ED NURSING®

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AMERICAN HEALTH CONSULTANTS

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Are your sedation practices safe? New ACEP guidelines offer help

A 12-year-old child is sedated in your ED after a fall off a second-story balcony before being taken for a computerized tomography scan. If the child's blood pressure lowered suddenly, would you react immediately?

If sedated patients in the ED aren't closely monitored, airway and respiratory problems can occur, says **Sharon Stapleton,** RN, CCRN, outreach education coordinator at Doernbecher Children's Hospital in Portland, OR. "Children should be not only monitored for all vital signs, including oxygen saturations, but should also be accompanied by a nurse qualified to assess pediatric airways," she says. "You must be ready to take over the airway with bag/valve/mask if necessary."

New evidence-based clinical guidelines from the Dallas-based American College of Emergency Physicians (ACEP) give recommendations for procedural sedation and analgesia.[1,2] "This is a key focus during JCAHO [Joint Commission on Accreditation of Healthcare Organizations] surveys," says Stapleton.

ED nurses must assess the patient constantly and thoroughly during the procedure, cautions **Juanita Bishop**, RN, quality assurance coordinator for the ED at South Miami (FL) Hospital. "The nurse is essentially taking the place of the anesthesiologist while the physician is occupied performing the procedure," she says.

Have all the equipment you possibly could need at hand, including monitor, oxygen saturation, automatic blood pressure set to cycle every five to 10 minutes, suction, and the code cart for any emergencies, says Bishop. "We primarily use Versed [midazolam HCl] and fentanyl in the ED," she adds. "Our nurses are trained in the procedure and do annual competencies to stay current."

EXECUTIVE SUMMARY

New guidelines for procedural sedation and analgesia from the American College of Emergency Physicians give updated approaches for assessment and monitoring.

- Some states prohibit nurses from monitoring airways of patients in deep sedation.
- Rapid administration of drugs is linked with hypotension and respiratory depression.
- Don't rely on parents to monitor sedated children.

Charts of all sedated patients are audited to make sure all steps were followed, she adds.

Each patient must have a targeted system review by the physician and be assessed for health status, says Bishop. "The nurse is assigned to the patient as a one-to-one until the procedure is complete and the patient is stable," she says. "The patient must be discharged with someone else driving them home if released in less than four hours."

Advocate for children

If your ED doesn't have specific guidelines in place for sedation of children, you should strongly advocate for this, urges Stapleton. "I applaud this group of authors for providing evidence-based recommendations on this subject," she says. "Most ED nurses tell me that children make them nervous and they don't see kids often enough to feel comfortable."

There are a wide range of medication choices for sedation and analgesia of children, and children may react differently to medications than adults, Stapleton notes. "Kids are not easy," she says. "You have to know what medication to give, how to give it, side effects of the medication in the pediatric population, and very importantly, correctly calculate smaller doses."

These medications often are ordered in micrograms/kg rather than milligrams/kg, so you must double-check all medication dosages and volume dosages, advises Stapleton.

To dramatically improve care of sedated patients in the ED, do the following:

• Know criteria for all levels of sedation.

The Joint Commission requires that practitioners administering deep sedation must have appropriate credentials, including the ability to recover patients from general anesthesia, notes **Gail McWilliams**, RN, CCRN, clinical nurse specialist for the ED at Shore Health System in Cambridge, MD.

"Physicians ordering these drugs need to be aware that registered nurses do not meet this criteria," she says. "Therefore, there must be a second physician present to administer the drug and monitor the airway during the procedure."

The ACEP guidelines state that ED physicians should coordinate all procedures requiring procedural sedation and analgesia with the ED staff, McWilliams says. There is a growing body of evidence supporting the safe use of propofol for procedural sedation by emergency physicians — but remember that nurses are accountable for their own professional scope of practice, she warns. Many state boards of nursing have issued declaratory rulings prohibiting nurses from monitoring the airway of patients receiving etomidate or propofol for procedural sedation, she emphasizes.

"I have been involved in situations where ED physicians behaved unprofessionally when told by ED nurses that their liability did not extend to the administration of these drugs," says McWilliams.

The drugs lack any available reversal agents, and though they are both relatively short-acting, there is a risk of patients drifting into deep sedation or even general anesthesia, she adds.

• Avoid overmedication of patients.

According to the ACEP guidelines, the key to avoiding complications in procedural sedation and analgesia is titration of drugs to the desired effect, since rapid administration of drugs may be associated with hypotension and respiratory depression.

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"Having personally experienced many procedural sedations when physicians repeatedly requested more meds be given before the previous dose had time to be effective, I would have hoped to see a more forceful reminder to the physicians to be patient and let the drugs do their job," says McWilliams. "This is one of the most common complaints I hear from nurses across the country."

• Know your protocols for monitoring.

In addition to having the appropriate number of personnel and equipment during the procedure, you must monitor the patient carefully including post-procedure, says **John Brennan**, MD, FACEP, FAAP, chair of emergency medicine at St. Barnabas Health Care System in Toms River, NJ. "A patient may have a shoulder reduction and be in a lot of pain, but when the shoulder is put back in place, the patient will have much less pain stimuli and may subsequently go into a deeper sedation," he says. "The nurse has to predict this, monitor it, and be prepared to treat a patient who goes into a deeper state of sedation."

You'll need to determine how post-procedure monitoring will be done when you have several other patients, notes Stapleton. "Parents are wonderful resources and should be utilized in many way, but, don't depend on them to monitor your child," she says. "You are responsible for this."

If hypoventilation isn't picked up on immediately, the child may become apneic and then bradycardic, says Stapleton. "It may occur quickly and then be hard to recover the child, even with bag/valve/mask ventilation," she says. "I have seen kids develop obstructive breathing after sedation because of the child's anatomy, which can lead to apnea."

• Know what to expect from moderate and deep sedation.

"If a child becomes deeply sedated with a dose that normally would only lightly sedate another child of the same age and weight, you would be able to quickly assess that and inform the physician accordingly," says Stapleton.

• Remember that analgesics and benzodiazepine given together may cause respiratory pattern changes.

An intubated pediatric trauma patient with multiple fractures, for example, will receive pain medications and also may be given benzodiazepines for anxiety, says Stapleton. This patient may exhibit signs of hypoventilation and hypotension, she says. "Be ready for it, and watch for these effects," Stapleton says. Shock symptoms in children are different than those in adults, she emphasizes. "Because they can compensate so well, if you don't pick up on the early compensated symptoms, then you may have a 'crashing' child," Stapleton warns.

References

1. American College of Emergency Physicians. Clinical Policy: Procedural sedation and analgesia in the emergency department. *Ann Emerg Med* 2005; 45:177-196.
2. American College of Emergency Physicians. Clinical Policy: Evidence-based approach to pharmacologic agents used in pediatric sedation and analgesia in the emergency department. *Ann Emerg Med* 2004; 44:342-377. ■

Decrease your ED's supply par levels and save

Do you store intravenous lines, pulse oximetry supplies, and disposable blood pressure cuffs in treatment rooms? If so, dollars are likely trickling out of your ED in the form of missing or uncharged supplies.

"We often wasted money on stocking supplies in nonacute rooms and having the par levels stay in the rooms," recalls **Vernon Craig Meche**, RN, BSN, CEN, ED nurse at Lafayette (LA) General Medical Center.

At Saint Vincent Hospital in Green Bay, WI, a team

EXECUTIVE SUMMARY

You can save thousands of dollars by decreasing supply par levels in ED treatment rooms, due to fewer missing or uncharged supplies.

- By stocking only six Level I fluid warmer tubings instead of 16, $650 was saved.
- A cart for intracranial pressure monitoring was disassembled and supplies stocked in surgery instead, for a $5,000 savings.
- $15,000 was saved by reducing supplies in treatment rooms based on utilization data.

of an ED nurse and two technicians reviews supply levels regularly to make sure they are not overstocked, with par levels assessed by usage and decreased if needed, says **Paula Hafeman**, RN, MSN, director of the cancer and emergency center. For example, the ED saved $650 by decreasing the number of Level I fluid warmer tubings, which cost $65 apiece, from 16 to six.

"If supplies are used infrequently in the past 12 months, we will check to see if they are stocked elsewhere in the hospital," she explains. "If available in another area, we will eliminate the supplies from the ED and acquire them from another area as needed."

For example, the ED had assembled a cart for intracranial pressure monitoring insertion based on a neurosurgeon's request, but after a year, the cart had been used only once. "The supplies were available in surgery, so we disassembled the cart and saved $5,000 on instruments," says Hafeman.

Uncharged supplies equal lost revenue

Lafayette's ED switched to an automated dispenser system (Pyxis SupplyStation, manufactured by Dublin, OH-based Cardinal Health) to replace supplies so items are automatically charged, says Meche. "We were losing a lot of revenue by not charging par items," he says. This loss usually occurred in high acuity patients in which the focus is on patient stabilization and treatment and possible transfer to a higher level of care, Meche says. "Often, charging items is a last thing on a nurse's mind," he says.

To decrease par levels of equipment in rooms, nurses now go to the Pyxis to procure supplies such as syringes, nasal cannulas, and blood pressure cuffs. Once supplies are used, they are automatically replaced using the patient's name and account number to restock. Only the par level of supplies is kept in the rooms, including two of each popular size of intravenous catheters, two saline locks, two occlusive dressings, and two tourniquets. "The nurse is limited to these amounts before going back to restock," Meche says. "Previously, individual ED technicians or nurses stocked rooms according to personal preferences. Some nurses had six or seven sets of Jelcos, blood pressure cuffs, and pulse oximetry devices."

Central supply monitors what is being taken, to ensure that all supplies are being charged. "The Pyxis can give a report at any time on which employee pulled what supply item and also can give a total inventory of all floor stock supplies," says Meche.

At first, nurses were frustrated with having to go to the automated medication dispenser cabinets for supplies that were once at their fingertips. "But when the staff saw how much floor stock was not being charged to the patient, attitudes did change," Meche says. He estimates that about 30%-40% of small par items were not charged before the switch.

The ED uses computerized charting to document all procedures and orders on-line, which provides much more accurate information then a handwritten record, he says. For example, if no supplies are charged for a procedure requiring an intravenous (IV) line, the audit department will call the unit to find out if the patient did have an IV, says Meche. "The charges are also compared to the doctor's orders," he adds.

ED equipment tech saves $15,000

At McKay-Dee Hospital Center in Ogden, UT, an ED equipment technician is in charge of stocking and

SOURCES

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ordering supplies, making minor repairs, and keeping nurses updated on new equipment, reports **Kayleen L. Paul**, RN, CEN, care center director for emergency, critical care, and trauma services. "We require this individual to be an emergency medical technician so he or she understands the needs of the department," she adds. "The tech works with a liaison from materials management who knows and appreciates how the ED works. Those two people, working together, are a great money-saving team."

Par levels are revised every six months based on utilization data, and supply areas have been redesigned to reduce inventory. "We used to have very decentralized supplies in every room, and the nurses hoarded like crazy," says Paul. "Now, minimal supplies are kept in the rooms, except for the resuscitation rooms, yet supplies are readily available in nearby carts."

Paul estimates that more than $15,000 has been saved in an 18-month period by decreasing reordered supplies and reducing par levels. "But the biggest saving is in decreased aggravation for staff, who waste less time looking for things," she says. "There is no more begging or arguing with materials management when we need something urgently in the middle of the night."

[Editor's note: Do you have a cost-cutting tip to share with ED Nursing *readers? If so, please contact Staci Kusterbeck, Editor,* ED Nursing*, 280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciKusterbeck @aol.com.]* ■

Clues offered on queries for stroke certification

Are you ready to put your ED's stroke care under the microscope to be inspected by surveyors from the Joint Commission on Accreditation of Healthcare Organizations? A growing number of EDs are applying for Joint Commission's Primary Stroke Center Certification program, which requires an on-site survey to assess whether stroke care meets national quality standards. **(See article to see changes made at one ED to improve stroke care, p. 67.)**

Here are specific questions asked at recently surveyed EDs:

• What do nurses document?

"The surveyor was interested in the preprinted chart form that we use for suspected cerebrovascular accident /transient ischemic attack [CVA/TIA], which gives us the timelines that we are to meet," says **Ken Lanphear**, RN, BSN, ED nurse at Borgess Medical Center in Kalamazoo, MI. **(See form used for stroke/ TIA notes on p. 66.)**

The form contains all the information needed to make a quick determination of the patient's neurological status, including nursing assessment, the time they were last seen normal, time to room, time when the ED was notified of the patient's arrival, door-to-physician time, when labs were drawn, time the stroke team was notified, time to computerized tomography/magnetic resonance imagine (CT/MRI), and time when tissue plasminogen activator (t-PA) was started.

• Which nurses care for stroke patients?

The surveyor wanted to know if all nurses in the ED cared for stroke patients or if certain nurses were identified as "stroke" nurses, says Lanphear. "We explained that in our ED, all nurses care for CVA/TIA patients," he says. All nurses use the National Institutes of Health (NIH) stroke scale, Lanphear says. "There are a few of us who have a more extensive neuro background, and we act as resources for our peers," he says.

• How often are patients given thrombolytic treatment?

"Unfortunately, as in most EDs, the answer is that we don't do it very often, because the patient usually doesn't fall within the required timelines," says Lanphear. "She asked why, and the answer was given that community education was needed, and that we are actively engaged in that process."

• What happens when a stroke patient arrives?

Ideally, the Joint Commission surveyor would have followed an actual stroke patient's care from the moment of their arrival in the ED, says **Diana Everley**, RN, BSN, ED clinical educator at Deaconess Hospital in Evansville, IN. "Since we did not have a patient that came in during the hours that the surveyor was here, we pretended."

Continued on page 67)

EXECUTIVE SUMMARY

To be certified by the Joint Commission, your ED will have to demonstrate that stroke patients receive consistent and timely care in adherence to national guidelines.

- Surveyors will want to know how often tissue plasminogen activator is given.
- Surveyors will follow a stroke patient if one arrives or will go through the steps that a stroke patient would.
- Nurses must be able to answer questions about every step in the process.

BORGESS MEDICAL CENTER
Kalamazoo, MI

ETC STROKE/TIA NOTES

Time of arrival to ETC_____ Triage Acuity 1 2 3 (should be 1)
Time last seen normal_____a.m./p.m.
Time last seen normal: ❑<3hrs (Notify ETC MD Immediately) ❑3-6hrs ❑6-24hrs ❑ >24hrs
Mode of Arrival: ❑EMS ❑Car ❑Ambulatory ❑Other_____
Arrived from: ❑Home ❑Hospital:_____ ❑Nsg Home:_____❑Other:
Chief Complaint:_____

ALLERGIES NKA
Latex Allergy : No Yes
MEDS: (None)

Have you recently been exposed to or are you a carrier of a communicable disease? No / Yes
TB Assessment: Productive cough: No / Yes, if yes refer to proto
ISOLATION: No / Yes
Physical Assault Victim: Do you feel threatened in any way or have you been physically hurt by anyone? No / Yes
NURSE SIGNATURE:

Weight Kg

Time: _____ To RM # _____
Time: _____ ETC physician notified of pt. arrival
Time: _____ ETC physician in to examine pt (door to MD < 10 minutes)
Time: _____ Labs drawn
Time: _____ IV: Ga: _____Location: _____Fld:
Time: _____ Stroke Team notified (via PATH)
Time: _____ To CT / MRI (door to CT < 25 minutes)
Time: _____ Return from CT / MRI
Time: _____ Stroke Team physician at bedside
Time: _____ tPA started (door to drug < 60 minutes)
Time: _____ Admit to: ❑Critical Care ❑Monitored bed ❑Med/Surg ❑Neuro Lab

Time								
Temp								
Pulse								
Resp								
BP								
Pulse Ox								
Pain (1:10 scale) 10 = worst								
Monitor Rhythm								
t-PA per IV: STAT _____total mg doses (0.9mg/kg) 1: 1 dilution of tPA (max dose 90mg) * see tPA order sheet								
Time								

SIMILAR EPISODES: No Yes (when_____)
PAST MEDICAL HISTORY:
Stroke TIA HTN DM CAD A-fib Chol
Prosthetic valve Bleeding (source_____) other:_____
SOCIAL HISTORY:
__ Smoker: Current Past Quit
(when_____)__ Recreational drug use: No Yes
(drug_____)
NEURO EXAM: Cooperative Uncooperative Combative Agitated Verbally abusive Non Verbal_ Mental Status: Alert Drowsy Somnolent Comatose
Follows commands: Completely Partially Not at all
Weakness: ARM: Rt Lt Both Neither
LEG: Rt Lt Both Neither
Numbness: ARM: Rt Lt Both Neither
LEG: Rt Lt Both Neither
Speech: WNL Slurred Difficult to understand Unintelligible Mute
Vison: Rt Eye: WNL Abnormal _____
Lt Eye: WNL Abnormal_____
RESP: Dyspneic Hyperventilating Shallow Apneic
Oxygen: None Nasal cannula Mask _____ L/min
Rt Lung: Clear Diminished Wheeze Crackles
Lt Lung: Clear Diminished Wheeze Crackles
CARDIAC: Irregular Regular
Monitor Pattern: _____
SKIN: WNL, Cool, Diaphoretic,
Injury: Intact Laceration Bruise Other_____
Color: WNL Pale Flushed Cyanotic
Mucous Membranes: WNL Dry Cyanotic
ABD: Soft Tender Rigid Other_____
GI bleeding: None Gross blood Melena
G/U: Burning Frequency Urgency Hematuria
Foley: None PTA Inserted in ED (time_____)
PREGNANCY: Yes/No, LMP _____G/P
Assoc. S/Ss: None N / V SOB Chest Pain Dizziness H/A
MUSCULOSKELETAL: N/A
Tender:: LA RA LL RL Edema: LA RA LL RL
+ Distal Pulse: LA RA LL RL Deformity: LA RA LL RL
- Distal Pulse: LA RA LL RL Discoloration: LA RA LL RL

Nurse Signature_____Time:

White = Chart Copy Yellow = ETC Educator/Outcome Specialist Copy

Source: Borgess Medical Center, Kalamazoo, MI.

SOURCES

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Here is what the surveyor asked:

— The surveyor informed the triage nurse of her symptoms, to ensure that she asked, "When was the last time you were seen without symptoms?" "She also asked the triage nurse how she would assign her a bed, and what would happen if the ED was full and we did not have any beds at the time," says Everley. "She let the triage nurse take her to a treatment room in the back."

— The surveyor told an ED nurse what she had told the triage nurse about her symptoms and their onset. "She then asked what would happen from there and asked the nurse if she would like to get any references, and let her grab the stroke folder that we have available," she says.

The nurse said she would get vital signs, do a quick assessment, start an intravenous line and draw blood, put an order in for a computerized tomography (CT) scan, notify the ED physician, and call the CT scan room to alert them that the patient was on the way.

— The surveyor asked the nurse what would happen when she returned from CT. The nurse discussed that she or the physician would complete the NIH stroke scale. The physician would review the results, lab work, CT results, and the patient's current vital signs.

— The surveyor gave the nurse hypothetical results: A negative CT, normal lab results, an NIH stroke scale score of 11, and normal vital signs. The nurse said she would get the inclusion/exclusion criteria from the physician, and the ED physician would discuss the results with the on-call neurologist.

— The surveyor asked the nurse to assume that the neurologist gave the OK to give t-PA, and questioned the nurse on how this would be given. She allowed the nurse to refer to the order set, and the nurse said that the patient would be transferred to the intensive care unit (ICU).

"The surveyor continued this line of questioning as she went to radiology and lab, up to the ICU, and so on," says Everley. ■

What has your ED done to improve stroke care?

When Joint Commission surveyors arrive in your ED to assess stroke care, they'll have one thing on their minds: What you're done to improve and speed assessment and treatment.

"We knew the best practices we would be judged on were: Lab drawn and sent within 10 minutes, patient seen by physician within 10 minutes, and patient to computerized tomography [CT] within 40 minutes," says **Pat Laufmann,** RN, BSN, director of emergency services at Saint Vincent Healthcare in Billings, MT. "Everything we did were minor things in and of themselves, but over all, they had a huge impact on making us successful."

Key improvements

ED nurses reported the following changes to surveyors, to demonstrate how these goals are met:

• Previously, if CT was ready as the patient arrived, sometimes the patient went there immediately before labs were drawn. "So in that case, we now draw the labs in CT," Laufmann says.

• Stroke patients take priority over all other labs. "We ordered red biohazard bags and place stroke lab tubes in those. The lab easily identify that they must grab these first," she says.

• During off hours, a CT technician was called in, but that is no longer needed. "They responded quickly, but still, it took time. We requested, and radiology agreed, that they would train more of their techs to do CTs, so we now have someone in-house 24/7," says Laufmann.

• Triage nurses now use the same five assessment questions used by paramedics in the field. "If yes to all, we activate the stroke team," says Laufmann. "It gave consistency to patients being assessed at triage and eliminated delays in those that they just weren't sure about." ■

SOURCE

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Try these tips to ease tensions with floor nurses

Do you bear the wrath of frustrated floor nurses due to factors beyond your control, such as crowded waiting rooms and hallways filled with admitted patients?

"The ED is the department that causes the most unrest to other hospital units," says **Carla Schneider**, RN, director of the emergency care unit at Hoag Memorial Hospital Presbyterian in Newport Beach, CA. Just when caregivers become comfortable, have an empty bed, and stabilize their critical patients, it all changes, Schneider says. "The empty bed is filled lickety-split, and the critical patient has to be transferred out for the new admit," she says.

To resolve conflicts, implement these strategies:

• Ask other departments for input before making changes.

Since ED nurses were frustrated with constant excuses about why beds weren't ready, a decision was made to fax report and send the patient up immediately, says Schneider. But before making this change, ED nurses met with the hospital's clinical practice council. "Other departments gave us input on what specific information they would need and asked us to call 100% of the time before we faxed reports."

• Invite nurses from other departments to observe triage in the ED.

To understand the need to move patients out of the ED as soon as possible, floor nurses are invited to sit in triage for 30 minutes and decide which of the patients will go to the one empty bed first, says Schneider. "We remind them that this decision is based only on a three- to five-minute triage without any monitoring or testing," she says.

• Have ED nurses spend time in other departments.

An "ambassador" program is being developed at Hoag Memorial that will allow nurses to work for a few hours in another department, says Schneider. For instance, if ED nurses want to know more about X-ray procedures, they can work with a radiology nurse for a few hours, or if a neonatal intensive care unit (ICU) nurse wants to sharpen her intravenous line skills with newborns that arrive in the ED, she can spend time there.

"We will build bridges by putting a face with the voice on the telephone," Schneider says. This will allow frontline staff to resolve issues between departments, she says. "When you see what they do, it all makes sense," Schneider says.

• Collaborate with other departments to find solutions.

At Methodist Hospital in Indianapolis, ED nurses participate in a monthly clinical practice council with staff from pharmacy, lab, dietary, administration, and environmental services. "There is a structure for voicing concerns and a process for resolution, fact finding, and intervention," says **Kathy Hendershot**, RN, MSN, CS, director of clinical operations for the emergency medicine and trauma center. "It is amazing when one nurse will speak up and several others chime in with their own experience."

Working together, ED and ICU nurses have come up with the following solutions: If there are four critical care patients and only one available ICU bed, the ICU nurse comes down to the ED to evaluate each patient jointly with the ED nurse. "They decide who goes first, then the ICU nurse helps place the others as quick as possible," says Hendershot.

Also, ED nurses often accompany the patient to arteriogram prior to transport to the inpatient bed, and now they call the ICU to ask for help. "If they can, the ICU nurses will meet us there and get a face-to-face report, and the ICU nurse assumes care of the patient," says Hendershot. "This allows the ED nurse to return to the ED, and the ICU nurse transfers the patient when the procedure is complete."

At Mecosta County General Hospital, a 78-bed hospital in Big Rapids, MI, there was an ongoing problem with admitted ED patients during change of shift, says **Kathleen M. Walter**, RN, BSN, the ED's clinical support nurse.

"The ED nurse wanted to give report and not have the next shift give report secondhand," she says. "Inpatient staff weren't always available for report because they may have had a crisis going on or had gotten slammed with direct admits."

To address this problem, ED and floor nurses formed a committee, including nurses who had worked on both units and nurses who were resistant to change. The following changes were made:

— The process of calling report was changed so that if the floor nurse is busy, ED nurses calling report can leave a voicemail message and send up patients immediately;

EXECUTIVE SUMMARY

To solve ongoing problems and reduce tension pertaining to patients being held in the ED, collaborate with nurses from other departments.

- Invite nurses to observe ED triage.
- Ask inpatient nurses for input about faxing reports.
- Have nurses voice concerns and offer solutions.

SOURCES

For more information on reducing conflicts, contact:

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- **Kathleen M. Walter**, RN, BSN, Clinical Support Nurse, Emergency and Cardiopulmonary Departments, Mecosta County General Hospital, 405 Winter Ave., Big Rapids, MI 49307. Telephone: (231) 796-8691, ext. 4131. Fax: (231) 592-4421. E-mail: kwalter@mcghhospital.com.

— ED nurses agreed not to hold patients to finish charting;

— Nurses agreed that occasionally an emergency on either unit may need to take priority.

"The goals have been met, and there is better understanding and patience on both sides," says Walter. "Members are proud of the changes they helped make."

[Editor's note: Do you have an idea for resolving conflicts with floor nurses to share with ED Nursing *readers? If so, please contact Staci Kusterbeck, Editor,* ED Nursing*, 280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciKusterbeck@aol.com.]* ■

4 ways to give psychiatric patients privacy in your ED

Imagine a sullen teenager bring brought to your ED by her mother, who tells you she is suicidal. Behind her you see a man clutching his chest and a woman who reports blurry vision. Would you take the time to bring the patient to a private area before asking if she intends to harm herself? What if a hearing-impaired elderly man reports recent depression and you have to shout when asking if he takes antidepressants?

If other patients or staff can overhear a patient's personal medical information, you are at risk for a violation of the Health Insurance Portability and Accountability Act (HIPAA), warns **Ilze Sturis Hallman**, APRN, BC, RN, CS, clinical nurse specialist for psychiatric emergency services at University of Michigan Health System in Ann Arbor. "Only the minimum necessary information needed for others to be able to do their jobs or fulfill their roles should be disclosed," she says.

Privacy and confidentiality often is overlooked in a busy ED, but this can have a negative effect on patient care, says **Carol A. Ziolo**, RN, LCPC, a mental health liaison specialist for the ED at Northwest Community Hospital at Arlington Heights, IL. "It is very difficult to develop a therapeutic rapport when a patient feels embarrassed by lack of privacy and perceives that everyone in the ED knows the reason for their visit," she says.

When caring for psychiatric patients, use these strategies to protect privacy:

1. Place patients in a private room if possible.

This privacy makes it more likely that the patient will give an accurate and complete history and not omit information about recent abuse or a suicide attempt, says Hallman. "If a private room is not available, placing the patient in a corner area of the ED for added privacy may be helpful," she says. "This has to be balanced with the need for added supervision for psychiatric patients, based on their presenting problem."

At Northwest's ED, two psychiatric rooms offer patients privacy for evaluations and behavior management, and the rooms have cameras so that patients can be observed by a sitter in another area, says Ziolo.

However, there are times when a private space just isn't available, acknowledges Ziolo. "There are many times that our two psych rooms are full, and we have to do evaluations with patients on carts next to the wall," she says. "During those times, we try to sit close to the patient and talk in a soothing tone of voice."

The goal is to obtain enough information to make a disposition as quickly as possible to remove the patient from the hectic ED environment, says Ziolo. "I explain to the patient that I understand that privacy

EXECUTIVE SUMMARY

If psychiatric patients aren't given privacy in your ED, this can have a negative impact on their care and put you at risk for a violation of the Health Insurance Portability and Accountability Act.

- Limit the number of staff who interact with patients.
- Ask patients to give consent for visitors and before calling insurance.
- Inform patients if auditory or visual monitoring is done.

SOURCES

For more information on privacy and psychiatric patients, contact:

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is lacking, but that I will make every effort to maintain confidentiality," she says.

2. Limit interaction with staff.

"We try to limit the number of staff who interact with patients," says Ziolo. "Patients get very agitated when asked similar questions by numerous staff, so we ask only staff who have a 'need to know' to interact with patients."

Although a lab technician may draw labs, the patient's nurse will often obtain blood and urine samples. "We also suggest the volunteers do not interact with the patients as they may not be educated on the appropriate information to tell the patient," says Ziolo.

For example, people without knowledge of mental health laws may tell a patient that they may leave anytime they want, regardless of the situation. "Many ED staff are not aware that patients can be held against their will when they are going to be admitted involuntarily," she adds. "Patients may get incorrect information and escalate to aggressive behaviors when they are told inaccurate information by the mental health team."

3. Obtain consent from patients.

Ask patients to sign release of information consent forms before calling insurance companies, and have patients give consent before visitors are allowed in the room, says Ziolo.

If the patient can't communicate, information can be obtained from a caregiver or family member if your clinical judgment determines that this is in the patient's best interest, says Hallman. For example, family members may be able to provide information about the patient's mental health history or current prescribed medications.

"If the patient is not incapacitated, obtain a written release of information from the patient for documentation purposes," she advises.

4. If monitoring is needed, inform patients.

At Cleveland Clinic Foundation, psychiatric patients who are at risk for harm or for leaving the ED are placed in a seclusion room for monitoring and are always informed when auditory and visual monitoring is done, reports **Nina M. Fielden**, MSN, RN, CEN, clinical nurse specialist for the ED.

The auditory monitoring is done by nursing personnel with headphones so no one else can hear. "It is possible for anyone within the nursing station walking by to see anyone being monitored, but no visitors or other patients outside the nursing station can see what is going on," she says.

The nurse responsible for the patient checks the patient in person every 15 minutes, and someone constantly sits at the monitoring station while the patient is in seclusion.

If a psychiatric patient is in the room with no need for seclusion or monitoring, the monitors are turned off. "Our policy specifically states that visual and auditory monitoring may not be used without the patient's knowledge and without someone constantly watching the monitor and listening with the headphones," says Fielden. ■

Don't assume dehydrated children always need IVs

When a child is vomiting and has diarrhea, is your first thought to give intravenous (IV) fluids?

"The literature shows that for a mildly to moderately dehydrated child, giving fluids orally works just as well," says **Lynn Daum**, RN, BSN, special projects coordinator for emergency services nursing at Cincinnati Children's Hospital Medical Center.[1]

Instead of starting IV fluids, nurses offer children a Popsicle. "That way, we can see how they do with a fluid challenge before jumping to IV fluids," she says. IVs are only given to children if their primary care physician has ordered fluids, can't keep Popsicles down, are severely dehydrated, or have not had sufficient urine output in the past 12 hours, Daum explains.

This means that about half as many children are

SOURCE

For more information on dehydration and pediatric patients, contact:

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getting IV fluids for mild/moderate dehydration, says Daum. "At this institution, at $109 a pop, that is quite a savings when you look at our numbers," she says.

Daum's ED treats more than 2,676 patients with gastroenteritis each year. Since an evidence-based guideline was implemented, ED visits for this complaint decreased approximately 22%. The guidelines state, "In children with moderate to severe dehydration, oral dehydration therapy is an effective and proven alternative to IV therapy. IV therapy is always recommended in the child with severe dehydration and obtunded mental status."

To reduce ED visits, instruct patients to give children enough fluids to keep up with fluid losses from vomiting or diarrhea, Daum recommends. "This can be tricky, but if the parents force fluid in any way the patient will take it, they will be able to manage the potential dehydration at home," she says.

Reference

1. Atherly-John YC, et al. Oral vs. intravenous rehydration in the pediatric emergency department. *Acad Emerg Med* 2001; 18:436. ■

Number of ED visits for injured elderly increasing

Are you treating more injured elderly patients in your ED? A report from the Bethesda, MD-based U.S. Consumer Product Safety Commission shows a 73% increase in the number of patients 75 and older treated for product-related injuries in EDs from 1991 to 2002, with falls the leading cause of injury.

"As this population continues to grow, we will see an ever increasing number of elderly trauma patients," says **Kathleen Loeffler**, RN, research nurse at Harborview Medical Center in Seattle. "Being prepared and proactive will be the best defense."

ED nurses can make a huge difference in the lives of their elderly patients by careful assessment, says Loeffler. "Understanding the unique physiological and anatomical differences in this age group and providing early, appropriate interventions is crucial for the best possible outcomes," she says. **(For more information on this topic, see "Simple steps reduce risks to elderly trauma patients," *ED Nursing*, December 2004, p. 18.)**

To improve care of elderly patients with falls, consider the following:

• Even a relatively minor fall can lead to serious complications.

Falls in seniors are related to the decreased functions of their special senses, which in turn lead to decreased vision and impaired gait, balance, and proprioception, says Loeffler. "Further complicating this are issues like syncope, medication interactions, drug or alcohol use, and delayed response times," she says.

• Falls may have multiple causes.

An overmedicated patient may trip over a scatter rug while wearing unsafe shoes, says Loeffler. "Those osteoporotic bones can snap like a dry twig," she says. "A sudden, awkward turn causes the femoral neck to fracture, leading to a 'fall from standing.'"

• Hip and femur fractures are common results of falls.

Blood loss from these injuries can range from 500 cc to 1,500 cc, says Loeffler. "Remember that the elderly cannot easily compensate for this change in blood volume," she says. "Keeping a blood pressure of 120 or greater and a hematocrit of 30 or higher is critical."

• Traumatic brain injury also is frequently seen with falls in elders.

The increased fragility of the cerebral blood vessels along with cerebral atrophy leaves more intracranial room to bleed and swell, says Loeffler. "Patients who come in complaining of a persistent headache that is often worse at night often have impressive subdural hematomas," she says. "Many times, the patient will give no history of trauma or perhaps a minor fall a few days prior to arrival in the ED." ■

COMING IN FUTURE MONTHS

- ■ Questions you'll have to answer for Joint Commission surveys
- ■ Don't miss patients at high risk for myocardial infarction
- ■ Reduce liability risks of patients who leave without being seen
- ■ Tips for handling common conflicts with physicians

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 *Are your sedation practices safe? New ACEP guidelines offer help* and *Don't assume dehydrated children always need IVs.)*
- **Describe** how those issues affect nursing service delivery. (See *4 ways to give psychiatric patients privacy in your ED.*)
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Decrease your ED's supply par levels and save.)*

13. Which is recommended for pediatric procedural sedation, according to Sharon Stapleton, RN, CCRN?

A. Having nurses administer deep sedation.
B. Use the same dosages as for adults.
C. If you give propofol, pain medication is not needed.
D. Monitor patients for hypoventilation and hypotension when analgesia is given with benzodiazepine.

14. Which is an effective way to save costs on ED supplies?

A. Allow nurses to stock rooms according to their own preferences.
B. Monitor supply usage regularly and decrease par levels as needed.
C. Avoid use of automated medication dispensers.
D. Encourage nurses to store extra supplies in treatment rooms.

15. Which is recommended when caring for psychiatric patients in the ED, according to Carol A. Ziolo, RN, LCPC?

A. Have multiple staff members interact with patients.
B. Avoid private rooms to reduce the patient's anxiety.
C. Ask patients for consent before visitors are allowed in rooms.
D. Don't inform patients if auditory monitoring is occurring.

16. Which is true regarding care of pediatric patients with mild to moderate dehydration, according to Lynn Daum, RN, BSN?

A. Giving fluids orally works as well as intravenous fluids.
B. Intravenous fluids should be given for any child with vomiting or diarrhea.
C. Giving fluids orally to dehydrated children is linked to adverse outcomes.
D. You should avoid giving fluids orally to children with diarrhea.

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