ED NURSING®

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IN THIS ISSUE

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ED nurses are responsible for 20% of EMTALA violations: Don't be next

Nurses may be blamed for half of all EMTALA violations, rightfully or not

- *Since a patient's insurance won't cover the ED visit because it's out of network, you say, "We can see you, but you'll get a bill. If you go to the ED down the street, your insurance will cover you."*
- *After you realize that an emotionally disturbed teenager will need care elsewhere, you suggest that he go directly to the other hospital to avoid an ED charge from your facility.*
- *Due to lengthy wait times, you recommend that parents take their child to a nearby children's ED.*

All of the above "helpful" comments made by ED nurses resulted in actual citations for violations of the Emergency Medical Treatment and Labor Act (EMTALA). If you violate EMTALA, you face fines of up to $50,000 per violation and possible termination of your hospital's Medicare provider agreement.

Although nurses can't be held individually liable under EMTALA, they can still be held liable under their state's Nurse Practice Act and be named in medical malpractice lawsuits, says **Shelley Cohen**, RN, CEN, an educator for Health Resources Unlimited, a Hohenwald, TN-based consulting company specializing in ED triage and health care leadership.

EXECUTIVE SUMMARY

Approximately 20% of violations of the Emergency Medical Treatment and Labor Act result from mistakes made by ED nurses, with most involving documentation issues, according to health care risk management experts.

- Documentation mistakes include omissions, failure to time entries, and poor legibility.
- Don't advise patients to go to another ED, even it would speed care or save them money.
- Anything that prevents or delays a medical screening examination is a potential violation.

ED nurses often wrongly assume that an EMTALA violation won't occur in their ED, says Cohen. "Nurses often think, 'We will never get a violation,'" she says. "Believe it — start reviewing actual cases." **(To access actual cases, see resource box on p. 27.)**

ED nurses often blamed

About half of existing EMTALA violations contain citations for which the ED nurse may be blamed, since the violations were not clearly due to errors by physicians or other hospital staff, warns **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.

"Often, however, violations such as improper completion of transfer documentation are labeled as a nursing error within the facility, but in reality should be charged to the physician," he adds.

EMTALA places full responsibility for the accuracy and completeness of the transfer documentation on the transferring physician, not the ED nurse, but many facilities delegate much or all of the transfer documentation responsibility to the nurse, says Frew.

"That is extremely hazardous, unless the transferring physician assumes the responsibility to review the documentation rather than merely signing a form placed in front of him or her," he says.

Frew estimates that 20% of EMTALA violations are caused by a mistake involving nursing personnel. "A clear majority of those involve documentation issues," he says.

Inspectors from the Baltimore-based Centers for Medicare & Medicaid will expect strict compliance with policies and procedures and probably will view any deviation from written standards as an EMTALA violation, says Frew. "When nurses fail to follow written procedures for triage classification, fail to document vital signs, or refuse to see patients because they are 'frequent fliers,' violations occur that are issues of nursing competence," he adds.

Documentation is critical

To avoid EMTALA violations, you must take the following steps:

• Don't leave gaps in your documentation.

The most common EMTALA mistake made by ED nurses is failing to sufficiently document the care that actually was provided, to prove to the inspector that it was done and done correctly, says Frew. "Gaps in documentation, failure to time entries, and poor legibility account for more violations than poor patient care decisions by nurses," he says.

Always include the following items in your documentation for transferred patients, advises Frew:

— An explanation of the benefit of transfer must state exactly what service or care will be received at the destination hospital that is not available at your facility.

— The statement of risk should contain at least one handwritten medical risk, using the worst-case scenario, other than accidents en route. "At the very least, increased pain is always a bona fide risk," notes Frew. "Anything that is not listed is a risk to the sending facility if it occurs or *could have* occurred but didn't."

— Forms must be signed by the appropriate individuals.

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SOURCES/RESOURCES

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The EMTALA Online Health Law Resource Center (www.medlaw.com) offers several free EMTALA resources, including case law examples based on actual violations. Click on "Court Cases."

The Sullivan Group's web site (www.thesullivangroup.com) lists several recent EMTALA cases with commentary. Click on "EMTALA." Under "EMTALA Case Reporter," click on "Enter Here" and "Enter Reporter."

— A list of all records sent to the receiving facility must be included.

— You must document a complete set of vital signs before the patient leaves the facility.

When ED patients at Bangor-based Eastern Maine Medical Center are transferred to nursing homes, acute care, or to an ophthalmologist for follow-up care, staff often get confused about whether transfer documentation is required, says **Karen Clements**, RN, BSN, department head nurse for the ED. "We have a saying, 'When in doubt, fill them out,'" she says.

Education and immediate feedback are the most effective ways to nip problems in the bud, says Clements. "I review documentation for most patient transfers," she says. "If there are any issues, I follow up with the sending nurse for on-the-spot teaching."

• Don't violate EMTALA when giving patients advice about their care.

Many violations are caused by ED nurses doing something they believe is helping the patient, such as advising the patient to go to an urgent care clinic for a minor problem to avoid a long wait, says Frew. "Simply put, if 'helping' the patient results in the patient not being seen and provided a medical screening exam at your facility, it is likely to be a violation of EMTALA," he says.

For example, ED nurses have advised parents to take their child to a nearby children's facility, says Frew. "ED nurses have told parents, 'Sorry, but kids have to go to the ED next door.' When they leave, a violation has occurred," says Frew. "These instances have occurred with children with fever, fractures, burns, and just about anything else."

In other cases, an ED nurse realizes that the patient will need care elsewhere and suggests that they go directly to the other hospital to avoid an ED charge at the first hospital. "When that patient leaves without an MSE, it is a violation," says Frew.

At St. Vincent Hospital's ED in Green Bay, WI, this scenario comes into play whenever ED patients ask for a pregnancy test at triage. "The free clinic sent us a note asking that patients be sent directly to them for free pregnancy testing," says **Paula Hafeman**, RN, MSN, director of the emergency center. "Nurses know that the clinic does testing for no charge, but they cannot refer the patient to the clinic unless a medical screening exam is done to determine if an emergent medical condition is present."

After the MSE is done, patients are given the information and make their own decision about where to get the pregnancy test, says Hafeman.

• Never refuse patients care.

Surprisingly, EMTALA violations still occur as a result of nurses actually turning patients away from the ED, says Frew. The bottom line is that once the patient or ambulance has crossed onto hospital property, anything that results in the patient leaving the premises may result in an EMTALA citation if the proper screening and transfer requirements have not been met, he emphasizes.

"Nurses turning away ambulances that present because the hospital is on diversion, or the ambulance had been told not to come to the facility, or the ambulance arrived at the wrong hospital by error, is a more frequently cited situation than one would anticipate, given the fact that EMTALA is almost 18 years old," he says. ■

Good contingency plans address severe flu outbreak

Prepare for the perfect storm this flu season

It's a frightening combination: A severe vaccine shortage, more than 80 million Americans at high risk for flu complications, and a nationwide ED overcrowding crisis. These three factors mean that emergency nurses could be faced with the prospect of the perfect storm — a surge of critically ill flu patients and no resources to care for them, warns **Arthur Kellermann**, MD, chairman of the department of emergency medicine at Emory University School of Medicine in Atlanta.

The Dallas-based American College of Emergency Physicians has issued a national call to action to prepare the nation's EDs for a surge of severely ill influenza patients.

"We all hope and pray for a mild flu season, but wishful thinking is a poor substitute for prudent planning," says Kellermann. **(See resource box on p. 29 for materials to address a flu outbreak.)**

"In December 2003, when the flu season hit us hard, we had to seek alternatives to ease ED overcrowding," says **Sherry Walter**, RN, MSN, CCRN, clinical director of the emergency care center at Northeast Medical Center in Concord, NC. Northeast saw almost 2,000 more patients than anticipated in that month alone, she says. "With the national vaccine shortage, there is the possibility that we may see a surge again this year."

To prepare for a widespread flu outbreak, consider the following:

• Redesign triage.

At Northwest Community Hospital in Arlington Heights, IL, nurses originally had planned to create a separate "flu unit" by relocating oncology patients, but this turned out to be a poor plan, says **Rosemary Kucewicz**, RN, BSN, ED manager. "Our VP of nursing thought that was a bad idea because that unit has all private rooms and we would not be able to cohort flu patients," she explains.

Instead, supply storage space will be relocated so that rapid influenza testing can be done at triage. "We want to be able to do flu swabs there and send specimens directly to the lab from triage," says Kucewicz.

At Northeast's ED, an office was relocated to create additional triage space. "Already this year, there have been times that we have used the third triage bay and needed a fourth one," says Walter.

• Implement disaster procedures.

During the previous flu season, Children's Healthcare of Atlanta's two EDs were operating at 200% of capacity, seeing an additional 3,000 patients a month compared to previous years, reports **Linda Cole**, RN, vice president of emergent services. "Our volumes were off the charts," she says.

For this disaster, the hospital was forced to implement emergency command procedures, says Cole. "You usually think of a disaster as a bus wreck or tornado, but it's really any time when the ED lacks adequate resources," says Cole.

Staff from finance, facility management, and inpatient nursing helped out in the ED with patient transport, paperwork, and customer service in waiting areas. "The only way we got through it was for the hospital to pull together as a team and not look at it like an ED problem," she says. "It may have started in the ED, but it very quickly became an issue for the entire hospital."

• Create a space for overflow patients.

When flu volumes rise dramatically, lack of space becomes a problem, including inpatient beds, ED beds, and even waiting space. "We had people waiting in very unusual places, such as the hospital lobby, because there was no physical space in our waiting room," says Cole. To address this, a four-bed day surgery area is used to hold ED patients during evening hours, and patients are moved to the ED's fast track during the day, she says.

At Northeast's ED, when more than 25 patients are waiting, a nine-bed outpatient area is used, staffed by an on-call ED nurse and technician, says Walter.

• Add technicians at triage.

Two additional ED technicians will be added at triage during peak volumes, says Walter. "One of the techs would be responsible for taking vital signs on patients upon arrival," she says. "This will hopefully prevent the person who is 17th in line from waiting with a blood pressure of 60 mmHg."

The second technician will perform flu testing, send

EXECUTIVE SUMMARY

If your ED has high volumes of flu patients, you'll need to implement alternatives to prevent overcrowding.

- Add space near triage to perform rapid influenza testing.
- Use areas outside the ED to care for patients during peak volumes.
- Add extra technicians at triage to take vital signs and complete flu tests.

SOURCES/RESOURCES

For more information on how EDs are preparing for the flu season, contact:

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FluSurge is a free spreadsheet-based model that estimates the surge in demand for hospital-based services during influenza pandemics. To download, go to: www.cdc.gov/flu, and under "References and Resources," click on "Pandemic Preparedness," and then "FluSurge (software and manual)." For more information about FluSurge, contact Martin Meltzer, PhD, Centers for Disease Control and Prevention, NCID/OD/OS, Mailstop C-12, 1600 Clifton Road, Atlanta, GA 30333. E-mail: qzm4@cdc.gov.

A Pandemic Influenza Response and Preparedness Plan with recommendations to facilitate response and recovery during and after an influenza pandemic can be downloaded at no charge at the Department of Health and Human Services web site (www.dhhs.gov/nvpo/pandemicplan). Click on "Core Document."

the test to the lab, and be on the lookout for results to notify the lead triage nurse, says Walter.

• Expedite discharge of ED patients.

If Northeast's ED is inundated with flu patients, the hospital's nursing supervisor is immediately notified to evaluate the entire hospital for alternatives, Walter says. "They have the big picture of what is going on throughout the hospital and can facilitate getting patients out of the ED and into an inpatient bed."

Here are some of the possible interventions:

— Calling on staff throughout the hospital to transport patients out of the ED, such as radiology transporters to bring stable patients to their assigned bed, and receiving units to come to the ED to transport their patients.

— Opening up discharge holding areas for patients awaiting rides home.

"This would allow housekeeping to proceed with cleaning the room and making it available for an ED patient," says Walter. ■

Checklist gives protection from exposure to flu

Hand washing and masks are key for patients, staff

When caring for patients with respiratory symptoms, do you always require them to put on surgical masks and perform hand hygiene?

"It is vital to require patients to practice respiratory etiquette and for staff to use droplet precautions," urges **Maryann Gierloff**, RN, MSN, CIC, infection control facilitator at Northwest Community Hospital in Arlington Heights, IL.

At Northwest's ED, "all avenues of communication" are being used to get this message out to staff, including newsletters, memos, formal inservices, e-mail, department meetings, corporate meetings and posters, says Gierloff. **(See resource box on p. 30 to obtain patient education posters.)**

To reduce exposure to flu, she recommends the following:

• If patients have respiratory symptoms, give them respiratory hygiene kits consisting of a box of tissues, surgical mask, and instructions in Spanish and English. "We worked with marketing to make the instructions user-friendly, with the goal of taking some of the stigma off wearing a mask," says Gierloff.

The instructions read as follows: "Dear patient or visitor: Individuals visiting hospitals often carry colds or other viral infections that can easily be passed from

EXECUTIVE SUMMARY

To prevent exposure to flu, always have patients use respiratory hygiene and use droplet precautions.

- Ask all patients with respiratory symptoms to put on masks.
- Wear a surgical mask, eye protection, and gloves when caring for these patients.
- Install hand-sanitizer dispensers in convenient locations.

one person to another. Medical studies have shown that covering the mouth and nose can dramatically reduce the spread of colds and viral infections. In order to provide you with the best possible care and to protect all individuals coming to the hospital, we kindly ask if you are coughing or sneezing, that you use the mask and tissues we are providing. Also remember to clean your hands after coughing or sneezing. Your cooperation is very much appreciated."

• Ask any patient who is coughing or sneezing to wear a surgical mask. If a patient's respiratory status is compromised to the point that they are unable to wear a surgical mask, staff use of droplet precautions, segregating the patient, and expediting care become even more important, notes Gierloff. "For patients who cannot wear a surgical mask, tissues are provided and patients are asked to use them when coughing, sneezing, or controlling nasal secretions," she adds.

• Ask patients with respiratory symptoms to perform hand hygiene using an alcohol rub or soap and water.

• Place patients with respiratory symptoms in a private room, cubicle, or waiting area as soon as possible, and expedite care.

In addition, ED staff members are instructed to use droplet precautions whenever caring for patients with any respiratory symptoms, as follows:

• Do not allow patients to cough or sneeze in your face. Wear a surgical mask to protect yourself.

• Use eye protection, gowns, and gloves as necessary.

• Perform hand hygiene after providing care to patients with respiratory symptoms.

• If close contact is not necessary, maintain a distance of three feet from individuals with respiratory symptoms.

Hand hygiene is essential

"We are now, more than ever, encouraging our staff to employ appropriate hand hygiene by inservices, properly stocked facilities, and convenience of location [of hand-washing stations]," says **Steve R. Rasmussen**, RN, CEN, clinical coordinator for the ED at Virginia Commonwealth University Medical Center in Richmond.

In addition to inservices, clinical coordinators and charge nurses routinely observe in clinical areas to see if staff members are performing hand hygiene. "Not only are we keeping existing conventional hand-washing areas stocked, but we have also added waterless hand stations in halls, triage areas, and high-traffic areas to encourage frequent use and convenience," he reports. "I have noticed increased use of the waterless products over conventional hand cleaning techniques."

SOURCES/RESOURCES

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Patient education posters on respiratory etiquette can be downloaded free of charge at the New York State Department of Health web site (www.health.state.ny.us). Click on "Influenza," and under "Educational Posters," click on the poster title "Don't Spread it Around," available in English, Spanish, Chinese, and Russian.

"Cover Your Cough" posters and fliers can be downloaded in English, Spanish, Vietnamese, Chinese, and Tagalog at the Centers for Disease Control and Prevention web site (www.cdc.gov/flu/protect/covercough.htm).

At Edward Hospital in Naperville, IL, hand hygiene has been addressed at every staff meeting, with inservices given by the hospital's infectious disease practitioner to provide current data on potential epidemics and encourage prevention, says **Randy Schmidt**, RN, charge nurse for the ED. There are sinks and soap dispensers in every patient room, and hand-sanitizer dispensers are mounted outside every patient room for staff and visitor use, he says.

"We added additional hand-sanitizer dispensers throughout the ED this year," he reports. "The inservices did help make staff more aware, and the hand sanitizers are used frequently."

There are about 40 hand dispensers throughout the ED currently, placed by patient rooms, nutrition areas, the staff lounge, stat laboratory, medication rooms, nursing stations, waiting areas, and triage. "Placement was chosen for visibility and ease of use," says Schmidt. "It is not necessary to enter any room to use a sanitizer.

They are easily accessible to everyone."

If patients with respiratory symptoms can't be brought back to a private treatment room immediately, masks are given, he adds.

"We also have signage in all the waiting areas regarding respiratory hygiene," says Schmidt. "Tissues, waste containers, and wall-mounted hand-sanitizer dispensers are located there as well." ■

Schull MJ, Mamdani MM, Fang J. **Community influenza outbreaks and emergency department ambulance diversion.** *Ann Emerg Med* 2004; 44:61-67.

Influenza outbreaks are linked with increased ED ambulance diversion, says this study from University of Toronto.

Researchers did a retrospective study in Toronto from 1996 to 1999 to see if influenza outbreaks resulted in more hours on diversion. For every 100 cases of influenza in the community, ED ambulance diversion increased by 2.5 hours per week. Throughout the four influenza seasons during the study, the average ED experienced 83 hours of additional diversion, which comprises 24% of the diversion that actually occurred during that period.

"Our study suggests that influenza in the community leads to brief, but substantial, worsening of ED ambulance diversion," the researchers write.

To reduce diversion hours during influenza outbreaks, they suggest the following:

• promote influenza vaccinations throughout the community;

• provide alternatives to the ED for medical care of patients with influenza complications;

• improve access to inpatient beds to free up the ED. ▼

Kline JA, Webb WB, Jones AE, et al. **Impact of a rapid rule-out protocol for pulmonary embolism on rate of screening, missed cases, and pulmonary vascular imaging in an urban U.S. emergency department.** *Ann Emerg Med* 2004; 44:490-502.

A rapid rule-out protocol doubled the number of ED patients evaluated for pulmonary embolism and increased positive scans from 8% to 11%, says this study from Carolinas Medical Center in Charlotte, NC.

The researchers compared results on all patients with suspected pulmonary embolism before and after the screening tool was implemented and found that length of stay decreased from 297 minutes from 385 minutes, and the number of missed diagnoses did not increase. Missed or delayed diagnosis of pulmonary embolism is a common cause of malpractice claims, and delay in diagnosis contributes to death and disability, note the researchers. They estimate the cost of materials needed at less than $3,500, with a cost per patient tested of under $20, as long as an arterial blood gas-analyzing machine is available in the ED.

"The present data show that a point-of-care clinical protocol doubled the number of patients evaluated for pulmonary embolism without increasing radiologic testing or ED length of stay," the researchers conclude. ■

JCAHO will look for evidence of falls prevention

Is your patient falls reduction program up to par? If not, you could have problems during your next survey by the Joint Commission on Accreditation of Healthcare Organizations. One of the new National Patient Safety Goals for 2005 requires you to reduce the risk of patient harm resulting from falls by assessing and periodically reassessing each patient's risk for falling and taking action to address any identified risks.

"For instance, you wouldn't want an intoxicated patient to walk to the X-ray room," says **Kim Colonnelli**, RN, BSN, MA, district director for emergency and trauma services at Palomar Pomerado Health in Escondido, CA. "That patient should go by wheelchair or preferably gurney."

To reduce risk of patient falls in your ED, you can do the following:

• Assess patients for fall risk.

EXECUTIVE SUMMARY

You are required to take steps to reduce the risk of patient falls in your ED, according to a new National Patient Safety Goal from the Joint Commission, effective Jan. 1, 2005.

- Place colored bracelets on patients at risk for falling.
- Interventions for patients at risk include bed alarms, side rails, and assessment of medications.
- Group at-risk patients together for closer observation.

At Bronson Methodist Hospital in Kalamazoo, MI, ED nurses use the Hendrich II Fall Risk Model to assess confusion, depression, altered elimination, dizziness, and mobility, says **Glenn Carlson**, RN, MSN, CCRN, clinical nurse specialist for the ED. **(See resource box, right, for more information.)**

If the patient's score indicates a risk of falling, the patient is placed on fall precautions, with a sign placed outside the door. "Our computer system lists choices for interventions for someone on fall precautions," he explains.

If your ED doesn't have an electronic system, then your assessment form should have interventions listed for all the areas assessed by the Hendrich scale, he recommends. Possible interventions include use of a bed alarm, presence of family members at bedside, continued assessment of medications that could be causing a patient to be at risk, and offering toileting at more frequent intervals, says Carlson.

Assessment and interventions are documented so that all staff will know if someone is at risk, why they are at risk, and what interventions have been attempted, says Carlson. "In addition, if the Hendrich tool is used and interventions are not applied, then you have done only half of the prevention, and someone looking at the chart would pick up on this," he adds.

• Use color to identify patients at risk.

Patients on fall precautions have a purple dot placed on their identification bands. "Even ancillary staff can quickly identify those at risk, as the identification band is looked at by everyone when the patient is asked their name and birth date as patient identifiers," says Carlson.

At Cape Canaveral Hospital in Cocoa Beach, FL, ED nurses place an orange bracelet on any patient at risk for falling, to alert staff that the patient needs additional precautions and assistance, says **Stacey Westphal**, RN, MS, CEN, clinical educator for emergency services. "If a patient asks to go to the bathroom, and I see an orange bracelet, I will get a wheelchair and assist them instead of sending them down the hall," she says.

• Re-assess patients at risk.

If patients are confused or continue with unsafe practices after continued reinforcement, they are placed on a "fall watch," says Carlson. Once on Fall Watch, a red eye is placed outside the patient's room to increase awareness that the patient is at risk, which is especially important for areas that don't have as much traffic and visibility, he explains. "Everyone that walks by that room is supposed to check and make sure the patient and the environment are safe, such as having a call light or bedside table within reach," says Carlson.

• Make changes in the ED environment.

Consider the need for call lights, the proximity of commodes, height of the bed, and hydration needs, says Carlson. "A good percentage of patients are trying to get to the bathroom 20 minutes after a meal or 20 minutes after their diuretic or laxative," he says. "Raising awareness of these issues is as essential as assessment for risk."

For elderly or medicated patients, use diversion techniques such as providing videotapes or televisions in rooms or enlisting the help of family members to help keep agitated patients calm, Colonnelli suggests.

• Address visitor falls.

At Palomar's ED, several falls occurred because of visitors sitting on the rolling stools that doctors use for

SOURCES/RESOURCES

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A comprehensive fall prevention, risk management and intervention program featuring the Hendrich II Fall Risk Model is available on the Internet, CD-ROM, and intranet system applications. The cost varies according to platform, individual content requests, and other custom features. For more information, contact: A. Hendrich, P.O. Box 5036, Clayton, MO 63105. Telephone: (866) 653-6660. E-mail: info@ahendrichinc.com. Web: www.ahendrichinc.com.

A free Falls Tool Kit with information on implementing a falls prevention program, effective interventions for high-risk fall patients, and educating staff on fall injury prevention is available on the VA National Center for Patient Safety web site (www.patientsafety.gov/fallstoolkit).

exams, reports Colonnelli. "So we added visiting chairs to every room and stenciled the rolling chairs 'Staff only' to help decrease the risk of falls." No visitor falls have occurred since, she says.

• Increase sitter use.

By clustering patients in together in one "pod" who require close watching, you can use one sitter for the group to reduce the cost, suggests Colonnelli. Using a single sitter instead of two saves about $150 per shift, she adds.

• Educate staff on the new patient safety goal.

Nursing assistants at Bronson attended a mandatory one-hour interactive lecture and completed a post-test, says Carlson. "The nursing staff was educated via a self-learning pack, with informal education at the bedside and formally at a skills fair," he says. "The nurses were required to return the post-test to the clinical nurse specialist." ■

Quicken treatment for heart failure with BNP test

After suddenly becoming short of breath, a 28-year-old woman in Tuscon, AZ, called 911 and was taken to Carondelet St. Mary's Hospital's ED in severe respiratory distress with blood pressure of 250/140. After B-type natriuretic peptide (BNP) testing was done, it was determined the patient was in congestive heart failure (CHF) and nesiritide was given.

"Within five minutes, the patient's blood pressure was down to 160/110, and she was no longer in respiratory distress. She was admitted to a low-acuity telemetry floor," says **Diana Platt Lopez**, RN, BSN, clinical educator for emergency services.

Although the woman's symptoms were indicative of congestive heart failure, the BNP nailed the diagnosis within 20 minutes, says Lopez. "It is even more beneficial in making the diagnosis in elderly patients with complex histories, such as those with a cardiac and pulmonary history," she adds.

Treatment would have been delayed without a clear-cut diagnosis, and the patient may have required intubation, resulting in increased length of stay, intensive care unit admission, and possible complications such as ventilator-associated pneumonia, says Lopez.

As a result of BNP testing, CHF patients are being treated earlier in the ED with nesiritide, says Lopez. "Sorting out if a patient truly has CHF early in their presentation leads to the patient receiving the correct therapy earlier," she explains.

A new report from Plymouth Meeting, PA-based ECRI, a nonprofit health services research agency, provides strong evidence that BNP testing improves outcomes for ED patients with symptoms of heart failure. **(To obtain a copy of the report, see resource box on p. 34.)**

BNP is a cardiac neurohormone that is secreted in response to increased ventricular volume and pressure, and elevated levels can indicate the presence of heart failure, says Lopez. "This is a quick blood test that results in an accurate diagnosis and a more expeditious application of proper treatment," she explains. **(For more information on BNP testing, see "Are you using BNP testing for heart failure patients?" *ED Nursing,* April 2003, p. 68.)**

EXECUTIVE SUMMARY

New research gives additional support to the benefits of using B-type natriuretic peptide (BNP) testing for ED patients presenting with possible congestive heart failure (CHF).

- BNP testing can determine the cause of symptoms such as shortness of breath.
- Treatment can be given more quickly and result in better outcomes.
- With use of BNP testing, nesiritide is given to CHF patients more often in the ED.

Faster diagnosis, faster treatment

Early identification of heart failure can significantly improve outcomes, says **Michele Gilbert**, RN, BSN, CCRN, CNN, education coordinator for the heart failure program at Hackensack (NJ) University Medical Center, where a recent study assessed the impact of BNP testing on clinical outcomes, including time to symptomatic relief and length of stay.

In a study of 100 patients, with 50 admitted to the hospital before the use of BNP and 50 admitted after the use of BNP, there was a 34% reduction in time until symptomatic relief and a 39% reduction in length of stay when the BNP assay was used.[1]

The laboratory has the BNP test results back within an hour, which enables ED staff to quickly provide correct and timely treatment to CHF patients, says Gilbert. "This translates into better, more focused care, quicker relief of symptoms, and cost savings through shorter length of stay and the avoidance of unnecessary treatment."

Use of BNP testing can help you determine if a patient is in heart failure, or if their symptoms are caused by isolated pulmonary, renal, or venous problems, says **Sonja D. Brune**, RN, MSN, CCRN,

SOURCES/RESOURCE

For more information about B-type natriuretic peptide testing, contact:

- **Michele Gilbert**, RN, BSN, CCRN, CNN, Education Coordinator, The Heart Failure Program at Hackensack University Medical Center, 20 Prospect Ave., Suite 201, Hackensack, NJ 07601. Telephone: (201) 996-2934. Fax: (201) 996-5703. E-mail: mgilbert@humed.com.
- **Diana Platt Lopez**, RN, BSN, Clinical Educator, Resource Clinician, Emergency Services, Carondelet St Mary's Hospital, 1601 W. St. Mary's Road, Tucson, AZ 85745. Telephone: (520) 740-6193. Fax: (520) 872-6641. E-mail: dplopez@carondelet.org.

The report, *B-Type Natriuretic Peptide for Diagnosing Heart Failure,* sells for $750 including shipping. To purchase a copy, contact ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. Telephone: (610) 825-6000, ext. 5170. Fax: (610) 834-1275. E-mail: dcummins@ecri.org. Web: www.ecri.org.

CCNS, staff nurse in the transplant intensive care unit at San Antonio-based Christus Santa Rosa Medical Center Hospital and former cardiovascular clinical nurse specialist at Central Cardiovascular Institute of San Antonio.

"Keep in mind, however, that renal disease, and to some degree, pulmonary disease, can cause a slight increase in BNP levels," says Brune. "Rarely are patients with [end-stage renal disease] going to have normal BNP levels." Conversely, obese patients have lower BNP levels than normal-weight patients, so even moderate increases may be of more clinical significance, adds Brune.[2]

In addition, the absence of crackles in lung fields does not exclude pulmonary edema, advises Brune. "Many patients with chronic heart failure have clear breath sounds even in the presence of elevated cardiac filling pressures resulting in fluid volume overload."

At St. Mary's ED, when diuretics don't appear to be working, patients are given nesiritide and avoid intubation, says Lopez. Nesiritide has been effective for hemodialysis patients who present short of breath and in need of dialysis, she adds. "We have averted intubation with a few of these patients by using nesiritide as a 'bridge' to alleviate their symptoms until the patients can be given a dialysis treatment," says Lopez.

Brune gives the example of a young, healthy patient who presented with shortness of breath after a viral syndrome and was treated with antibiotics for a presumed upper respiratory infection, but the patient returned to the ED when symptoms worsened. At that point, an echocardiogram revealed that an ejection fraction of 20%, indicating significant left ventricular systolic dysfunction.

"While this scenario is not seen in epidemic proportions, it is not an isolated event either," says Brune. "A BNP level most likely would have signaled a decline in left ventricular function at the initial presentation and could have triggered more aggressive treatment for suspected viral cardiomyopathy, thus improving the long-term outcome of this patient."

References

1. Abstract. Presented at: The 7th Annual Scientific Meeting of the Heart Failure Society of America. Las Vegas; September 2003.
2. Mehra MR, Uber PA, Park MH, et al. Obesity and suppressed B-type natriuretic peptide levels in heart failure. *J Am Coll Cardiol* 2004; 43:1,590-1,595. ■

Mobile monitoring system improves ED's efficiency

Would you rather move a seriously ill patient with chest pain and shortness of breath from one room to the next so he or she can be monitored — or bring the monitor to that patient?

At Mecosta General Hospital, a 74-bed hospital in Big Rapids, MI, an ED's investment in a $250,000 mobile

COMING IN FUTURE MONTHS

- ■ Update on new contraindications for heparin
- ■ Don't miss life-threatening cardiac problems
- ■ Creative strategies for Joint Commission's medication goal
- ■ Dramatically improve care of patients in sickle cell crisis

SOURCE

For more information on mobile cardiac monitoring systems, contact:

- **Virginia R. Keusch**, RN, Critical Care Services Clinical Manager, Emergency and Cardiopulmonary Departments, Mecosta County General Hospital, 405 Winter Ave., Big Rapids, MI 49307. Telephone: (231) 796-8691, ext. 4381. Fax: (231) 592-4421. E-mail: gkeusch@mcghhospital.com.

cardiac monitoring system not only improves patient care, but cuts staff time related to transferring patients from room to room, reports **Virginia R. Keusch**, RN, critical care services clinical manager for the ED.

She estimates the productivity costs saved by the Escort system (manufactured by Orlando, FL-based Invivo Corp.), which can be used for any monitored patient, are $75 per day or $27,375 annually, which includes staff time spent moving patients, making electrode changes, changing beds, etc. In addition, patients now can be monitored in all of the ED's 11 beds instead of only the four rooms containing hardwired monitors, she says.

There also is a potential savings by avoiding staff injury caused by pushing stretchers around unnecessarily, adds Keusch.

Previously, if four patients were being monitored and two were on telemetry, no monitors would be left if a chest pain patient came in, she explains. "Nurses would have to confer as to which of the four monitored patients could be moved off the monitor and left either without a monitor or downgraded to a telemetry pack."

The patient deemed at less risk than the new patient would have to be disconnected and their stretcher moved to another room, or even the hallway, says Keusch. "This domino situation could continue throughout the day to the frustration of everyone, with stretchers moving room to room," she adds.

The goal was to invest in a system that was not cost prohibitive, had up-to-date technology, a good maintenance contract, and a training program for nursing and bio-med staff, says Keusch. "We researched about six companies and then had demonstrations from four companies," she says. "We were impressed with the ease of use and functionality of the Invivo product."

Patient satisfaction has improved significantly since the system was implemented, reports Keusch. "Moving them around was stressful for patients and their families and might have inadvertently given the message of not being as important as another patient," she says. "Our time now can be better spent with the patients settled into one room." ■

If you suspect an alcohol problem, use these tools

While assessing a patient, your gut feeling may be that he or she has an alcohol problem. But do you lack the resources to appropriately screen these patients and intervene as needed?

The Emergency Department Alcohol Education Project: Screening, Brief Intervention, Referral, and Treatment web site offers free tools to improve screening and care of alcoholic patients in the ED. The ED offers a "teachable moment" to encourage change in at-risk drinking behavior, says **Judith Bernstein**, PhD, associate professor of maternal and child health at Boston University's School of Public Health, and co-developer of the site.

The site gives you a protocol to screen patients in the ED, developed with the realities of overcrowding, lack of privacy, extreme time pressures, and multitasking in mind, says Bernstein. (Click on "Brief Intervention Techniques.") "A rationale is provided for going beyond the ED's traditional 'treat-and-street' mission to address at-risk and dependent drinking," she says. "Techniques and strategies are offered that have been shown to be feasible and effective in the ED setting." Links to other educational materials allow you to compare different types of interventions.

ED nurses around the country are finding creative ways to use the site's resources, reports Bernstein. "In some EDs, the slides and cases on the web site have formed the basis for a formal workshop," she says. "Other ED nurses have gotten together in informal study groups to review the materials and practice role-playing using the tools provided." ■

Vital Signs

Site: Emergency Department Alcohol Education Project: Screening, Brief Intervention, Referral, and Treatment
Address: www.ed.bmc.org/sbirt
Contact: Judith Bernstein, PhD, Associate Professor, Maternal and Child Health, Boston University, School of Public Health, 715 Albany St., Talbot Building, West Wing, Fifth Floor, Boston, MA 02118. Telephone: (617) 638-4484. E-mail: jbernste@bu.edu.

CE instructions

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

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

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

CE*questions*

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

- **Identify** clinical, regulatory, or social issues relating to ED nursing. (See *ED nurses are responsible for 20% of EMTALA violations: Don't be next* and *Quicken treatment for heart failure with BNP test.)*
- **Describe** how those issues affect nursing service delivery. (See *Good contingency plans address severe flu outbreak.)*
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Checklist gives protection from exposure to flu.)*

1. Which of the following is in compliance with the Emergency Medical Treatment and Labor Act, according to Stephen A. Frew, JD?

A. Directing a patient to a nearby hospital because your ED is on diversion.
B. Suggesting to parents that a child be taken to a nearby children's facility to save time.
C. Advising patients that another nearby ED will accept their insurance.
D. Referring patients to a clinic for a free pregnancy test only after the medical screening examination is completed.

2. Which of the following is recommended for patients with respiratory symptoms, according to Maryann Gierloff, RN, MSN, CIC?

A. Give masks to patients only upon request.
B. Ask all coughing or sneezing patients to put on masks.
C. Offer surgical masks only to patients with confirmed influenza.
D. Give patients tissues instead of masks to reduce costs.

3. Which is recommended to reduce ED overcrowding in the event of a severe flu outbreak, according to Rosemary Kucewicz, RN, BSN?

A. Performing rapid influenza tests at triage.
B. Relocating oncology patients.
C. Moving triage to a new location.
D. Avoiding use of technicians to perform vital signs.

4. Which is a result of BNP testing for ED patients, according to Michele Gilbert, RN?

A. Decreased use of nesiritide.
B. Fewer patients receiving the correct therapy.
C. Increased use of intubation.
D. Quicker diagnosis of congestive heart failure.

Answers: 1. D; 2. B; 3. A; 4. D.