ED NURSING

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IN THIS ISSUE

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Assaults against ED nurses are largely unreported: Act now to prevent violence

While you're starting an intravenous line, an intoxicated patient suddenly begins shouting vulgar language. Would you report this incident? What if the patient threatened or shoved you?

Verbal and physical assaults on ED nurses are alarmingly frequent, but they often go unreported, according to sources interviewed by *ED Nursing.* "If someone is injured they can fill out an incident report — but we know this is underreported, especially when it is verbal abuse," says **Denise Proto**, RN, MS, CEN, nurse educator for emergency services at Gwinnett Medical Center in Lawrenceville, GA.

Too often, emergency nurses have the attitude "it's part of the job," says **Karen Clements**, RN, BSN, MSB, department manager and administrator for the ED at Eastern Maine Medical Center in Bangor. "For too long, we have had to endure verbal and physical abuse," she says. "Our profession teaches us to 'nurse' everyone, even those that call us names and take a swing at us."

A new study finds verbal threats, physical assault, and even stalking are common occurrences in EDs. Of 171 ED physicians surveyed, 76% reported experiencing at least one violent act over the previous 12 months, and nearly one-third were victims of physical assaults, with intoxicated patients inflicting 45% of assaults. Despite frequent violence, less than a third of EDs surveyed had 24-hour security, according to the study.[1]

"I think that nurses are probably even more on the front line than physicians when it comes to confronting potentially violent patients and may be at even higher risk," says **Terry Kowalenko**, MD, program director of the emergency medicine residency program at University of Michigan in Ann Arbor and the

EXECUTIVE SUMMARY

By encouraging nurses to report incidents involving verbal and physical abuse by patients, you can boost morale and obtain needed resources for security and training.

- Enforce a "no-tolerance" policy for abuse in your ED.
- If nurses press charges against a patient, show support and testify if needed.
- Bring staff concerns to administrators after an assault occurs.

study's lead author.

In many cases, verbal and physical abuse are never reported by ED nurses, says Kowalenko. "In a busy ED, people don't have time to report these incidents," he says. "There is a perception that this is part of the territory, and people become desensitized to it."

To encourage nurses to report verbal and physical abuse, do the following:

• Support nurses who press charges.

At Eastern Maine's ED, a "no-tolerance" policy for verbal and physical aggression applies to any patient, visitor, or employee. "In our ED, we have changed our entire culture concerning this issue," says Clements. The policy states, "Violence, intimidation, harassment or threats thereof, toward an employee, patient, medical staff member, visitor, or toward the facility or its equipment must be reported *immediately* to the first available manager and to the security department. Every employee is obligated to make such reports."

Managers and administrators enforce this policy to the point that they go to court to testify against chronic offenders, she adds. "We have even barred some patients from our hospital [for all but emergency care]. We have had several visitors and a few patients escorted from the ED." One example was a girlfriend who became quite disruptive by calling nurses vulgar names and threatening staff. She was arrested for disorderly conduct, Clements recalls.

You'll need to determine whether the violent behavior has medical causes or not, and provide appropriate medical treatment based on the circumstances, says **Len Giambalvo**, Eastern Maine's vice president of legal services. "However, if patients are violent, they lose their right to confidentiality as far as is necessary to get law enforcement assistance and to prosecute any crime," he says. "We will not take care of them if it is dangerous to us, to other patients, or to visitors to do so."

The ED's case manager, vice president for patient care services, and Clements have testified against patients who have abused or assaulted staff. "Most have received jail time and also restrictions if they return to the ED," she says. "They can only come to the ED for emergent medical needs. A few have been singled out to have a police escort with them when they arrive."

Nurses won't take action unless they feel they have the backing of higher-ups, says Clements. "Once we did the first prosecution, staff got in line to report these incidents," she says. "Staff now cut articles out of the local paper when any patient or visitor has had charges pressed. This boosts other nurses to do the same."

The decision to report is left up to the nurse, says Clements. "We do not pressure staff in reporting to the police," she says. "However, we do expect them to fill out an incident report for tracking and to follow up with employee health if needed."

The power of data

• Track the number of incidents.

By documenting all incidents that occur in your ED, you will have more ammunition to lobby for needed resources, says **Kathy Hendershot**, RN, director of clinical operations for the ED at Clarian Health Partners in Indianapolis. Hendershot asked for additional security for the ED over a two-year period, but her requests were denied.

"I then looked at all reports of incidents for the past year and found that the ED had more officer calls than any other department," she says. "We were able to

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The Crisis Prevention Institute offers one-day, two-day, and four-day training programs in nonviolent crisis intervention training to manage disruptive and assaultive behavior. For more information, contact:

- **Crisis Prevention Institute**, 3315-K N. 124th St., Brookfield, WI 53005. Telephone: (800) 558-8976 or (262) 783-5787. Fax: (262) 783-5906. E-mail: info@crisisprevention.com.

show that an officer needed to be in the ED full-time around the clock. This is a situation where extra documentation helped."

Security officers fill out a formal report after any incident involving theft, arrests, or escort from the property, says Hendershot. "Before, these reports were kept in security and not formally shared with us," she says. "I now get a copy of those reports. This helps me to keep informed in a more timely manner."

The reports revealed that a large number of incidents involved psychiatric and intoxicated patients, which supported the need for additional education for these areas, adds Hendershot. She recommends asking pharmacists, psychiatrists, and behavioral health staff to give inservices to ED nurses. "We did our own in-house training on physical restraints and de-escalation, taught by our behavioral care staff," she says. "Pharmacy and psychiatry gave excellent information on drugs that can be therapeutic for agitated patients."

Security now works very closely with ED staff in tracking incidents, says Hendershot. "They come to our clinical practice meetings, participate on our behavioral care task force, and are involved with any redesign issues," she says. "They are a very valuable resource."

• Ask for resources right after incidents occur.

In four months, there were three assaults on ED nurses at Beth Israel Deaconess Medical Center in Boston, resulting in neck injuries and facial bruising. "Our nurses were very upset, and it was a constant topic of discussion," says **Michelle McCool Heatley**, RN, BSN, CEN, director of ambulatory operations and emergency services. "I asked staff what they would like to see us do. I solicited feedback at staff meetings and documented e-mails and phone calls."

After the second assault occurred, Heatley brought her nurses' concerns to administrators, along with data from incident reports. She asked for 24-hour security coverage in the ED, with additional coverage in the psychiatric, substance abuse, and triage areas.

"After the third assault occurred, the administrative process for approval of additional resources sped up. I think that the incidents and the documentation from the staff drove the process more than dollars," says Heatley. As a result, a 24-hour security guard was placed in the psychiatric assessment area, in addition to a security guard out front.

In addition, eight hours of annual mandatory crisis prevention training is now given on site by the Brookfield, WI-based Crisis Prevention Institute, and about 60% of ED staff is currently trained. **(For more information, see resource box, at left.)** The ED has not had an assault in the seven months since these measures were implemented, she reports.

Nurses are encouraged to report incidents and asked to include as many specifics as possible. "Violence is only going to get worse in the ED, as psychiatric and substance abuse services become less available and length of stay increases," Heatley says. "The need is getting greater and won't go away anytime soon."

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Are you missing adverse drug events in the elderly?

If an elderly man came in complaining of dizziness, would you suspect a connection to a medication the patient is taking?

A new study shows that EDs often miss adverse drug events (ADEs) pertaining to misuse of prescription and over-the-counter medications in elder patients, especially ones unrelated to the patient's chief complaint.[1]

If patients report syncope, hypotension, nausea, vomiting, abdominal pain, constipation, diarrhea, or headache, this may be due to improper use of prescription medications, says **Steven D. Glow**, RN, MSN, FNP, adjunct assistant professor at the College of Nursing at Montana State University-Bozeman in Missoula. "Just look at the list of common adverse effects for several medications, and these will appear as common themes," he says.

To improve assessment of elder patients for ADEs, do the following:

• Ask the right questions at triage.

It may not be clear that a patient's complaint is related to an ADE, says **Shelley Cohen**, RN, CEN, an educator for Health Resources Unlimited, a Hohenwald, TN-based consulting company specializing in ED triage and health care leadership. Obtain current accurate information on prescriptions, over-the-counter medications, herbal supplements, and vitamins that the patient claims they are taking, she recommends. Ask patients the following questions, advises Cohen:

— Do you know the names of the medications you are *supposed to be taking*?

— Which of these are you *actually taking now*?

— How often do you take them?

— What are the doses of each of these?

— Are you taking any vitamins? If so, what are the names, and how often do you take them? How many at a time do you take?

— Are you taking any herbal agents? If so, which ones, how many, and how often?

If you feel that the patient's complaint could be related to a medication, ask the following questions:

— How long have you been taking this medication?

— Did you take your dose for today yet?

— Have you had these symptoms before? If yes, how long ago, and did you see a doctor for them?

Encourage elderly patients to bring medications with them to the ED, recommends Glow. "The bottles have much valuable information including prescriber, quantity, and date, which may assist the nurse in screening for ADEs," he says.

• Differentiate side effects from an ADE.

Side effects from a medication are not necessarily an ADE, notes Cohen. For example, if a patient becomes drowsy after taking 25 mg promethazine, this is an expected side effect, not an adverse reaction, she says. "The patient is warned about this common side effect, and the bottle is even labeled with a caution sticker to alert the patient to this," she says.

However, if the same patient takes the same drug and dose and has a dystonic reaction, this is an adverse event because it is unintended, undesirable, and generally unexpected, says Cohen.

If you're not sure whether a patient's reaction is truly an ADE, contact pharmacists, she adds. This can be very confusing. "Sometimes the side effect becomes an ADE when it requires discontinuing the medication or specific treatment related to those symptoms," Cohen says. "Anytime we suspect an ADE, even if we are not sure, we report it to our pharmacy. They review the case and determine if it needs to be reported."

Involve the patient's pharmacist in your assessment process, Glow recommends. "When I am stuck, I ask the patient the name of their pharmacy and call their pharmacist, who is often able to assist in clarifying the patient's current medication plan," he says.

• Ask patients how they keep track of medications.

"If the patient cannot describe an organized system such as drug boxes, color coding, or calendars for keeping track of their medications, the current problem may be too much or too little of their medication," says Glow.

He points to the Joint Commission's National Patient Safety Goals requiring you to reconcile a patient's medications across the continuum of care, including obtaining and documenting a complete list of the patient's current medications, and communicating a list of the

EXECUTIVE SUMMARY

Symptoms of dizziness, vomiting, headache, or abdominal pain in older patients may be related to misuse of prescription or over-the-counter medications.

- Ask patients how long they've taken medications, if they've taken the drug today, and if they've had the symptoms before.
- Encourage patients to bring medications with them to the ED.
- Involve pharmacists in determining whether a patient's complaint is due to an adverse drug event.

SOURCES

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patient's medications to the next provider of service. "If patients discharged from the ED are referred to a primary care provider, a list must be compiled on discharge," says Glow.

Record this information electronically so it can be accessed during the patient's next ED visit, Glow recommends. "Providing the patient with a written list of medications at discharge would enhance the continuity of care," he says.

Reference

1. Hohl CM, Robitaille C, Lord V, et al. Emergency physician recognition of adverse drug-related events in elder patients presenting to an emergency department. *Acad Emerg Med* 2005; 12:197-205. ■

Cutting-edge protocols boost care of severe sepsis

ED nurses playing an ever-increasing role in care

(Editor's note: This is the first of a two-part series on sepsis in the ED. This month, we cover protocols using updated approaches for care of septic patients in the ED. Next month, we'll report on effective strategies to educate nurses on new monitoring procedures being used in the ED.)

An elderly woman tells you she's been ill for several days and has very low blood pressure, but her vital signs are otherwise normal. Would you suspect impending septic shock in this patient? Do you have a way to determine if this patient is getting sicker?

Severe sepsis occurs in more than 750,000 patients a year and has a mortality rate of 28%.[1] "We are now understanding that sepsis is responsible for as many deaths as myocardial infarction in this country," says **Stephen Trzeciak**, MD, an ED and critical care physician at Cooper University Hospital in Camden, NJ.

However, this life-threatening condition often is overlooked in the ED, which can have devastating results, says **Nathan Shapiro**, MD, research director for the department of emergency medicine at Beth Israel Deaconess Medical Center in Boston.

Evidence-based guidelines from the Surviving Sepsis Campaign call for aggressive early goal-directed therapy (EGDT) for sepsis patients beginning in the ED, and research has shown a 16% reduction in mortality rates when ED patients were treated with EGDT.[2] However, many EDs have not yet adopted these recommendations, he says.

"Unfortunately, although there is a lot of interest starting to stir, many EDs have been slow to adopt EGDT," says Shapiro. (**For more information on the guidelines, see "New sepsis guidelines urge you to revamp care: Delays can cost lives," *ED Nursing*, June 2004, p. 85.)**

However, the number of EDs using early protocols for sepsis will increase dramatically in the near future, Shapiro predicts. "ED nurses are playing an ever-increasing role, especially when EGDT is involved," he says. "In our ED, the nurses truly drive the protocol and take a large share of the responsibility." **(See the ED's protocol on p. 90.)**

Your ED's sepsis protocol should address early identification, treatment goals, and a plan to transition care to the appropriate setting, says Shapiro. You need

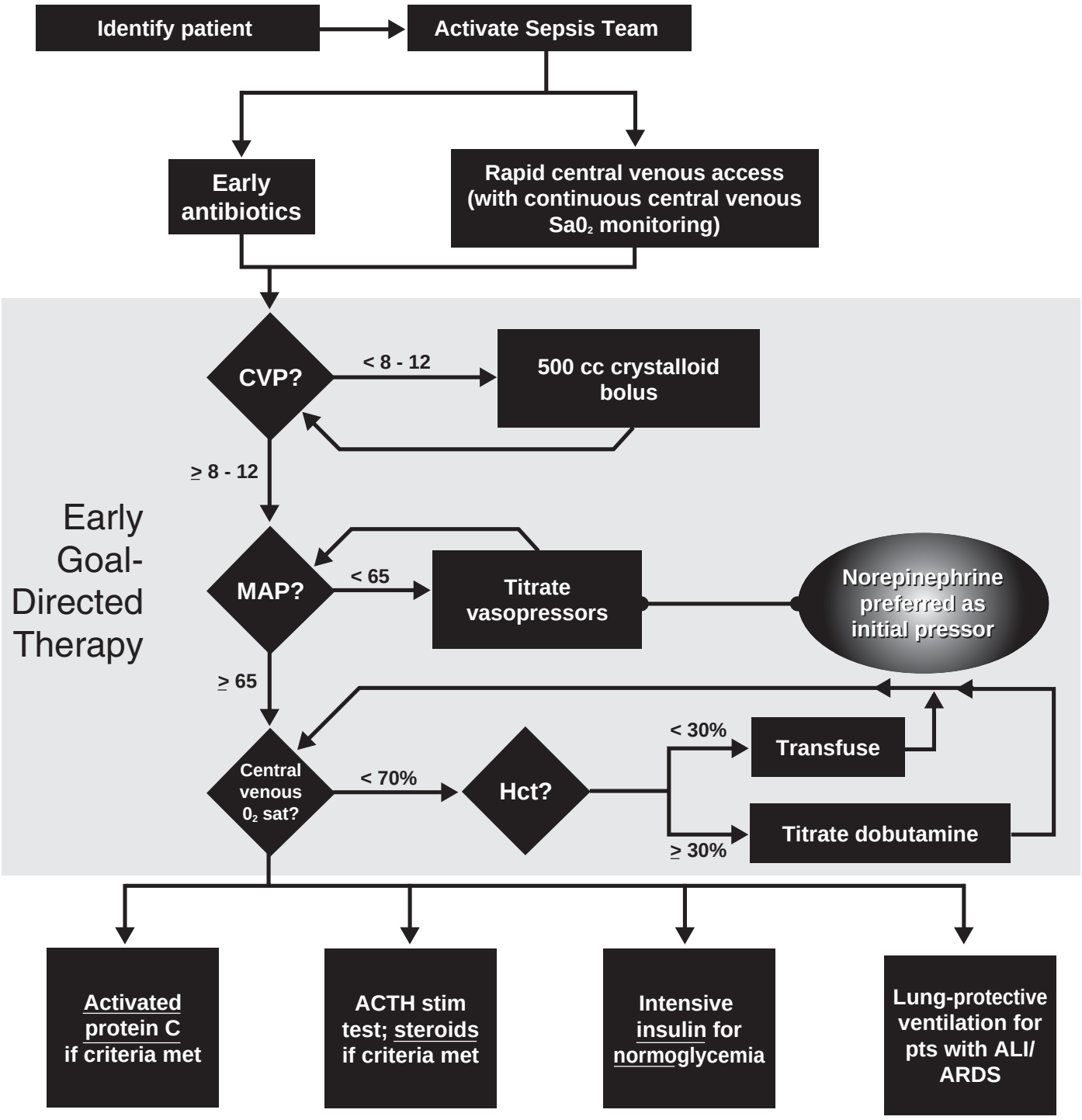
(Continued on page 91)

EXECUTIVE SUMMARY

New guidelines recommend early goal-directed treatment in the ED for sepsis, which causes as many deaths as myocardial infarction in the United States. Very few EDs have implemented these practice changes.

- Look for hypotension and tachycardia, and perform routine lactate screening in patients with infection.
- Septic patients may not appear as sick as they actually are.
- Signs of deterioration include persistently low central venous pressure or very low saturation of central venous oxygen.

ED Protocol for Sepsis



The Multiple Urgent Sepsis Treatments (MUST) protocol. $Sa0_2$ = oxygen saturation.
CVP = central venous pressure. MAP = mean arterial pressure. 0_2 = oxygen saturation. Hct = hematocrit.
ACTH stim test = adrenocorticotropin stimulation test. ALI = acute lung injury. ARDS = acute respiratory disorder syndrome.

Source: Shapiro NI, Howell M, Talmor D. *Acad Emerg Med* 2005; 12:352-359. Used with permission.

to maintain a high index of suspicion for identifying patients with sepsis or who may develop sepsis, he adds. "Looking for hypotension and tachycardia is a start, and we advocate routine lactate screening in patients with infection to detect patients with hypoperfusion," Shapiro says. "In our ED, we use the mantra 'blood culture equals lactate.'"

Example of a protocol

At Cooper University Hospital, a severe sepsis EGDT protocol was developed based on the new guidelines. The following steps occur for patients who present with clinical symptoms of sepsis and evidence of hyperfusion:

- Patients are given supplemental oxygen and fluid resuscitation.
- Central venous pressure is measured, and if less than 8 mm mercury (Hg), aggressive resuscitation is given with crystalloid fluid boluses.
- Mean arterial pressure or systolic blood pressure is assessed. If the reading is under 65 mmHg or systolic blood pressure is under 90 mmHg, vasopressor therapy is started using norepinephrine or dopamine.
- Saturation of central venous oxygen is determined, and if under 70% and hematocrit is under 30%, red blood cells are transfused and inotropic support is given.

Tools to spot deterioration

Septic patients often don't appear terribly sick, but frequently deteriorate rapidly after leaving the ED, says **Karen Slutsky**, RN, ED clinical manager at Cooper University Hospital.

"They don't necessarily present as ill as they actually are. And previously, we didn't have very good markers or indicators to tell us that patients would get so sick," Slutsky says. "By the time you recognized how sick they were, patients were often past the point of return."

With acute myocardial infarction, an electrocardiogram is a clear-cut indicator that will identify when a patient's ST segment is going up, says Trzeciak. "We do not yet have that type of a diagnostic tool for predicting acute multiorgan dysfunction in severe sepsis," he notes.

Instead, you have to look for signs of systemic inflammation, such as elevation of temperature, heart rate, respiratory rate, and white blood cell count, and in addition, look for markers of acute organ dysfunction and hypoperfusion, he says.

Monitoring in the ED allows nurses to catch signs of deterioration, such as persistently low central venous pressure or very low saturation of central venous oxygen, says Trzeciak. "This currently represents best practice for severe sepsis management and motivated us to be early adopters of this therapy," he says.

The sepsis protocol has a dramatic impact on patient outcomes, but this may not become apparent until after the patient has left the ED, notes Trzeciak. "We can't necessarily expect to see dramatic things right in front of our eyes, because the way sepsis patients die is from persistent multiple organ failure later on, with withdrawal of support down the line in the ICU," he says.

In the past, the patient would have gone to a medical/surgical floor without being monitored, and the condition would have been picked up by the critical care team only after the patient started to decompensate, which could be a day or two later, explains Slutsky. With the new protocol, EDs are able to respond to patient's changes much more quickly, she says.

"This was not even an option in the past," says Slutsky. "This was all totally new to everyone, but it's now become the norm in our ED — just like t-PA for stroke a few years ago."

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2. Rivers E, Nguyen B, Havstad S, et al. Early goal-directed therapy in the treatment of severe sepsis and septic shock. *N Engl J Med* 2001; 345:1,368-1,377. ■

SOURCES

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Use these tips if you suspect a suicidal patient

More than 200,000 patients are treated in EDs each year for self-inflicted injuries. Yet many of these patients do not receive a psychiatric assessment, says **Debra Houry**, MD, MPH, associate director for the Atlanta-based Center for Injury Control at Emory University.[1,2] As a result, suicidal patients may leave EDs without getting appropriate care, which is dangerous for patients and legally risky for nurses, she adds.

"EDs are very busy places, and sometimes nurse and physicians do not assess a patient thoroughly enough to realize how suicidal they are," says Houry.

To improve assessment of potentially suicidal patients, do the following:

• Determine whether the patient is actively suicidal.

"We have spent many hours educating our staff about assessing suicidal patients," says **Mary G. Kelley**, MS, ARNP, CEN, triage coordinator for the ED at Carondelet St. Mary's Hospital in Tucson, AZ. A psychologist gives inservices addressing suicidal assessment for ED nurses, and Kelley includes recognizing potentially suicidal patients in the triage class required of all new nurses.

Validated tools such as the Brief Psychiatric Rating Scale are too long and complex for practical use in the ED, says Houry. Instead, she recommends asking the patients if they've had any thoughts about hurting themselves or if they've been sad or depressed lately. If the answer is yes, use the "SAD PERSONS" mnemonic for assessing risk of suicide:

- **S**ex, male;
- **A**ge, advanced;
- **D**epression, possibly recurrent;
- **P**revious suicide attempts;
- **E**thanol abuse;
- **R**ational thinking loss;
- **S**ocial isolation;
- **O**rganized plan to commit suicide;
- **N**o spouse;
- **S**ickness.

"People with these risk factors are at greater risk for suicide completion," says Houry.

At Carondolet's ED, all patients who present with a complaint of depression, detoxification from drugs or alcohol, agitation, or suicidal ideation are asked if they have thoughts of hurting themselves or others, says Kelley. "We follow up with addressing their behavior if it is incongruent with their answer," she says. "An example would be someone who is fidgety, with eyes that dart around the room as you talk to them."

In this case, Kelley recommends saying, "You seem anxious, is there something you are not telling me? I am here to keep you safe." If you give them another opportunity to respond, most patients will tell you what they are feeling, she explains.

The patient's behavior is assessed and documented at triage, says Kelley. For example, if the patient is quiet, withdrawn, and without eye contact but denies suicidal ideation, that patient will be watched carefully and treated as if they were suicidal, she says. "The suicidal patient is considered high acuity, 1 on a 1 to 4 scale, and treated as such."

• Evaluate the need for restraint.

You need to make sure a suicidal patient doesn't leave before psychiatric evaluation, and this step may require restraint, says Houry. "Any patient whose chief complaint is suicidal thoughts should be brought back immediately and assessed," she stresses. "In addition, anyone the nurse or physician feels is at imminent risk for harm should have suicide precautions including restraint and being placed in a locked room."

• Take patients out of the main ED if possible.

After a potentially suicidal or homicidal patient is medically cleared, they are placed in a quiet, safe place with security nearby, using an area staffed by a nurse and behavioral health technician, says Kelley. The annex is away from the ED, locked, safe, and quiet, she says. "They are still our patients, cared for by ED staff who are specially trained, but this keeps this population out of the ED. It provides better care for the patient and a safer environment."

This procedure has reduced use of behavioral restraints dramatically, she adds. "Frequently, we send the patient to the annex from triage," says Kelley. "The physician does an exam in triage, and the patient is sent up with orders." Any patient who is suicidal is not allowed to return to the waiting room unless they are with family, who will stay with the patient temporarily, until a room is available.

• Discourage the use of contracts in triage.

Kelley points to the American Psychological Association's guidelines for management of suicidal behavior,

EXECUTIVE SUMMARY

If you suspect a patient may be suicidal, ask patients if they have thoughts of hurting themselves or feel depressed, and observe their behavior.

- Patients with suicidal ideation may require restraint.
- Bring patients out of the main ED if possible.
- Don't assume very old or young patients can't be suicidal.

SOURCES

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which states that a "suicide prevention contract," which is a written or verbal agreement that the patient will not harm themselves, is not recommended in EDs, since they are dependent upon an established physician-patient relationship.[3]

"We assume they will attempt suicide and treat them as such," says Kelley. Patients are asked to remove their clothing and put a gown on, and belongings are taken from the patient, placed in a bag, and removed from the room. "This helps avoid any surprises, like someone having a cigarette lighter and trying to light the oxygen on fire," she says.

• Don't make assumptions.

Sometimes when a patient is very old, suicide is not seriously considered by the nurse, but chronic health problems, the recent loss of significant other, financial problems, or lack of family support all put an elderly patient at risk, says Kelley. "They are less likely to express actual ideation but may discuss hopelessness or profound sadness," she says. "Frequent injuries or adverse drug reactions may actually be suicide attempts."

You also should have a high index of suspicion for very young patients, and consider factors such as the child's environment and possible sexual abuse, recommends Kelley. "Is the child a straight-A student who is under a lot of pressure? Are they talking of death a lot?" she asks. "Frequent injuries may also be failed suicide attempts, as well as child abuse."

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Do patients leave with life-threatening conditions?

When a patient in your ED left without being seen (LWBS), you have two major worries: That the patient left with a life-threatening condition, and your increased liability risks.

"LWBS patients are one of the hot points for EMTALA [Emergency Medical Treatment and Labor Act] investigations, and carry a medical malpractice threat as well," warns **Stephen A. Frew**, JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals.

To reduce risks of LWBS patients, do the following:

• Track all patients.

Be sure that you have someone available close to your ED entrance to log all potential patients, says **Marc Augsburger**, RN, BSN, manager of the emergency care center at Covenant HealthCare in Saginaw, MI. "You need to know who left without being seen, in case the Centers for Medicare & Medicaid Services (CMS) asks to see your log, he says. "It also gives you a time frame as to how long the patient waited."

The ED has a greeter who logs in the patient's name and chief complaint before triage. "If a patient complains that he came to the ED and didn't get seen or got ignored, he should still appear on that log," Augsburger says. "The greeter is the first set of eyes and can keep nursing staff from missing anyone coming in the door who may walk out undetected."

• Document carefully.

Document the history given by the patient and any reassessments that occur while the patient is waiting, says **Pamela S. Rowse**, RN, quality/risk consultant for the ED at St. Rose Dominican Hospital in Henderson, NV. "Six hours sitting in a waiting area without a

EXECUTIVE SUMMARY

When patients leave without being seen, there is a risk of adverse outcomes, malpractice lawsuits, and violations of the Emergency Medical Treatment and Labor Act.

- Track all patients who leave without being seen.
- Document assessments and interactions with patients prior to their leaving.
- If patients won't sign a refusal of care form, document their exact words and all attempts made.

SOURCES

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reassessment of vital signs is going to open up major legal inquiries," she warns.

If you can't get a patient seen quickly enough, document your communications with physicians and charge nurses, says Rowse. "The bottom line is, if you can't get a bed for a patient, go directly to the ED physician," she advises. "They are concerned about their liability as well and will generally make certain that adequate intervention and placement occur. If this doesn't work, then move up your chain of command."

• Avoid violations of EMTALA.

If a LWBS patient refuses care, this is not in itself a violation of EMTALA, says Frew. "These events, however, cause investigators to focus on the incident, the circumstances, the allegations, the policies and procedures, and any documentation," he says. "As a result of this close scrutiny, hospitals are frequently cited for violations directly related or associated with the LWBS event."

If the patient left because they felt that they were being discriminated against, it becomes an EMTALA issue, says Rowse. Body language such as shrugging of shoulders, the rolling of eyes, or a curt response can make patients feel unwelcome, she warns. "Unintended negative comments can result in patients leaving and ultimate negative outcomes," she says. Avoid statements such as the following, advises Rowse:

— "Well, as you can see, we are extremely busy. You are going to have a very long wait."

— "You will have to understand that there will be a minimum of a four-hour wait to get into the back."

— "There are a lot of people that are more critical than you, and you will just have to wait your turn."

These incidents are sometimes investigated as a direct complaint from a patient, which typically occurs when patients think that their care was denied or delayed because of their financial status, says Frew.

Reviewers will look for documentation that details your interactions with the patient up to the time of leaving, he says. "CMS expects literal compliance with hospital policies and procedures and affords very little margin for nursing personnel to deviate from the written process," he notes. "In the absence of documentation, CMS is prone to accept the patient's interpretation of events, which typically results in the hospital being cited for a violation."

• Have patients sign a refusal of care form.

The form must state the hospital's obligations, the risks of leaving without assessment, and the benefits of staying for completion of medical screening and stabilization, says Frew. "Forms must be individualized as much as possible, and checkbox forms are often faulted as inadequate," he notes.

At Covenant's ED, an "against medical advice" form advises patients that if they choose to leave, their condition could worsen. "Only a small portion of patients do sign the form, but we try to capture as many as possible," says Augsburger.

If the patient fails or refuses to sign the refusal of care form, document all efforts to obtain the signature and why they were unsuccessful, advises Frew. "It is also helpful to document the exact language that the patient used to refuse the signature," he says.

If the patient leaves without your knowledge, that also needs to be documented. "Some hospital policies and procedures require that a patient's name be called at least three times over 15 minutes to confirm that they have left," says Frew. "Document by noting the fact that the name was called and at what times." ■

COST-SAVING TIP

Ask nurses to save $2 per day in your ED

When ED nurses at Martin Memorial Medical Center in Stuart, FL, were challenged to come up with ways to save just $2 per day, results were dramatic, reports **Patricia Scott**, RN, BSN, CEN, ED nurse leader.

"Over the course of a year, we saved over $2,000," she says.

Scott passed along a list of common supplies and what they cost, and nurses submitted ideas via e-mail or verbally. "I encouraged them to think of whatever they could to help out," she says. "We streamlined where we kept supplies, reduced duplications, cut down stock to what we really needed, and eliminated waste by not leaving things out to get dirty and contaminated."

Winning ideas

Here are some of the cost-saving ideas submitted by nurses:

• The ED switched to prefilled syringe solutions, which cost $46.74 for a case of 120. "This is one of the biggest changes we made," Scott reports. The prefilled syringe solutions are a lot less expensive and save labor, she says.

"We do not have to store, manipulate, or dispose of needles used to draw up the saline," she says. "At an average time of one minute per draw of saline, that is two hours extra nursing time for each case of syringes."

About 15 cases are used per month, which frees up 30 hours of nursing time for patient care, says Scott. "The staff is very appreciative of any timesaving or labor-saving devices brought to the clinical area."

• A charge nurse developed a new system for stocking, by switching to cabinets in each area instead of supplies kept in treatment rooms. The cabinets are located conveniently to the user, with limited stock in the critical care rooms. Bins were installed on walls to hold electrodes, nonsterile gauze, hemoccult cards, alcohol pads, and lubricant packages.

"This kept the smaller supplies limited and clean," says Scott. "Hoarding was not allowed, and just-in-time use out of the centrally located supply area was encouraged."

• Inventory was reduced on some seldom-used items, such as certain sizes of needles, and nurses decided that an intravenous (IV) tray needed only eight 20-gauge angiocaths instead of 25.

"Before, the trays were stuffed full," Scott recalls. It is very easy to walk through the medication room and replace items if needed during the shift, she says. "We pay $1.52 per angiocath," says Scott. "Cutting out half the IV trays and half the stock saved over $250 each month."

• It was determined that nonsterile gauze worked as well for some procedures as sterile gauze.

"We looked at how we were using the gauze," says Scott. "For example, if we were using the gauze like a washcloth, as nasal drip pads, or for padding bony prominences, instead of ripping open a sterile box, we used nonsterile."

Sterile gauze costs 33 cents for 10 gauze, compared with 95 cents for 200 nonsterile gauze, she explains.

• Some supplies were standardized to reduce inventory.

"We realized that we didn't need five kinds of tape," says Scott. They reduced the stock to paper tape, plastic tape, and limited Coban. "We axed foam tape, ¼-inch tape, and 6-inch tape," Scott says. 'We keep 1-inch and 4-inch rolls of silk-like tape only." ■

SOURCE

For more information, contact:

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COMING IN FUTURE MONTHS

- Update on a new treatment for intracerebral hemorrhage
- What Joint Commission surveyors are asking about medications
- Prevent dangerous drug errors during changes of shift
- Novel approaches for pediatric pain management

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.

The semester ends with this 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 *Cutting-edge protocols boost care of severe sepsis* and *Do patients leave with life-threatening conditions?*)
- **Describe** how those issues affect nursing service delivery. (See *Use these tips if you suspect a suicidal patient.*)
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Assaults against ED nurses are largely unreported: Act now to prevent violence.*)

21. Which of the following is recommended regarding assaults in the ED, according to Karen Clements, RN, BSN, MSB?
A. Avoid pressing charges against patients under any circumstances.
B. Discourage nurses from reporting incidents to police to avoid negative publicity.
C. Support assaulted nurses by testifying against violent patients.
D. Minimize staff discussion about incidents to avoid a negative impact on morale.

22. Which is recommended to comply with new guidelines for sepsis patients in the ED, according to Nathan Shapiro, MD?
A. Postpone monitoring until the patients are admitted to the intensive care unit.
B. Perform routine lactate screening in patients with infection to detect hypoperfusion.
C. Suspect impending septic shock only in patients who appear severely ill.
D. Avoid time-consuming monitoring procedures.

23. Which should be done if you suspect a patient could be suicidal, according to Mary G. Kelley, MS, ARNP, CEN?
A. Don't perform an assessment unless you use a validated tool such as the Brief Psychiatric Rating Scale.
B. Assume that very old and very young patients are at a low risk for suicide.
C. Consider the patient's behavior as well as their responses during your assessment.
D. Use verbal contracts at triage to discourage suicide attempts.

24. What are effective ways to reduce risks of patients who leave without being seen, according to Stephen A. Frew, JD?
A. Track only patients who are at risk for adverse outcomes.
B. Reassess patients only if they report worsening symptoms.
C. Warn patients that they may have to wait a very long time to be seen.
D. Document interactions with the patient up to the time of leaving.

Answers: 21. C; 22. B; 23. C; 24. D.