

"It is our practice that verbal orders are to be accepted only in an emergency, when life, limb, or eye is compromised or threatened," says **Sylvie Simpson**, RN, an ED nurse clinician at Orlando (FL) Regional Healthcare. "All other verbal orders must be followed with a written order for nursing to initiate them."

At Harford Memorial Hospital in Havre de Grace, MD, it was common for nurses to request an order and then write it for the physician, but physicians are now expected to write their own orders, says **Barb Baughman**, RN, director of emergency services. "We also had to work with the private attendings in the ED," she says. "The rule became: If you are in the ED, you need to write it."

Still, the ED ends up with many telephone orders for inpatients admitted through the ED, which make up about 70% of admissions. In order to obtain written orders, attending physicians are contacted before patients are transported to inpatient units, says Baughman. "We remind them they can fax the order to us. The idea is that we will take verbal orders, but it should be the last resort," she says.

• **Create a "pre-chart" order sheet.**

A "pre-chart" order sheet is used in Edward Hospital's ED when a patient is in the treatment area but a chart is not available yet. Staff members write down orders on the sheet at the time the physician calls out the order, says DiMarco. The form uses a checklist format for commonly ordered diagnostic studies with a space to record the time ordered. **(See Pre-Chart Order Sheet on p. 6.)**

EXECUTIVE SUMMARY

The ED uses verbal orders more frequently than other departments, so there is a higher risk of error.

- Verbal orders should be used only in an emergency.
- Verify verbal orders by reading back to the physician.
- To reduce verbal orders, use standing orders and electronic systems.

Continued on page 7)

EDWARD HOSPITAL
801 South Washington St.
Naperville, IL 60566
630-355-0450

PRE-CHART ORDER SHEET

TIME ORDERED	DIAGNOSTIC STUDIES
	☐ CBC _____
	☐ HEMOGRAM _____
	☐ LIVER
	☐ BMP
	☐ CMP
	☐ LIPASE ☐ AMYLASE
	☐ PT _____
	☐ PTT
	☐ TSH/T4
	☐ ETOH_____
	☐ ABG _____
	☐ QUANT HCG
	☐ DRUG LEVEL _____
	☐ UA ☐ GC/CHLAMYDIA
	☐ URINE DRUG SCREEN
	☐ WET PREP
	☐ CULTURE
	☐ EKG ☐ OLD EKG ☐ OLD CHART
	☐ MONITOR
	☐ ORTHOSTATIC
	☐ RESTRAINTS
	☐ IV FLUIDS/RATE _____
	☐ SALINE LOCK
	☐ DIET _____
	☐ CARE MAP
	☐ O2 SAT
	☐ O2_____
	☐ ASA CLASS SYSTEM
	☐ P 123456
	☐ PEAK FLOW

TIME ORDERED	DIAGNOSTIC STUDIES
	☐ URINE DIP _____
	☐ URINE PREGNANCY
	☐ ISTAT
	☐ ACCUCHECK

ORDER SETS

	☐ AMI ☐ CHAMPION ☐ OD
	☐ MYOCA ☐ 1ST TRIMESTER
	☐ ASSAULT ☐ DATE RAPE DRUG
	☐ CSF
	☐ EXPOSED
	☐ SOURCE
	☐ SEPSIS ☐ STROKE
	☐ PSYCH

RADIOLOGY

	☐ X-RAYS
	☐ CT
	☐ US

MEDICATION/TREATMENTS

TIME SEEN BY MD_____

MD SIGNATURE _____

RN SIGNATURE _____

PATIENT LABEL

PRE-CHART ORDER SHEET

Source: Edward Hospital, Naperville, IL.

SOURCES

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The physician or nurse writes the patient's name on the pre-chart, since labels are not yet available. The nurse calls back the order after it is written, and the physician signs the pre-chart. This order form becomes part of the ED medical record. It is not used for subsequent orders if the normal ED record is available, reports DiMarco.

"We have had very good compliance with this process from the ED physicians and nurses," she says.

• Use a "check-back" process.

This process was implemented for unit clerks who receive verbal orders from physicians, such as orders to page a particular attending or to order a specific test for laboratory or X-ray, says DiMarco.

Many times, the physician would ask to have an attending physician paged, but the page was never returned because the unit clerk had not heard the request or the incorrect physician was paged, she notes. Another common problem was a physician writing an order for a lab or X-ray but getting no acknowledgment from the unit clerk, says DiMarco.

"The intent of the new check-back process is that the physician knows the unit clerk heard what was asked, and that any necessary clarification can be made at the time of the order," she says. "This is new, and we are managing the process to ensure there is compliance."

• Increase use of standing orders.

At Orlando Regional's ED, protocols were revised to include more standing orders with the goal of reducing verbal ordering for standard interventions, says Simpson. "This helps you to define orders for patients who have not been diagnosed yet, and it also decreases turnaround times when initiated at onset of care."

• Use electronic systems for ordering.

Currently, an electronic documentation system is being developed at Orlando Regional's ED to allow private physicians to enter orders for nursing from outside the hospital, reports Simpson. "The philosophy is that physicians should be responsible for effectively communicating their orders to nursing," she says.

• Perform audits to assess procedures for verbal orders.

At Harford Memorial, a monthly safety goal audit that includes verbal orders is done on the ED.

"We either do direct observation or ask what the procedure is for verbal and telephone orders, and score units for a correct answer," says Baughman. "Completing these audits allows us to target those who are noncompliant, and this is included on their annual evaluation." ■

No. 1 EMTALA mistake: Confusing triage and MSE

What's the most common mistake resulting in potential violations of the Emergency Medical Treatment and Labor Act (EMTALA) made by emergency nurses? Most likely, it is confusing triage for a medical screening examination (MSE).

"This is a major misconception in many facilities," says **Stephen A. Frew**, JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals.

ED nurses often believe that the triage classification determines whether EMTALA applies, or that triage is the MSE required by EMTALA, but these are dangerous misconceptions, he warns. Penalties include fines of up to $50,000 per violation and possible termination of the hospital's Medicare provider agreement.

"Triage does not meet the medical screening requirements," he says. "Triage only determines the order in which patients receive the medical screening."

The fact that the patient is triaged as "nonurgent" doesn't mean that the patient does not have an emergency medical condition as defined by EMTALA, says Frew. "The patient still must be seen and evaluated under EMTALA."

The MSE has nothing to do with triage and is not a sorting process, says **Shelley Cohen**, RN, CEN, a

EXECUTIVE SUMMARY

Triage does not meet the requirements for a medical screening examination (MSE) under the Emergency Medical Treatment and Labor Act.

- Triage only determines the order in which patients receive the MSE.
- The purpose of an MSE is to determine if an emergency exists.
- The required resources will differ for individual patients, and they will range from a brief assessment to extensive laboratory tests.

consultant and educator for Health Resources Unlimited in Hohenwald, TN. "It is a determination to answer one question: Does your patient have an emergency or not?"

To avoid violations of EMTALA, you must do the following:

• Read the law.

Educate yourself on the definition and requirements of the MSE under EMTALA, and review your medical screening practices accordingly, says Cohen. "Read an actual copy of the federal law and learn the difference between triage and a medical screening examination. Then, ensure all ED registration staff understand the difference as well," she recommends. **(To obtain a copy of the law, see resource box, right.)**

ED nurses should participate in educating unlicensed staff about MSE requirements, adds Cohen.

In addition, if administration is considering using nurses to perform the MSE, get something in writing from your state board of nursing that confirms this is within your scope of practice, she advises.

• Remember that examination is different for every patient.

"Each patient will require different resources from your hospital to figure out whether an emergency exists," says Cohen. She gives the example of a man with an earache, no history of injury or other complaints, and normal vital signs. If a physician peeks his head in the door without even talking to the patient, reviews the triage notes, and decides it's not an emergency, that may be the patient's MSE.

In contrast, a 28-year-old female with abdominal pain would require more extensive testing to comply with the requirements, says Cohen. "Her screening exam may include a report from a radiologist after an abdominal ultrasound is done, because the presence of an ectopic pregnancy would be a medical emergency," she says.

• Don't discuss money before the MSE is completed.

When you are finished triaging the patient, the patient may go to an exam room, a registration desk, or back to the waiting room, says Cohen. "If the next step involves questions about ability to pay, you have to ask yourself if the medical screening exam is being delayed," she says.

For example, if patients are being registered at the bedside, you can ask any questions about anything you want except for the ability to pay, which must be delayed until after the MSE is done, says Cohen.

If the patient is waiting for the next step in care to begin, you could conceivably argue that discussion about payment is permitted, because this discussion is not causing any delay in care, says Cohen. For example, if you are waiting for the results of an abdominal ultrasound and you still don't know if the patient has an emergency, it might be legally defensible to address payment issues while waiting.

"It may take an hour and 15 minutes to get a report back from radiology, and you are not delaying anything," says Cohen. "But could somebody take that to task? Sure they could."

The best rule of thumb is to always put the patients' interests first, Cohen recommends. "You can 'what if' this whole EMTALA thing to death, and the bottom line will always be, did you do what is in the best interest of the patient, and did you do what was reasonable in that particular situation," says Cohen. "If you look at the specific wording of the law, it uses the word 'reasonable' repeatedly for a reason." ■

SOURCES/RESOURCE

For more information about medical screening examinations and the Emergency Medical Treatment and Labor Act, contact:

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To obtain the full text of the Emergency Medical Treatment and Labor Act regulations, go to www.medlaw.com. Under "New EMTALA Regulations Released — Effective 11/10/2003" and beside "Download regulations in PDF format," click "View."

Are you comfortable caring for seriously ill children?

Many ED nurses are wary of caring for sick or injured children, but these patients have unique needs that every nurse must be prepared for, says **Nancy Blake**, RN, MN, CCRN, CNAA, director of critical care services at Children's Medical Center in Los Angeles. Adverse outcomes may occur if pediatric education is allowed to fall by the wayside, she warns.

"The statistics across the country are that anywhere from 20%-30% of the ED visits are children — so all EDs see kids. But many adult nurses would rather not take care of pediatric patients because they don't feel comfortable with it," she says. "Also, in rural areas, they may not have educational resources in the community."

Pediatrics patients are *not* just small adults, says Blake. "There are unique characteristics in children that are both physiological and psychosocial."

There are anatomical differences in children that could cause problems that wouldn't necessarily be a problem with adults, says Blake. "For example, the airway in children is much smaller in diameter, and a small amount of mucus or swelling in the airway could cause a problem in an infant," she says.

Without effective inservices, problems such as poor airway management, multiple attempts to start intravenous lines, inadequate pain management, unnecessary transport to other facilities, and lack of emotional support for patients and families are bound to occur, says **Ginger Young**, RN, clinical educator for the ED at Children's Medical Center Dallas. "Fear of the pediatric patient is often a big obstacle for those nurses used to the adult population," she says. "Lack of knowledge and the emotional component is also difficult."

If ED nurses are not effectively inserviced on the medications and equipment to use for pediatric patients, they could give incorrect dosages that could cause a sentinel event, warns Blake. "They also might not have the appropriately sized equipment for a child and have an untoward outcome because of inappropriate equipment," she says.

To ensure your ED provides appropriate care of pediatric patients, do the following:

• Enroll in pediatric courses.

Blake recommends taking the Pediatric Advanced Life Support (PALS) class provided by the Dallas-based American Heart Association. **(See resource box on p. 10 for more information.)**

"This is a very good course to teach the basics of emergency resuscitation," she says. For the basics of pediatric emergency nursing, she recommends the Emergency Nursing Pediatric Certification (ENPC) course, given by the Des Plaines, IL-based Emergency Nurses Association. **(See resource box on p. 10 for more information.)** "It gives a basic overview of all pediatric emergencies, including pediatric trauma and child maltreatment."

If your hospital doesn't offer this training, find out if a local pediatric facility does, recommends Blake. At Children's Hospital Los Angeles, PALS classes are offered monthly, and ENPC classes are offered quarterly. "These classes are always full, and we offer the training to outside nurses," Blake says. "Many local hospitals actually send two to four of their nurses to every class, so within two years they can have their entire staff trained without offering it on site."

• Take on-line courses.

If you can't obtain funding for off-site education or a course is not available in your area, consider taking the on-line program *Essentials in Critical Care Orientation*, offered by the Aliso Viejo, CA-based American Association of Critical Care Nurses. **(For more information, see resource box, p. 10.)** "This has the basic pediatric content about developmental care in pediatrics and unique disease processes seen in pediatrics," says Blake.

• Invite experts to give inservices.

Many transport teams who work with pediatric populations have education services available, says Young. "They will gladly come to an ED and provide inservices to the staff," she says.

If you have one or two nurses in your ED who have

EXECUTIVE SUMMARY

Even if your ED rarely treats children, you must be prepared for the unique needs of these patients. If pediatric education falls by the wayside, adverse outcomes can occur.

- If your hospital doesn't offer pediatric emergency nursing courses, find out if a local pediatric facility does, or take on-line courses.
- Invite local transport teams and experienced nurses to give inservices.
- Survey nurses about their education needs, and assign groups to give presentations on these topics.

worked with the pediatric population, tap into their knowledge base by having them inservice the staff on problem areas, suggests Young. "Get a respiratory therapist to teach staff how to assess an airway and how to suction a pediatric patient," she advises.

SOURCES/RESOURCES

For more information on pediatric education, contact:

- **Nancy Blake**, RN, MN, CCRN, CNAA, Director of Critical Care Services, Children's Hospital Los Angeles, 4650 Sunset Blvd., Mailstop 74, Los Angeles, CA 90027. Telephone: (323) 669-2164. Fax: (323) 953-7987. E-mail: nblake @chla.usc.edu.
- **Ginger Young**, RN, Clinical Educator, Emergency Center, Children's Medical Center Dallas, 1935 Motor St., Dallas, TX 75235. Telephone: (214) 456-5686. E-mail: ginger.young@childrens.com.

The Pediatric Advanced Life Support (PALS) course provides information and strategies needed to recognize and prevent cardiopulmonary arrest in infants and children. For more information, contact:

- **American Heart Association**, National Center, 7272 Greenville Ave., Dallas, TX 75231. Telephone: (877) 242-4277. E-mail: eccinfo@heart.org. Or to find a list of PALS courses in your area, go to www.americanheart.org. Click on "CPR & ECC" and "Find a Class Near You."

Emergency Nursing Pediatric Certification (EPNC) is a 16-hour course providing training in pediatric emergency nursing, including pediatric trauma and resuscitation. For more information, go to the Emergency Nurses Association web site (www.ena.org.) Click on "CATN II/ENPC/TNCC" and "ENPC." For a list of individuals to contact in your area, click on "Listing of ENPC contacts by state." Or contact:

- **ENA**, **Course Operations Department**, 915 Lee St., Des Plaines, IL 60016-6569. Telephone: (800) 900-9659 or (847) 460-4120. Fax: (847) 460-4001. E-mail: jmika@ena.org.

Essentials in Critical Care Orientation is a web-based tool to teach nurses the basics of critical care. A site license for a one-year term costs $1,500 with additional fees for each end user. For more information, contact:

- **American Association of Critical Care Nurses**, 101 Columbia, Aliso Viejo, CA 92656-4109. Telephone: (800) 394-5995 ext. 8870 or (949) 362-2000. Fax: (949) 362-2021. E-mail: ecco @accn.org.

• **Have nursing grand rounds.**

At Children's Medical Center Dallas, ED nurses were surveyed about the areas for which they wanted additional education. "We then compiled a list of the top 10 subjects," says Young.

Two or three nurses paired with an ancillary staff member such as a respiratory therapist, pharmacist, or social worker, and an attending physician. The group developed an inservice for topics such as trauma in the pediatric patient with a child abuse component, sepsis, and Kawasaki's disease. "This also was an education for the staff who presented," she says. ■

COST-SAVING TIP

Save $1,000 by having secretaries order supplies

In 2003, the ED at Indiana University Hospital in Indianapolis finished the year $327 over budget for supplies. As of August 2004, it was $725 under budget. What made the difference? Handing over the role of supply ordering to unit secretaries.

"In my first year in a new role as an ED manager, I struggled with keeping the cost of office supplies within budget," says **India Owens**, RN, BSN, ED clinical manager.

The unit secretaries traditionally had ordered supplies, and this made sense as they were the closest to the actual work being done, she says. "It did not seem prudent to change the process to make myself the gatekeeper," she says. "They knew what they needed to do their work and to support the nursing staff and the physicians."

However, Owens noticed a lot of unnecessary expenditures. "For instance, each week an order would be placed for 200 3x5 index cards," she says. "When I questioned the secretaries, they told me they liked to use those for scrap paper because they were less easily misplaced."

In 2004, Owens gave ownership of the supply budget to the secretaries and called a meeting to announce the dollar amount that they had to spend for the year. She explained that it was their responsibility to manage supplies within budget and that they had free reign on what they ordered or when they ordered it, as long as they stay within that dollar amount for the year.

"I am excited to say they have taken up the challenge and have become prudent stewards of the hospital's money," says Owens. "I have witnessed them collaboratively making decisions to purchase less expensive items

than they previously chose, chiding the nurses on the number of pens they are losing, and recycling paper for scrap pads."

A side benefit is improved morale of the secretarial staff. "They feel empowered — and they know to a penny how much they still have left in their account," says Owens.

[Editor's note: For more information, contact: India Owens, RN, BSN, Clinical Manager, Indiana University Hospital, 550 N. University Blvd., Room 1574, Indianapolis, IN 46202-5250. Telephone: (317) 278-8306. Fax: (317) 278-0943. E-mail: IOwens@clarian.org.] ■

Know risk of antibiotic for patients on some meds

Are you aware of the life-threatening risks of the antibiotic erythromycin for patients taking certain medications? Researchers found that patients given this antibiotic who were also taking calcium-channel blockers, antifungal drugs, or antidepressants had a five-times greater risk of sudden death from cardiac causes than patients who did not take these drugs.[1]

The study's findings allow you to make informed choices about which antibiotics should be used for these patients, says **Carolyn Clancy**, MD, director of the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ), which cofunded the study.

The researchers did not find the same increased risk for patients who took the medications with other antibiotics. "Clinicians should avoid prescribing erythromycin to patients taking these medications, because there are safer alternatives," she says.

Previously, there were case reports linking erythromycin, a very commonly used antibiotic, with an increased risk of arrhythmias and cardiac deaths, says Clancy. "What this study showed is that this risk is increased if people are already taking a drug that interferes with the metabolism of erythromycin," she says.

While the prior case reports focused on patients receiving intravenous erythromycin, this study looked at oral erythromycin and found the same increased risk of cardiac deaths in patients taking one of the other drugs, Clancy notes. "What this means for ED nurses is that they should seek to use another alternative, or raise questions if patient is on a calcium channel blocker and someone recommends prescribing erythromycin," she says.

This underscores the importance of teaching patients to carry medication cards listing current drugs and dosages, says Clancy. She recommends directing patients to the AHRQ web site, which lists "5 Steps to Safer Health Care" (www.ahrq.gov/consumer/5steps.htm). "If you know the patient is being treated for high blood pressure or has a fungal infection and is likely to be on medications, then it's safer to use an alternative," adds Clancy.

SOURCE

For more information about the risks of erythromycin, contact:

- **Carolyn M. Clancy**, MD, Director, Agency for Healthcare Research and Quality, John M. Eisenberg Building, 540 Gaither Road, Rockville, MD 20850. Telephone: (301) 427-1200. Fax: (301) 427-1201. E-mail: carolyn.clancy@ahrq.hhs.gov.

Reference

1. Ray WA, Murray KT, Meredith S, et al. Oral erythromycin and the risk of sudden death from cardiac causes. *New Eng J Med* 2004; 351:1,089-1,096. ■

BINDERS AVAILABLE

ED NURSING has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **ahc.binders@thomson.com**. Please be sure to include the name of the newsletter, the subscriber number and your full address.

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COMING IN FUTURE MONTHS

- ■ Comply with JCAHO's falls reduction safety goal
- ■ Easy steps to perform a neurological assessment
- ■ Improve documentation to avoid EMTALA violations
- ■ Quick ways to resolve conflicts with other departments

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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 in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE*questions*

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

- **Identify** clinical, regulatory, or social issues relating to ED nursing (See *Are you about to be sued? Make practice changes now, avoid disaster,* and *No. 1 EMTALA mistake: Confusing triage and MSE.)*
- **Describe** how those issues affect nursing service delivery. (See *Reduce the risks of verbal orders with these steps.)*
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Dramatically improve care of your trauma patients.*)

17. Which of the following is recommended to decrease liability risks for emergency nurses, according to Kathie Eberhart, BSN, RN, CEN, a legal nurse consultant?
A. Never add any documentation after the fact, regardless of how soon afterward you remember the omission.
B. Give critical care patients held in the ED the same level of care given to all ED patients.
C. Avoid documenting a physician's response to abnormal vital signs.
D. Be aware of your state's regulations regarding nurse staffing ratios for critical care patients.

18. Which is recommended to improve care of trauma patients, according to Jean M. Marso, BSN, RN, trauma coordinator at University of Colorado Hospital?
A. Get a baseline body temperature as soon as possible.
B. Don't waste valuable time taking a patient's temperature until he or she is stabilized.
C. To stabilize pelvic fractures, cross the patient's ankles.
D. Avoid using the rapid infuser/fluid warmer unless patients already are in hypothermia.

19. Which is recommended for use of verbal orders in the ED, according to Sylvie Simpson, RN, an ED nurse clinician at Orlando Regional Healthcare?
A. Encourage use of verbal orders by physicians.
B. Use standing orders to decrease use of verbal orders.
C. Instruct nurses to request orders and write them down for physicians.
D. If physicians are not present in the ED, verbal orders are the only option.

20. To comply with EMTALA, which is accurate, according to Shelley Cohen, RN, CEN, a consultant and educator for Health Resources Unlimited?
A. Triage can substitute for an MSE.
B. The MSE process is the same for each patient.
C. Each patient will require different resources to determine whether an emergency exists.
D. Nonurgent patients do not require an MSE.

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