ED Management®

The monthly update on Emergency Department Management

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'Blue man' throws ED into divert, cause remains unknown for 9 hours

Despite preparation, training, manuals, event teaches valuable lessons

When the patient first presented at the entrance to the ED at Greenville (SC) Memorial Hospital on Nov. 9, 2004, his face was blue, with a burning sensation on his face and in his lungs. What transpired between that moment and the time the ED resumed normal functions following a nine-hour divert demonstrates the value of careful disaster planning and the sobering reality that all the planning in the world can't guarantee a flawless response.

What's equally important, as the ED director subsequently demonstrated, is the recognition that such plans must be reviewed and updated continually, and every incident should be viewed as a learning experience.

An unknown substance

The patient, who worked at a nearby UPS facility, accidentally spilled a commercial dye on himself, relates **Martin Lutz**, MD, medical director of emergency services for the Greenville Hospital System (GHS), of which Greenville Memorial is one of four facilities.

"He did not know what it was," says Lutz, who was not present in the ED at the time. "He was lifting boxes, the blue powder came on him, but he didn't see it. A co-worker told him he 'looked like a Smurf,' and their safety officer brought him here." This is a common presentation scenario, when the patient bypasses the EMS system, pre-hospital decontamination, and pre-notification of the ED.

The patient went inside the building and presented to triage, which involved

Executive Summary

Don't ever assume your disaster plan is completed; continual review is essential.

- Make sure all ED staff, greeters, and patient reps know where your decontamination facilities are.
- Wherever possible, avoid exposing the patient to visitors and minimize staff contact.
- Inform quarantined individuals about the situation and symptoms they should look for.

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passing through part of the waiting room. The triage nurse at once noted his exposure to an unknown substance and took him as quickly as possible to the closest negative pressure room. Because the facility has four external "decon," or decontamination showers, as well as a decon room, "In retrospect, it probably would have been better to take him outside," Lutz notes — or better yet, he should have been decontaminated at the workplace. But given the ultimate unfolding of events, the failure to decon the patient outside was "good and bad," he says.

In reality, the failure to take the patient back outside once he was in the building may not have been a serious error, notes **Kathy J. Rinnert**, MD, MPH, assistant professor in the division of emergency medicine at the University of Texas Southwestern Medical Center in Dallas.

"If the negative pressure room is geographically very close, like 3 or 4 feet down the hall, then so what?" she offers. "The overriding concern is you do not want to take someone with a potential exposure deep into the complex or facility. If you do not know what the substance is, you want to be very careful about who you expose this person to, including health care providers."

It's also critical, Rinnert adds, to leave any equipment you use, including patient care items such as blood pressure cuffs, with the contaminated patient in a treatment room until you have identified the substance.

Protocols come into play

Once the patient was in the negative pressure room, the on-duty staff were familiar with what needed to be done, says Lutz. "We have been using the Hospital Emergency Incident Command System [HEICS] for about 10 years," he notes. **(For more on HEICS, see "The Joint Commission is watching: Is your disaster response plan in order?" *ED Management,* July 2004, p. 73.)** As part of their disaster preparation, each of the four campuses of the GHS conducts routine emergency preparedness drills.

Greenville, in fact, has *two* specific manuals — HEICS and the GHS disaster manual; both include policies and procedures for hazardous materials. There are separate sections for chemical, radiological, and biological exposures, Lutz adds, and now, following this event, there will be a fourth category: "unknown substance." **(For more on optimal responses to unknown substances, see article, p. 15.)**

"Following our policies, the nursing supervisor went to the manual and made the appropriate phone calls," he relates. The supervisor's job, Lutz says, was to call the fire department on 911 and request a hazmat (hazardous materials) team, in-house nursing administration, and the on-call administrator who would be the incident commander if an incident command needed to be activated.

"[The administrator] came in from home and assumed a safe position outside the building," Lutz explains. A sample of the powder was taken to the

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State Law Enforcement Division in Columbia, SC, which was several hours away, for identification — a major cause for the nine-hour divert. The state lab ultimately determined the commercial dye was nonhazardous, it posed no threat to the public, and the patient had suffered an allergic reaction.

Initially, the fire department recommended diverting all noncritical patients. "Until we knew what the substance was, they didn't want anyone to leave. Using a very cautious approach, the waiting room was closed, and people in there had to remain. The patient rep went around and explained the situation to them," Lutz notes. Meanwhile, noncritical patients were diverted to four nearby hospitals.

Rinnert notes that when there is a potential exposure, the ED and the hospital have a medical and ethical imperative to explain the situation to anyone asked to remain in the facility.

"This was the appropriate action; any time there is potential exposure, the hospital now has the responsibility to monitor them for signs and symptoms, but it is also required to tell and report to them what happened, that they may have been exposed, and symptoms to look for that should be reported," she adds.

Lessons lead to redesign

In the wake of this incident, a number of changes are being instituted at Greenville Memorial. Perhaps the most dramatic is the impact it has had on the planned design of a new ED.

"Because of this incident, we are redoing the whole front area," Lutz adds. "What we had originally developed was a very nice lobby, but we have now moved it back a bit and moved the triage rooms almost to the front door. That way, people won't be walking through the waiting room."

This makes good sense to Rinnert. "The triage nurse needs to be close to the front door," she says. "Ours is four feet inside the doorway."

In addition, Lutz says, a series of two or three questions are being prepared for the triage nurses. Patients are asked their occupation, which can help narrow down possible sources of exposure.

There are other changes being made in the hospital ED. For example, all of the triage rooms now will be negative pressure rooms, as will the waiting room. And dosimeters (radiation detecting equipment) will be place at the entrance. "If someone comes in who is exposed to radiation, the dosimeters will beep and give us an alarm," he explains. The patient will be directed immediately outside, until appropriate containment and decontamination preparations are made. This addition is "a one-time fixed cost" to put the equipment in the front door, he notes. Dosimeters cost about $500.

The new ED will also be divided into four zones, so if one area is contaminated, the others will not be. "We have also developed a backup triage plan," Lutz notes. "If someone does come into triage, we have a family room by the ambulance entrance that we can convert into triage space."

A renewed emphasis is being placed on the awareness of the external decon facilities. "Besides educating the triage nurses, we have a small group of meeter-greeters, and there will be some education for them, as well," he adds.

Finally, GHS is going to lobby for a lab facility in the upstate area of South Carolina. "If we had our own lab, everything would have been much, much quicker," Lutz notes. ■

Unknown substance: When do you shut down?

When a patient presents at your ED with exposure to a potentially hazardous, but unknown substance, under what conditions do you shut down or limit operations? And what can you do to minimize your department's downtime?

Emergency medicine observers agree that the last thing you want to do is shut down your ED, says **Christopher Cannon**, FACHE, system director at the office of emergency preparedness for Yale New Haven (CT) Health System.

"You have to be extremely careful about when and how you make that decision," he advises. "One of the main reasons for shutting down an ED clearly is that there are other patients or employees at risk — the potential for cross-contamination. That really is the

Source/Resource

For more information on diversion and reopening strategies, contact:

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For more information on hazardous materials, contact:

- **Chemical Transportation Emergency Center** (CHEMTREC). Phone: (800) 424-9300. Web: www.chemtrec.com.

overarching worry of the ED director: Am I going to contaminate the ED and the hospital, which is going to create an even greater risk to taking care of patients, and to the employees?"

The first step is to isolate and decontaminate the patient. "That's critical," Cannon explains. In the case of an unknown substance, he says, a chemical is a little easier to identify than a biological agent, for example.

"The hospital may have some way of doing chemical detection," he offers. "There are strips out there now on the market, and some EMS and hazmat teams have them, and hospitals need to look into them." (Manufacturers of these strips include Safety Solutions, Boynton Beach, FL; and Smiths Detection, Warren, NJ, manufactures a chemical detection device.)

An excellent source for help in identifying unknown chemicals is the nearest poison control center, adds **Kathy J. Rinnert**, MD, MPH, assistant professor in the division of emergency medicine at the University of Texas Southwestern Medical Center in Dallas.

"They are absolutely phenomenal for telling you which labs can do assays for chemicals," she notes. The poison control center plays a critical intermediary role when an exposure has taken place in a public setting. The poison center will be providing resource information to the on-scene hazmat teams, to the local media, to the general medical community, and likely will also be able to coordinate communications between the different hospitals treating patients.

The centers, Rinnert explains, have pre-emptive partnerships with resources that can do testing on a 24/7 basis, "and they need to be able to guarantee expedited turnaround time when you have potential exposures," she says.

Another good source is the Chemical Transportation Emergency Center (CHEMTREC), a clearinghouse of information about hazardous materials, Rinnert says. **(For contact information, see resource box, above.)** "You can type in a patient's signs and symptoms, or the MSDS [the Material Safety Data Sheet, which appears on chemical containers] and it will spit you out all types of information — signs and symptoms, and if there is a low or moderate chance there has been exposure," she explains.

As long as the substance remains unknown, "you should be getting *no* EMS traffic — whether it's critical care or not." Rinnert asserts. Ultimately, she adds, this level of diversion is the hospital's decision, which they pass on to the EMS agencies. "You can only tell EMS you are on trauma divert; it's still up to the medic to make the determination as to which is the next closest facility, and if they can, in fact, give credence to your request for divert," Rinnert says.

In terms of ensuring that you will reopen as quickly as possible, Cannon recommends taking the following steps:

- Identify the substance as soon as possible; determine who has been affected.
- If the ED is contaminated, follow appropriate procedures to decontaminate it.
- Have the ability to shut down individual rooms, or portions of the facility.
- Make sure that housekeeping, as well as your own clinical staff, know how to bag and isolate contaminated products.
- In case of a terrorist attack, know your chain-of-custody issues as they pertain to working with law enforcement representatives. ■

Uninsured children: An untapped revenue source?

ED enrollment expands services to young patients

Each day, approximately 75,000 children present for treatment in the nation's EDs, and according to two recently published studies, they represent not only an opportunity to cure, but an opportunity to expand your ED's revenues as well as its social outreach to this large group of young patients.

According to a new study in the *Annals of Emergency Medicine,* there are 8 million uninsured children in the United States, and an enrollment program in your ED targeting such children can generate enough revenue to more than pay for the program costs.[1]

In this pilot study, a well-trained, dedicated worker was hired to enroll uninsured children seeking care in the ED. During the 10-month study period, 4,667 uninsured children were seen at Children's Hospital of Michigan, Troy, during the enrollment program hours, and 39% (1,083) filed applications. The vast majority

Executive Summary

Simple procedures and staff changes can yield new benefits to your department and hospital's bottom line.

- Simply handing out application forms can increase child enrollment by approximately 14%.
- Hiring a new, dedicated worker to enroll children will pay for itself many times over.
- Once children are enrolled, financial benefits grow over time with each return visit to your ED.

(84%) of those applications were accepted, and 67% of applicants were enrolled in Medicaid.

During the study period (September 2001 to June 2002), average revenue to the facility from each outpatient ED visit for Medicaid was $135.68, the average other insurance visit was $210.43, and the average uninsured visit was $15.03.

The study authors subtracted the revenue typically received from an uninsured patient ($15.03) from the average Medicaid payment ($135.68) to calculate the amount of revenue the hospital was losing from uninsured children who could be enrolled in Medicaid ($120.65). Based on this amount, researchers found total annual revenue the hospital could be receiving if these uninsured patients were enrolled in Medicaid was $224,474; and the net revenue, after accounting for the program costs, was $157,414. (*Editor's note: These figures represent revenues for the hospital — not for the physicians.)*

"Since this started as a pilot program, we wanted to make sure the revenue generated was based on people employed — in this case, a total of three FTEs [full-time equivalents]," explains **Prashant Mahajan**, MD, MPH, pediatric emergency medicine physician at Children's and the paper's lead author. "Even if you take out full labor costs, it still leaves some money."

Reinforcing the message

A second study,[2] which is going to press in the *American Journal of Public Health*, supports and expands this message, notes **James A. Gordon**, MD, MPA, assistant professor of medicine at Harvard Medical School, attending physician in the department of emergency medicine at Massachusetts General Hospital in Boston and the lead author.

"The two studies together deliver a more powerful message than either one alone," says Gordon, who also authored an editorial about Mahajan's paper in *Annals.*[3] "In *Annals,* you had a single-center study where case workers helped parents fill out insurance applications for uninsured children" he says. The authors report how the hospital can recoup expenses for the social outreach workers simply from the proceeds of retroactive insurance benefits.

The new *American Journal of Public Health* study is a multicenter trial — data from four urban EDs across the country — with a control group and an intervention group. Study staff distributed state-sponsored health insurance applications to families of uninsured children presenting for care. "If the children showed up uninsured, we simply handed the family an application," Gordon notes. The study team followed up by telephone as well as by reviewing state records after 90 days and found they could nearly quadruple the odds that the kids would be insured successfully.

"By studying both a control and intervention group, we were able to quantify that simply handing out applications can lead to coverage for an additional 14% of uninsured children. Applied to EDs across the country, that translates to coverage for hundreds of thousands of additional children each year," he adds.

Outreach also key

Gordon adds that it's essential to have social outreach workers as part of your ED care team. "If you only pay attention to patients' medical issues, and not their social circumstance, then you will not have contributed to their overall health as much as you could have," he asserts. "What the Michigan study shows is if you have social outreach workers participating in helping to enroll uninsured children, it will also provide hospital revenue to cover personnel costs."

Gordon says he has had a long-standing interest in social outreach in an ED setting, but the question always has arisen as to how it could be supported financially. "In Michigan, they showed you can create a program where everyone benefits," he observes. What's more, Gordon continues, the revenues demonstrated in the Michigan study do not represent all the potential revenues such an approach could generate.

Sources

For more information on enrolling uninsured children through the ED, contact:

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"This study just quantified the amount of money that would have been recouped from retroactive payment for the *original* ED visit," he adds. "Now that these patients are hooked up with insurance, they will be more likely to seek regular care in their local health system. Retroactive compensation for a single ED visit may only be the tip of the iceberg — clinic and specialty visits can now be reliably compensated, as well as return visits to the ED."

Gordon notes that in his work he has found that the ED is one of the sole institutional contact points for disadvantaged families. "And it may be the contact point for many who present for free health care that they otherwise might not be able to afford — and the perfect site for insurance enrollment," he concludes.

At the very least, "EDs across the nation should hand out state-sponsored health insurance applications to all uninsured children presenting for care," Gordon adds.

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Saving lives is more than 'virtual' with teletrauma

System adds value by eliminating some transfers

On Nov. 21, 2004, an 18-month-old baby was injured critically in a car accident with three fatalities. The baby was rushed by paramedics to the ED at Southeast Arizona Medical Center in Douglas, a small, rural town along the U.S.-Mexico border. The baby was in shock and had lost almost two-thirds of her blood from multiple injuries. She was minutes from death, and the nearest trauma center was in Tucson, more than 100 miles away.

In the Douglas ED, the doctor called the University Medical Center (UMC) Level 1 Trauma Center in Tucson for assistance. Activating the new teletrauma system using the Arizona Telemedicine Program network, the trauma surgeon at UMC, **Rifat Latifi**, MD, University of Arizona associate professor of clinical surgery and associate director of the UMC trauma program, was able to see the baby and examine her injuries.

Executive Summary

Hooking up your ED to a regional system enhances the care your staff can give patients.

- With cameras and computers to guide distant experts, invaluable consults become possible.
- The number of patients who receive treatment within the golden hour increases dramatically.
- When transferring patients, the receiving facility has more detailed knowledge of the care you've given.

He and UMC's trauma team looked at the patient's vital signs, X-rays, and lab test results and "virtually" led the doctor and nurses in Douglas through the emergency medical procedures. The baby was resuscitated and, once stabilized, transported to UMC for further treatment. She is expected to recover.

"The physician here was relatively new — it was maybe her first or second shift, and it was a major pediatric trauma," recalls **Debra Thornby**, RN, the ED nurse manager. "Doing a femoral IV [on an infant] is not the easiest thing, and Dr. Latifi helped talk her through it; it's so unbelievably helpful."

Latifi is even more emphatic: "If we had not had this connection, that child would have died," he asserts. "I have been a physician since 1982 and have never felt better in my life for saving a patient's life than I did saving that little girl that day."

System aids rural facilities

The University of Arizona Department of Surgery Section of Trauma and Critical Care, the Arizona Telemedicine Program, and UMC, Southern Arizona's only Level 1 Trauma Center, created the Southern Arizona Teletrauma and Telepresence (SATT) Program to assist trauma patients in rural communities. SATT provides a live consultation link — including state-of-the-art videoconferencing, telemetry, digital X-rays, and ultrasound — between the trauma team at UMC and rural EDs in the southern section of the state.

Douglas was hooked up to the system, which is subsidized by the state, in November. "Dr. Latifi contacted me last summer with a proposal to accept having the system placed in our hospital," recalls **Edward Young**, MD, medical director of the Douglas ED. He notes that there was no cost at all to his hospital.

The system basically is a workstation with a computer screen, Thornby explains. "You can type in the patient's name, the medical problem, then a vital sign

Insist on telemedicine at your regional trauma center

If you're an ED manager at a rural health care facility, you should insist that the regional trauma center serving your areas has telemedicine facilities, advises **Rifat Latifi**, MD, associate professor of clinical surgery, director of surgical critical care and associate director of trauma and critical care, and telesurgery and international affairs at the Arizona Health Sciences Center in Tucson.

Not only are the benefits to patient care undeniable, argues Latifi, but the cost of a system can be recovered with just one or two cases.

"The most expensive [telemedicine] system I've seen costs about $37,000," he notes. "But such a system will save you a lot of money by [avoiding] unnecessary transfers."

Latifi recalls a recent case in which a patient had been pinned under a car. When taken to the ED at Southeast Arizona Medical Center in Douglas, he had a significant laceration in his forehead.

"If I did not have a way to see this guy [through his teletrauma system], I would have said, 'Put him in a helicopter and send him here,'" he notes. "It's 100 miles, which by air costs close to $15,000."

However, Latifi says he was able to actually visualize the wound itself, advise the ED doc to get a CT scan, and if there was no brain injury [which turned out to be the case], to put him in ambulance for transfer.

"I had another patient the other day with a gunshot wound to the chest," he continues. "When we learned [remotely] there was no hemothorax, we determined the patient could be managed over there. In the past, a patient with the same injury would have meant an automatic helicopter trip here and another $15,000."

In addition, Latifi notes, since trauma center patients typically are not paying patients, the hospital also saves money by avoiding treating patients who have been transferred unnecessarily.

There are other savings realized which, while not directly related to the hospital, are important nonetheless, he adds.

"Think of what the family goes through when you transfer an injured patient," Latifi offers. "It's relatively easy for us: You put them in an ambulance or a helicopter, and there you go — but there are 15 cousins, brothers, wives, children who also need to travel. Just imagine what we are saving society!"

For all these reasons, he explains, "If I was an ED manager in a small hospital *anywhere* in the country, I would insist the place I send patients to — or receive patients from — have a video teleconference system. There's no reason they should *not* have one."

The bottom line, Latifi points out, is that it's just not that large an investment for a trauma center.

"And even if they don't get a [state] grant, as we did, and have to buy it, since they would likely save a lot of money on the first one or two patients who are *not* transferred there, it would pay for itself in the first week," he concludes. ■

monitor can be put into the patient and read up at UMC. There's also a camera, so the doc at UMC can actually look at the patient and zoom in if they need to. They can even look at the X-rays when we put them on the view box."

The incident with the infant was the most dramatic so far because, according to Latifi, a person injured in a car accident in a small town is nearly twice as likely to die from his/her injuries as a person in an urban area. Trauma victims have the best chance of survival if the right resources and expertise intervene within the "golden hour," the first hour after injury, he explains.

Still, it's not the only time the teletrauma system has proved invaluable, Thornby adds. "We recently used it with a bad eye injury," she says. "The doctor in Tucson was able to actually see the pupil, and assess and recommend treatment for the damage to the eye."

It's clear that you also can manage very serious traumas over the network, adds Latifi, recalling the time he was invited to see a patient who had a Glascow coma scale of 15. "From the time Dr. Young saw the patient

Sources

For more information on the Arizona teletrauma system, contact:

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until three minutes later when I was at our telesystem site, the guy's mental status had deteriorated significantly,"he explains. "I zoomed to the face and saw his eyes were closed. We got his eyes open, and he had gone into coma."

In light of this change in condition, the patient's management was totally changed; he was intubated before he could be transferred to UMC.

"Then he was operated on within one hour of getting here for the major head injury," Latifi concludes.

Such assistance is especially important in the Tucson area, where there is only one trauma center, Thornby notes. "It even helps the doctors up there [in Tucson] see what's going on and determine whether a patient needs to come there," she explains.

That aspect of the system has made it "immensely helpful," Young adds. "Their physicians can see the patient, aid with stabilization, recommend various treatments, and make transfers faster and a lot easier without duplicating interventions." ■

Paperless system solves problem of lost chart costs

Patient complaints now are handled in minutes

Three months may not seem like a very long time to evaluate a new paperless system, but "so far, so good" can accurately be applied to the T-System EV being used at the department of emergency medicine at University of North Carolina (UNC) Hospitals in Chapel Hill.

One of the major reasons for going paperless was that "we were losing approximately 4% of our paper charts," notes **Jim Larson**, MD, medical director of the department of emergency medicine, and since the system was implemented Nov. 9, 2004, not a single chart has been lost.

This is not insignificant, notes Larson. "You can't bill for [lost charts], and it creates a medical/legal risk," he says. "We figured we'd see an instant improvement."

There's also been a vast improvement in dealing with patient complaints, adds **Jeff Strickler**, RN, MA, clinical director of emergency services. "In the old system, you would invariably have to search for the paper record, which would take days to weeks to review, and then go on to the next step," he observes. "Now, I'm turning complaints around in minutes."

What's more, Strickler says, cost-benefit projections indicate that savings in transcriptions alone could make the investment in software and licensing fees cost-neutral.

"The way our internal accounting system was set up, the ED would incur an expense for people from the medical records department to come to us when physicians would dictate a note, which would be done for all ED visits," he explains.

Executive Summary

Before going paperless, know what you're looking for and what the expected benefits are.

- The most technologically advanced system in the world is worthless if your doctors can't use it.
- The system will have greater value if your nurses can chart on it as well.
- A careful cost-benefit analysis should tell you ahead of time whether the system will pay for itself.

User-friendly for docs

The primary consideration in selecting this particular system, developed by T-System Inc. in Dallas, was how easily it could be understood and used by ED physicians, Larson explains. "It doesn't matter if your system is easily networked [to the main hospital system], if it's not easy for physicians to use," he notes. "This one is fairly intuitive."

"Our residents had already been familiar with [T-System's] paper system in our community hospital setting," adds **Abhi Mehrotra**, MD, assistant medical director in the UNC department of emergency medicine. "The computer screen looks like the templates you see from the paper system."

To enter the medical record, the provider selects a chief complaint — for example, chest pain — and then with a series of checks and backslashes, creates a history for the patient. The system then will take these notations and put them into a prose format.

There are about 20 units in the department, most of which are desktop workstations, although there are several rolling carts with laptops as well, for use within patient rooms. "At some points, there are 50 people using the system at the same time," Mehrotra says.

Almost immediately after the charts are notated and locked, they are shipped electronically to the in-house hospital system, WebCis.

"They are then available for viewing immediately by residents, primary attendings, or any services consulting on the patient," he explains.

"The other really nice thing is before you would have to hunt down the nurses' charts to look for vital signs, and so on. Now, the nurses are charting on the

Sources/Resource

For more information in the T-System EV contact:

- **Abhi Mehrotra**, MD, Assistant Medical Director, UNC Department of Emergency Medicine, Chapel Hill, NC. Phone: (919) 966-5933. E-mail: abhu@med.unc.edu.
- **Jeff Strickler**, RN, MA, Clinical Director of Emergency Services, UNC Department of Emergency Medicine, Chapel Hill, NC. Phone: (919) 966-0068. E-mail: jcstrick@unch.unc.edu.
- **T-System Inc.**, 4020 McEwen Drive, Suite 200, Dallas, TX 75244. Phone: (800) 667-2482. Web: www.tsystem.com.

system itself, so if I'm concerned about the patient in room 12, I can just look for his vitals on the system," Mehrotra says.

Like Strickler, Mehrotra sees benefits to the new system in terms of transcription —- and not just in hard dollars. "Before this, our attendings were dictating notes that were then transcribed and put in our homegrown system, and it was very time-consuming," he recalls.

Strickler notes that for every eight-hour shift, he typically would spend three to four hours after the shift or before the next one dictating. Now, after an eight-hour shift, Mehrotra spends perhaps an hour completing his charts. "That's a big difference," he asserts. "If you're tied up with charting, that takes productivity away from research and administration."

Management benefits seen

Speaking of administration, Strickler has seen a number of benefits to the paperless system from a managerial standpoint. "It's tremendously more useful," he asserts. "From my desktop and office, I can get a very good picture of what's going on in the department from [the chart] tracking."

The system also includes what Strickler calls "canned" administrative reports. "In the past, we had to do some data manipulation — download data from the main backbone system, load it into Excel, manipulate, and then *finally* we had something usable," he notes. "Now, we can get volume, LOS, timelines, and even carve it up by different sections in ED — or even a particular day of the week."

Much of that information is more accurate as well, Mehrotra adds. "Before when patients came in, we had LOS stamps for when they came through triage; now, when the greeter sees them, the timing starts right then, and you can see the entire stay," he notes. "It makes you realize exactly how long patients actually take to go through the department." ■

'15-30' commitment key to reduced wait times

Added personnel, equipment speed patient flow

"Dramatically reduced emergency department waiting times" was one of the major reasons cited for the awarding of this year's Malcolm Baldrige National Quality Award to Robert Wood Johnson University Hospital (RWJ Hamilton) in Hamilton, NJ.

This recognition makes RWJ Hamilton only the fourth health care facility to ever win the prestigious award.

At the heart of the turnaround was the hospital's "15-30" concept — a commitment to patients that they would see a triage nurse within 15 minutes of entering the ED, and a physician within 30 minutes, or the ED would absorb the treatment fee.

In tracking its performance, the ED at RWJ Hamilton finds it is meeting its target more than 98% of the time.

The "15-30" concept was pioneered by the RWJ facility in New Brunswick, NJ, recalls **Debbie Cardello**, the COO at RWJ Hamilton, but her facility had to implement its own targeted initiatives to make it successful there.

"We began considering it in 1998," she notes. "We took a similar approach [to RWJ New Brunswick], but we had lots to do to accomplish it since we were paying so much attention to throughput."

An interdisciplinary team was assembled, which included the medical director of the ED, Al Rodriguez, MD; the administrative director; the lab; X-ray; admissions; finance; and administration.

"We knew we would need them all to support the effort to improve throughput," Cardello explains.

The first step was to increase the number of telemetry beds, so patients could get through more quickly.

"We initially added 20, and ultimately 32, which has doubled our total," she notes.

Executive Summary

Approach throughput as a continuous process. Explore all possible avenues for improvement.

- Adding another triage nurse and physician during peak hours can enhance fast-track care.
- The acquisition of additional telemetry beds, if financially feasible, can affect performance significantly.
- When evaluating results, consider the entire process, rather than focusing just on average wait time.

Sources

For information on improved ED wait times, contact:

- **Debbie Baehser**, Vice President, Patient Care Services, Robert Wood Johnson University Hospital Hamilton, One Hamilton Health Place, Hamilton, NJ 08690. Phone: (609) 586-7900.
- **Debbie Cardello**, Chief Operating Officer, Robert Wood Johnson University Hospital Hamilton, One Hamilton Health Place, Hamilton, NJ 08690. Phone: (609) 586-7900.

Staffing also was increased. "We added a 24-hour triage nurse, and [we] added another physician for peak hours and a separate one for fast track, which we call Prompt Care," Cardello reports. "We also added a greeter, and one bedside registrar per shift."

In addition, she notes, a pneumatic tube system was installed to expedite receipt of lab results.

Create a rapid-admit team and unit

While a number of changes were made at the outset, the overall improvement in patient flow also depends on constant reevaluation and new initiatives, explains **Debbie Baehser**, vice president of patient care services.

"Over the years, we have developed more initiatives to support the program," she notes. "Because our volume has increased so dramatically, the numbers change all the time."

One of the initiatives added later was the development of a rapid-admit team, which is a nursing staff to support the inpatient unit. "This helps us treat patients more quickly in the ED and get them to [inpatient] beds," Baehser explains.

Members of the rapid-admit team go to the nursing unit where the patient is admitted and complete all paperwork.

The team began with one additional RN per shift, and now a second RN has been added during the peak hours of 11 a.m. and 11 p.m. "It has been very beneficial," she says.

Also, about a year ago, an admissions unit was started, which is a six-bed unit that helps to pull patients out of the ED, where quick treatment can be initiated. "These patients are there for four hours or so, and then sent to an inpatient unit," Baehser explains.

While initially one triage nurse was added, there are now two additional nurses during peak hours. "We also trialed having a physician in triage this summer, and it greatly helped decrease wait times," she says.

Then, in December, the hospital authorized the institution of computerized physician order entry, which will enable physicians to enter their own orders in a more timely manner.

A multidisciplinary team continually monitors ED processes, as well as those in other areas of the hospital that affect the ED. The team includes the nursing director, the ED medical director, Cardello, Baehser, plus ancillary and inpatient units.

"We monitor inpatient units as well as the ED, because they dramatically impact [flow in] the ED," explains Baehser, adding that the hospital uses a color-coded chart (green, yellow, red) that indicates the status of the ED, and specific interventions other departments can institute to help return the ED to "green" status if it is in yellow or red.

In evaluating the impact of all these initiatives, RWJ Hamilton decided against simply calculating "before" and "after" average wait times, Cardello says.

"We started to monitor our progress and found that a more comprehensive look would be helpful," she explains. "So, we've tracked the number of refunds we give — which have been very low, under 1% or 2% — rather than measuring timeliness per se," Cardello continues.

In addition, the department has found that its left-without-being-seen numbers are lower than 2%, "which is really a best practice across the nation," she adds. The hospital also keeps track of patient satisfaction.

These days, Cardello notes, "very few people are registering complaints." ■

It's not over: Prepare for a strange flu season

This year is a wild card, and anything still could happen. First, we had a dangerous shortage of influenza vaccine, followed by many high-risk people who couldn't get or decided to forgo immunization.

Fortunately, this has been a mild flu season — so far. But February and March are the historical peak months for influenza activity, and the large numbers of high-risk unprotected people make this a potential recipe for disaster. Influenza vaccine shortages and delays are a recurring problem, and at some point, we inevitably will face another influenza pandemic.

Are you and your hospital prepared if we run out of luck? Do you know where to turn for guidance and help? Do you know how to prevent the spread of this infectious disease? Or how to handle major staff shortages due to record absenteeism?

Thomson American Health Consultants has developed an influenza sourcebook to ensure you and your hospital are prepared for what could happen this flu season — or the next flu season.

Hospital Influenza Crisis Management provides the information you need to deal with ED overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients.

This sourcebook addresses the real threat of a potential pandemic and the proposed response and preparedness efforts that should be taken in case of such an event. Major guidelines and recommendations for influenza immunization and treatment are included, along with recommendations for health care worker vaccination and the efficacy of and criteria for using the live attenuated influenza vaccine.

Hospital Influenza Crisis Management will offer readers continuing education credits. For information or to reserve your copy at the price of $199, call (800) 688-2421. Please reference code 64462. ■

Correction

In our November 2004 issue, in an article titled, "Focus on process slashes average cycle time by 37%," the correct title of the hospital parent system is North Shore — Long Island Jewish Health System. In addition, GE Healthcare is located in Waukesha, WI. ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, with the March 2005 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME *questions*

25. According to Kathy J. Rinnert, MD, MPH, University of Texas Southwestern Medical Center, a negative pressure room may be as desirable as an external decon facility if:
    A. You know what substance a patient has been exposed to.
    B. It is located deep within your facility.
    C. It is just a few feet from the hospital entrance.
    D. There are no other patients in that room.
26. Christopher Cannon, FACHE, system director, Office of Emergency Preparedness, Yale New Haven Health System, says the following strategies can minimize the time your ED is on divert:
    A. Identify the unknown substance as soon as possible.
    B. Have the ability to shut down individual rooms.
    C. Follow appropriate procedures to decontaminate the ED.
    D. All of the above
27. If all the EDs in the country simply handed out Medicaid insurance applications to uninsured children, how many more children would be covered annually, according to James A. Gordon, MD, MPA, assistant professor of medicine at Harvard Medical School, attending physician in the department of emergency medicine at Massachusetts General Hospital?
    A. 75,000
    B. 100,000
    C. 150,000
    D. Hundreds of thousands
28. Which of the following is *not* among the advantages of a teletrauma system cited by Rifat Latifi, MD, University of Arizona associate professor of clinical surgery?
    A. Faster treatment for trauma patients
    B. Lower fees for treatment of trauma patients
    C. Access to the help and knowledge of more experienced trauma physicians
    D. Significant savings through avoiding unnecessary transfers
29. According to Jim Larson, MD, medical director of the department of emergency medicine at University of North Carolina Hospitals in Chapel Hill, the most important consideration in choosing a paperless medical records system should be:

COMING IN FUTURE MONTHS

■ How to deal with unwanted visitors in your ED

■ Area hospitals postpone elective surgeries to help EDs fight overcrowding

■ Elderly patients: A growing crisis for Alaska's EDs?

■ Do you know how your patients feel about your ED and medical errors?

A. Ease of physician use
B. Ease of nurse use
C. Ability to interface with existing hospital systems
D. Cost

30. The ED at Robert Wood Johnson University Hospital used the following strategies to reduce wait times:
A. Doubling the number of telemetry beds
B. Adding a triage nurse
C. Creating a rapid-admit team
D. All of the above

CE/CME objectives

- Implement managerial procedures suggested by your peers in the publication. (See *'Blue man' throws ED into divert, cause remains unknown for 9 hours* and *Unknown substance: When do you shut down?* in this issue.)
- Discuss and apply new information about various approaches to ED management. (See *Paperless system solves problem of lost chart costs.)*
- Share acquired knowledge of these developments and advances with employees. (See *Saving lives is more than 'virtual' with tele-trauma* and *'15-30' commitment key to reduced wait times.*)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *Uninsured children: An untapped revenue source?)* ■

CE/CME answers

25. C 26. D 27. D 28. B 29. A 30. D

BINDERS AVAILABLE

ED MANAGEMENT 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.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at **www.ahcpub.com/online.html.**

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ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

If the Joint Commission surveyor doesn't understand how your ED is compliant, what should you do?

You can win disagreements with surveyors — here's how

When you have a patient in your ED who isn't breathing, you make resuscitation a priority, and worry about patient identification later. But what happens when you have an accreditation surveyor who says you absolutely can't give any medication to any patient without addressing patient identification?

Well, after you finish pulling out your hair . . .

One hospital administrator encountered the above scenario in her ED during a survey by the Joint Commission on Accreditation of Healthcare Organizations.

She subsequently called the Joint Commission account representative and it's Standards Interpretation Group.

"The [Standards Interpretation Group] said it was not the intent to delay medical care in an emergency situation before having an identification number," says **Julie Gresham**, RN, clinical manager of nursing administration and the Joint Commission coordinator for Tulare (CA) District Healthcare System.

The Joint Commission removed that deficiency from Tulare's report, she notes.

EDs are different

EDs have long struggled with the fact that their way of complying with standards may look different from the rest of the hospital, because EDs *are* different from the rest of the hospital.

The examples are numerous: nutritional screening, falls prevention, pain assessment, history and physical examinations, and pharmacy pre-review of medication orders, just to name a few, notes **Bud Pate**, director of clinical operations improvement at The Greeley Company, a Marblehead, MA-based consulting company that specializes in accreditation, quality improvement, medical staff credentialing, medical staff functioning, and patient flow.

"They're all done, but they're done differently" in the ED, he adds. "Because care is expedited, it will look different than the inpatient process."

Follow these 5 steps with surveyors

The biggest misconception among ED managers and others is that when your individualized approach isn't recognized by the surveyor, you can't disagree, says **Joe Cappiello**, BSN, MA, vice president for accreditation field operations at the Joint Commission.

"Of course you can disagree," Cappiello points out.

Pate agrees. "There's a place and a time to do it, and a way to do it, but the biggest misconception

Executive Summary

You can disagree with a surveyor, but the disagreement should be handled privately and calmly.

- If what the surveyor is saying doesn't make sense, say, "Help me understand." Ask if it is a suggestion or a deviation from compliance.
- Contact the Standards Interpretation Group together.
- If all else fails, electronically submit clarifying evidence of standards compliance.

is that what they say is gospel or that they understand your system perfectly," he says.

Consider these suggestions for a successful discussion when you disagree with a surveyor:

• **Don't react with anger.**

Make the discussion friendly, Pate suggests. Don't disagree with a surveyor in front of other staff, he says. "Do it in a positive way, giving them mutual respect," Pate adds.

Sometimes, people's reactions are exaggerated by the level of tension during a survey, Cappiello says. However, surveys should not be tense situations, he maintains.

"If you have done all things you should, in other words, filling out periodic performance reviews, you're engaged in continued readiness — all the things we have talked about for years — the survey should be your chance to demonstrate compliance," he continues. "It shouldn't be viewed as single event, test, or battle."

• **Ensure you understand the surveyor.**

Make sure you understand the surveyor's issue or request, Cappiello says.

The standards and the requirements of the Joint Commission make sense from a patient safety or efficiency standpoint, Pate explains.

"Therefore, if what the surveyor is saying doesn't make clinical sense, you need to hang with it until you understand the clinical sense of what's being said; otherwise, you can't address it," he says.

Differentiate between a suggestion and a requirement for improvement, Pate advises. You can ask, "Was this a suggestion or a deviation from the standard?"

He suggests that if the surveyor says it is a deviation from the standard, and you don't understand how that statement makes clinical sense, say, "Help me understand. What should we be doing?"

"It may become apparent that they misunderstood the process," Pate says. "Or they may understand, but they think your process doesn't comply with the standard."

In the latter case, let them explain the logic of the standard to you, he advises.

• **Discuss — don't debate.**

"There are scenarios when people get so protective of what they've accomplished that any sort of criticism of that or negative reflections on that work really does cause some emotional response," Cappiello says.

That reaction leads to a back-and-forth debate of "we are in compliance" and "I don't see it," he explains. Try to understand the surveyor's point of view and what the surveyor is trying to identify, Cappiello suggests.

"Often, a surveyor specifies noncompliance because the surveyor can't identify the process or forms or can't extract compliance from staff," he adds.

If the surveyor leaves your department without the issue being resolved, there is time built into the survey schedule during which you can work with your survey coordinator to discuss the issue, Pate says.

Do your homework

However, if you reach that point, you'd better do your homework, he warns. "Ask, 'Exactly what standard or element of performance are we talking about?'" Pate suggests.

Then look it up in the manual. Also, go to the Joint Commission web site (www.jcaho.org) and under the "Standards" heading, look up frequently asked questions (FAQs) by clicking on "Standards FAQs — Ask a Question," he advises.

If you still disagree with the surveyor, sit down with him or her in a private meeting to discuss the situation, Pate suggests.

"There's a fine line between waiting to be convinced and being argumentative," he points out. "Again, saying 'Help me understand' is a perfect way to frame it."

• **Call the Joint Commission together.**

If you are unable to resolve the issue, you and your survey coordinator can request that all of you call the Joint Commission's Standards Interpretation Group, Cappiello suggests.

"Do it together so you can hear the same thing at the same time," he advises.

Sometimes, staff members may call the Joint Commission privately, not give a full rendering of the situation, and ask for guidance. Subsequently, they come back to the surveyor and say, "I've just called the Standards Interpretation Group and they say 'X,Y, Z.'"

"That's not fair, because the surveyor hasn't had a chance to share with the Standards Interpretation Group what they've seen on site," Cappiello says.

• **Submit clarifying evidence of standards compliance.**

Finally, if there still is a recommendation for improvement in the final report and you still disagree, you can submit clarifying evidence of standards compliance electronically.

Sources

For more information on how to handle disagreements with surveyors, contact:

- **Joe Cappiello**, BSN, MA, Vice President, Accreditation Field Operations, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL. E-mail: jcappiello@jcaho.org.
- **Julie Gresham**, RN, Clinical Manager of Nursing Administration, Joint Commission Coordinator, Tulare District Healthcare System, 869 Cherry St., Tulare, CA 93274. Phone: (559) 688-0821. E-mail: jgresham@tdhs.org.
- **Bud Pate**, Director, Clinical Operations Improvement, The Greeley Company, Marblehead, MA. Phone: (781) 639-8030. E-mail: bud.pate@verizon.net.

For example, the surveyor may have asked for a particular document or data that couldn't be provided, Cappiello says.

You don't have to send the actual document or data to the Joint Commission, he says. Instead, you can provide the date of the form, the date it was signed, or other information that would clearly demonstrate that the form was there but not obtainable.

About 50% of the recommendations for improvement that are appealed through this process are overturned, Cappiello points out.

He acknowledges that ED managers do raise the issue that their processes are not understood by surveyors.

"The other side of the coin is, we are very clear in our messages and ongoing training that there is not a single way to accomplish or come into compliance with a standard," Cappiello explains.

There are 5,000 EDs across the country that are geographically, structurally, and professionally different, and each has different compositions of staff, he notes.

"But there are general principles that guide each ED in the conduct of care," Cappiello adds. "As we think about standards, we try to develop standards that are not proscriptive, but flexible enough that these individual units can find themselves and demonstrate compliance within the standards." ■

Surveyors scrutinize patient rights compliance

Pain management is just one focal point

Executive Summary

EDs have several areas where they can fail to comply with patient rights standards.

- Include pain assessment on the delayed nurse report, and reassess for pain.
- A patient rights statement must be given to all patients, whether they are admitted.
- Have admission criteria. They may be included in your scope of service document.
- Ensure your staff members know who obtains consent for emergency procedures such as catheterization. Blanket policies can address cases that don't have consent.
- Give patients information on advance directives, and find out if the patient is a no code.

Do you work on decreasing your turnaround time by faxing the delayed nurse report rather than calling upstairs? If so, is pain assessment on there?

"It should be, because [the surveyors] are going to look for it," says **Eileen Whalen**, MHA, RN, vice president of trauma, emergency, and perioperative services at University Medical Center in Tucson, AZ. Whalen spoke at the last leadership meeting of the Emergency Nurses Association.

Even better is to include the last dose of analgesics, Whalen adds.

The Joint Commission on Accreditation of Healthcare Organizations is paying particular attention to pain management in the ED, Whalen says. For example, EDs can be cited for failing to reassess pain, she points out.

Other critical areas of compliance with patient rights standards in the ED include:

- **Patient rights statement.**

Have a copy readily available to your patients as they come into that emergency department, Whalen advises. "Many of you probably have that in your admission packet, but patient rights have to be readily available to every patient," she says. Post them, and ensure they spell out that patients are included in decision making.

- **Admission criteria.**

Many ED managers think it's preposterous to have admission criteria in an ED because they take every patient who comes in the door, adds Whalen.

"Well, you don't keep everything that comes in the door," she points out. For example, patients may be transferred to a higher level of care. "That should be documented in admission criteria," Whalen says.

Many hospitals already have admission criteria in their scope of service document, she points out. "It's OK to say 'My admission criteria are included in my scope of service document,'" she advises.

• **Appropriate communication.**

The standards point out that patients have a right to appropriate communication, and one potential problem area comes up with patients who don't speak English or aren't able to communicate well with providers, says **Amy Wilson**, MPP, CPHQ, associate project director at the Joint Commission.

In addition, patient rights statement should be posted in all the appropriate languages, sources say.

• **Informed consent.**

EDs are expediting patients to the catheterization lab for definitive treatment, but what type of informed consent is the ED patient getting? asks Whalen.

Surveyors will ask your staff about doing the informed consent on emergency catheterization procedures, she warns. "And that's just one example," Whalen adds.

In doing the tracer methodology, if a survey says that a patient had a procedure in the ED, they're going to go look for that consent, she continues.

However, EDs can have blanket policies about what procedures you consent and what procedures you don't consent, she advises.

"Make sure you know those policies, so if they come up with one you didn't have to consent, you can answer, 'Oh, you're not going to find a consent on that patient' for whatever reason," Whalen notes.

• **Advanced directives.**

One problem area for EDs is lack of respect for patient wishes regarding do-not-resuscitate orders.

Clinically, you need to know if the patient is a no code, she adds.

Also, for every admitted patient, the hospital has to ensure there's information about advance directives on that chart. "It starts in the ER," Whalen explains. "It starts at those outlying facilities that transfer into your mother ship.'"

You don't need to conduct a detailed interview with the patient, she says. "It's information about the advance directive," Whalen adds.

• **Denial of treatment for financial reasons.**

The Joint Commission has the right to examine your patient records to ensure the ED is complying with the Emergency Medical Treatment and Labor Act.

• **Access to bioethics committee.**

One final tip from Whalen: Ensure your staff know how they can access a bioethics committee for any issue. "Whether or not they've ever been to a bioethics committee, they need to be able to articulate those answers [about how to access them]," she advises. ■

Source

For more information on complying with patient rights standards, contact:

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Topics announced for random surveys

Random unannounced surveys conducted in 2005 by the Joint Commission on Accreditation of Healthcare Organizations will focus on these fixed areas in hospitals:

- assessment and care/service;
- infection control;
- patient safety.

The Joint Commission conducts one-day surveys at a randomly selected 5% of accredited organizations. Also, during the random surveys, surveyors focus on variable components based on each hospital's performance, and those variable components take priority over the fixed areas. Random unannounced surveys will end in January 2006 when the Joint Commission begins conducting all accreditation surveys on an unannounced basis.

For questions about random unannounced surveys, contact Kevin Hickey, director of the Management Support Unit at the Joint Commission. Phone: (630) 792-5872. E-mail: khickey@jcaho.org. ■