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IN THIS ISSUE

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SEPTEMBER 2005
VOL. 8, NO. 11

EDs aren't following heart attack guidelines: Revamp protocols now

Even smallest ED can meet recommendations for time frames

Minutes after a man dialed 911 and was rushed to an ED in rural Minnesota, the patient was on a helicopter being transported to a hospital 60 miles away to receive percutaneous coronary intervention (PCI) to open a blocked left anterior descending artery.

"The patient spent 17 minutes in the ED, 15 in the air, and in total took 61 minutes from arrival to the opening of a totally occluded artery," says **Barbara Tate Unger**, RN, FAACVPR, director of the Level 1 cardiac emergency program at the Minneapolis Heart Institute Foundation and Abbott Northwestern Hospital, also in Minneapolis. "He went home two days later."

This case is just one example of dramatic improvements in care received by heart attack patients in rural and community EDs as a result of the "Level 1 Heart Attack" program, a collaborative effort between the Minneapolis Heart Institute and 30 EDs.

Patients with heart attacks probably would expect that EDs are following current treatment guidelines, but this often is not the case. A new study reports that one-third of EDs are not complying with guidelines from the American College of Cardiology (ACC)/American Heart Association (AHA) for patients with ST-segment elevation myocardial infarction (STEMI).[1]

In 1994, the Bethesda, MD-based National Heart Attack Alert Program (NHAAP) gave specific recommendations to reduce delays in ED diagnosis

EXECUTIVE SUMMARY

One-third of EDs without cardiac catheterization labs aren't complying with guidelines for ST-segment elevation myocardial infarction (STEMI), and protocols often are incomplete.

- Your ED's protocol must address triage, patient transport, and transfer criteria.
- Use a group pager to notify all appropriate units of an STEMI patient's arrival.
- Measure your ED's compliance to identify areas for improvement.

and treatment for MI patients. The goal was — and is — 30 minutes from patient arrival to treatment. "In 2003, nearly 10 years later, 33% had neither written protocols nor guidelines in general for the process of managing the expeditious care required for the potential MI patient," says **Mary Hand**, MSPH, RN, coordinator for the NHAAP, who points to the study's findings.

In addition, the updated 2004 ACC/AHA guidelines recommend that patients receive PCI within 90 minutes, and the surveyed EDs had an average time to PCI of 192 minutes. "The concern is that delays well beyond the 90 minutes will preclude patients from getting timely treatment," says Hand.

Hospitals put themselves at risk by not following the community standard of care for STEMI, which is spelled out in the ACC/AHA guidelines, says **David Larson**, MD, an ED physician at the 100-bed Ridgeview Medical Center in Waconia, MN, and the study's author. "Having a written protocol is a tool that will help nurses and physicians follow the guidelines."

Delays and inconsistent care were identified at Larson's own ED, which lacks a cardiac catheterization lab or 24-hour on-site cardiology. "We found that delays to reperfusion occurred while waiting to talk to the cardiologist," he says. "Also, the recommendations for a specific patient often depended on who the cardiologist was, and the time of day and day of the week."

The problems stemmed from the fact that the ED lacked a clear guideline for patients with STEMI. "I found that many EDs around the state had the same problems," says Larson. "This impression prompted me to do the survey."

The researchers discovered that even if EDs did have guidelines, they often did not address which patients get transferred and which receive thrombolytic therapy.

"I believe that we should be treating STEMI just like trauma: with clear hospital-specific guidelines that address triage and transport criteria," says Larson.

Smaller hospitals need help in doing this from their referral centers, he says. "This is exactly what is recommended in the most recent AHA/ACC guideline."

To address the problem, researchers developed the Level 1 program, with a goal of 90 minutes to treatment, even for EDs up to 240 miles away from receiving hospitals, reports Unger. Each of the 30 participating EDs now has a protocol that specifies exactly what treatment is given before a patient is transferred, including a rapid assessment, blood draws, chest X-rays, and medications, with the goal of transfer within 30 minutes.

As a result, medication compliance, lab testing, and patient preparation has improved dramatically at the participating EDs, reports Unger. (**See steps of protocol on p. 123.)**

"They have prepared patients for an angio in as little as 14 minutes," she says. Average time to PCI decreased from 192 minutes to 98 minutes.[2]

This proves that even the smallest ED can comply with national guidelines and best practices for MI patients, says Unger. "Some EDs have a census of fewer than four patients a day and a staff of two," she says. "They may get one of these cases every two months."

Since ED nurses may rarely see MI patients, pocket cards were developed listing the steps of the protocol for quick reference.

Unger emphasizes that this is not a one-size-fits-all program. "Some EDs do not have a helipad, so ground transport to an airport is needed, but other EDs have an in-house lab, secretaries for faxing, and a helipad out the back door," she says.

However, every participating ED sets the same goal: A patient should be transferred within 30 minutes.

Only half of the EDs surveyed had quality assessment processes in place for STEMI. EDs need to monitor the

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ED Nursing® (ISSN# 1096-4304) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending at Atlanta, GA. POSTMASTER: Send address changes to **ED Nursing**®, P.O. Box 740059, Atlanta, GA 30374-9815.

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Criteria: ST-Elevation Myocardial Infarction or New Left Bundle Branch Block*

- Activate team: Emergency physician and nurses, lab, and radiology
- Dispatch transport team — helicopter or ground advanced life support. Consider fibrinolytic if anticipated delay in transfer
- Contact Minneapolis Heart Institute (one phone call to activate)
- Monitor, oxygen, intravenous (IV) line, and draw routine labs
- Aspirin 325 mg by mouth
- Clopidogrel 600 by mouth
- Nitroglycerin 0.4 SL (repeat as needed or IV drip)
- Heparin loading dose 60 u/kg (max 4,000 u), followed by continuous infusion 12u/kg/hr (max 1,000 u/hr)
- Beta-blocker: Metoprolol 5 mg intravenously every five minutes x 3 (unless contraindications)
- Morphine sulfate as needed for pain
- Chest X-ray: Portable
- Second IV (saline lock)
- Attach hands-free defibrillation pads
- Consider anxiolytic for transport
- Transfer: In door — out door time goal fewer than 30 minutes

* Onset of symptoms fewer than 12 hours.

Source: Minneapolis Heart Institute Foundation.

time of the patient's arrival and the time it takes to obtain an ECG, make a treatment decision, administer lytics, or time to PCI or transfer, says Hand. "Only by monitoring these times and regularly assessing and improving them can EDs feel confident they are continuously improving the care of the patient with an MI."

Nurses at the participating EDs now receive reports on compliance, such as whether patients received beta-blockers and aspirin, and they look for novel ways to cut delays, says Unger. "Before, nurses would know they had an MI in the ED, but there would be no follow up whatsoever," she says. "Now nurses can hear positive feedback on their work and feel more empowered."

Based on input from nurses, EDs have made practice changes such as having nurses perform blood draws while starting intravenous lines for angiograms and creating a tool box with prepackaged medications for quick access, says Unger.

Grand Itasca Clinic & Hospital's ED in Grand Rapids, MN, is staffed with two nurses and a single physician. When a heart attack patient arrives, a group pager is sent to the intensive care unit, ED clinicians, laboratory, X-ray, registration, and respiratory.

"It was essential to make teamwork happen spontaneously with one call-out," says **Kathy Helmbrecht**, RN, ED clinician. "We need our two ED nurses to initiate care for our heart attack patient, instead of making phone calls."

Patients now are in a cath lab and under a cardiologist's care at Abbott within 120 minutes from the time they walk in the door of the ED, she reports. "Our goal is to have the patient in and out of our ED doors in 30 minutes."

The page sets everything in motion simultaneously. For example, X-ray technicians bring the portable X-ray machine to the ED, process the chest X-ray, show it to the physician, then package it up to go with the patient to the receiving ED.

"A rural ED is not staffed like the metro EDs; our nurses need to wear multiple hats," says Helmbrecht. "But patients who come to our rural ED are within two hours away from a cardiologist's care and the cath lab opening up a plugged artery to save their life."

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Do physicians comply with verbal orders policy?

Your ED has a policy that verbal orders are to be used in emergencies only — but a medical staff member routinely calls in telephone orders for patients. What do you do?

Although verbal orders have been identified as high-risk for many years, their use still is very common in EDs, says **Christine B. Macaulay**, RN, MSN, CEN, nursing practice specialist and former ED project coordinator/clinical nurse specialist at Children's Hospital of Philadelphia.

"I can remember 20-plus years ago, as a new ED nurse, my preceptor saying 'Try not to take verbal orders, because mistakes can happen,'" she recalls. "EDs need clear policies regarding safe practices, and the nurse is the key to reinforcing the standard of care when a physician is resistant to writing orders in nonurgent cases." **(For information on what to document if physicians aren't compliant, see related story on p. 125.)**

To reduce use of verbal orders, do the following:

• Insist on written orders when physicians are present.

At Community Medical Center's ED in Missoula, MT, if the physician is physically present, they cannot give a verbal order, and nurses cannot accept these, says **Steven D. Glow**, RN, MSN, FNP, care flight nurse and adjunct assistant professor at the College of Nursing at Montana State University-Bozeman, Missoula Campus.

"The nurses have been handling the implementation of this policy by informing the physicians, 'I cannot accept a verbal order when you are present. Here is the chart so you can write it down,'" he says.

In trauma and code situations when verbal orders are given, nurses may write the order and read it back to the physician, but the physician must sign the documentation at the end of the event, says Glow.

Consistent practice by ED nurses made resistant physicians more compliant, he notes. "I believe consistency is the key," Glow says. "If physicians can play one nurse against the other, as in 'Nurse A always lets me give verbal orders,' the policy breaks down."

• Use a scripted approach.

Develop a list of sample responses for nurse to say when physicians give verbal orders, Macaulay advises. "The key is to have all staff approach the standard in a consistent, positive way," she says. For example, Macaulay recommends saying, "I will be glad to get that medication. Could you write the order on the medical record as I go for the med?"

• Resolve conflicts with joint education.

At University of Utah Hospitals and Clinics in Salt Lake City, the medical director insisted that the ED couldn't function without verbal orders and refused to enforce compliance, says **Denna Collier**, APRN, clinical nurse coordinator for the ED.

This was in direct conflict with requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements, Collier says. "While this issue was addressed, it was not in time to affect practice before our JCAHO survey," she says. "We were lucky that no verbal orders occurred while the surveyor was in the department."

The Joint Commission requires that you reduce use of verbal and telephone orders and implement a "read-back" process to verify verbal orders when they are used. To ensure compliance, hold a joint inservice with a representative from medicine and nursing, Collier recommends. "That person is then responsible for relaying

EXECUTIVE SUMMARY

The Joint Commission on Accreditation of Healthcare Organizations requires that EDs take steps to decrease use of verbal orders, but compliance often is a problem.

- Inform physicians that orders must be written if they are present except in emergencies.
- Use a consistent approach to improve physician compliance.
- Ask physicians to spell out words if necessary.

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information back to the department," she says. "The kicker here is that all involved parties must believe and support the chosen JCAHO educator."

• Ask physicians to limit telephone orders.

"In nonteaching hospitals when a patient is admitted to the hospital, attendings may try to call in all the orders for the admission," says Macaulay. "In teaching facilities, this is less of a problem."

When admitting physicians at Community Medical Center attempt to call in admission orders, they are put on the phone with the ED physician, who writes the orders on the admission order form, reports Glow.

In Edward Hospital in Naperville, IL, telephone orders previously were taken by ED nurses at the request of the attending physician out of convenience, so they wouldn't get a second call from the floor, reports **Sharron Chivari**, RN, APN-CNS, clinical leader of the ED. Now, attending physicians are asked to give only enough admitting orders to cover the patient until they make rounds, instead of orders for the next two or three days. "This has reduced the number of orders per patient significantly, thereby reducing potential errors."

Physicians were reminded that some orders may be routine for floor nurses, but unfamiliar to ED nurses, which increases the risk of errors. They also are asked to sign off on telephone orders when they first see the patient.

In the past, nurses were inconsistent with reading back telephone orders to clarify them, adds Chivari. To address this, a policy was implemented requiring nurses to read back every item that the physician orders, and physicians may not include blanket orders such as "continue all current medications taken at home." Instead, these orders must be specified individually.

"Our quality assurance monitors now reflect consistent compliance with our read-back policy for every order," Chivari reports. "I personally have had difficulty with some of the heavy accents of the physicians. For physicians I just can't understand after repeating a couple of times, I ask them to spell the word. They may not like it, but it's preferable to making a mistake." ■

When physicians won't comply, then document

At Swedish Medical Center in Seattle, verbal orders are accepted only when a patient's life or limb is in danger; otherwise, the physician must write the order, says **Judy Street**, RN, manager of emergency services.

"I audit the process visually and staff receive verbal counseling if they are not following the standard," she says. "Support from our medical director has been key in making this work."

However, physicians occasionally are noncompliant, and when this occurs, nurses are asked to document this lack of compliance on a quality variance report. "The report allows us to track and identify a pattern of behavior," Street says. "This is reported through our organizational quality assurance process as well."

Once a pattern is identified, the ED medical director is responsible for addressing the problem. In addition, nurses are notified verbally and in writing, with notice sent to physicians, that if standards are not met, the nurse may be subject to formal verbal counseling.

"Physicians are advised they are putting the nurses at risk by not complying," Street says. "Peer pressure is a powerful tool."

Recently when a physician gave a verbal order for a nonemergent task to a nurse, two other nurses asked if the nurse was unaware of the standard. The nurse then turned to the physician and said, "'You need to write it.' Throughout the rest of the shift, the nurse made sure orders were written," she says.

Nurses also may report a problem with noncompliance to the ED manager or medical director via voicemail or e-mail, adds Street.

Another nurse was advised that continuing to accept verbal orders could result in corrective action. "The nurse was also told that if further incidents occurred, this would be part of her permanent file as well as reflected in her annual performance appraisal," she says.

If the physician gives a verbal order and the patient is injured as a result of the care ordered, the burden is on the nurse to prove that he or she fulfilled the physician's order accurately, says **Penny S. Brooke**, APRN, MS, JD, a Salt Lake City-based nurse attorney specializing in health care legal issues.

"The nurse always should read the order back to the physician to verify that the nurse heard the order

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correctly," says Brooke. When orders are given by telephone, have a second nurse on the line to verify the order, she recommends. "It is always good to document details, such as a verifying witnesses' name, in case you need to refresh your memory at a later date," she adds.

If a verbal order has not been signed by the physician in a timely manner, contact the physician to remind them, advises Brooke. "It is important to document this contact and to take the next steps if the physician does not follow through," she says.

If a physician refuses to comply, go up the chain of command and document this action, says Brooke. "Documentation of the steps taken to have a noncompliant physician sign a verbal order also may be submitted as an incident report," she adds. "Risk management is interested in having hospital policies and procedures followed." ■

Are cancer patients getting inadequate care in your ED?

EXECUTIVE SUMMARY

Cancer patients often are treated inappropriately in the ED, ED nurses say, and life-threatening emergencies may be missed.

- Patients may require higher doses of pain medications.
- Don't miss underlying conditions unrelated to the cancer.
- Treat neutropenic infection immediately with broad-spectrum antibiotics.

After ED nurses detected a mild fever in a cancer patient, a decision was made to start treatment *after* the patient was admitted to the floor.

"It was over three hours before the patient had the first dose of antibiotic, and the patient subsequently died," says **Linda Young**, RN, MSN, faculty member at Montana University College of Nursing-Missoula Campus.

It's unknown whether this patient's death could have been prevented if treatment had been started immediately in the ED, but one thing is certain: Cancer patients with life-threatening emergencies are at risk for being undertreated in EDs, she says.

"ED nurses may mistakenly undertreat pain, immobility, or gastrointestinal issues due to lack of understanding of the underlying problem," Young warns.

If a patient with breast cancer told you she was unusually tired lately, would you suspect hypercalcemia? "This is the most common life-threatening disorder associated with cancer," says **Gail McWilliams**, RN, CCRN, CEN, clinical nurse specialist for the ED at Shore Health System in Cambridge, MD.

Symptoms may be very vague, including fatigue, confusion, and signs of dehydration, and they may occur gradually, she adds. "Large amounts of urine combined with decreased appetite, nausea, vomiting, and other signs of dehydration are good clues."

To improve care of patients with oncological emergencies, do the following:

• Give enough pain medication.

Pain may be severe enough to bring a cancer patient to the ED, and patients may require much higher doses than usually administered, says Young. "The uncontrolled pain of the cancer patient may be underestimated."

• Review treatment history.

You need to know which pain medications the patient is taking and in what dosages, says Young. "If the patient has recently had chemo, it is important to know this, as many types of chemo are excreted in their original state, and extra precautions may be needed when contacting body fluids," she says. "If the patient has had a radiation implant, it would be important to know if anyone is pregnant, as they would have to avoid this person."

• Consider underlying conditions.

Bowel obstruction from an encroaching tumor may be dismissed as constipation, or back pain from spinal cord compression may be mistaken for a sprain, says Young.

Ken Lanphear, RN, ED nurse at Borgess Medical Center in Kalamazoo, MI, says, "It is easy to be sidetracked and attribute the presenting signs and symptoms to cancer, when in fact it may be a problem in another system."

For example, a lung cancer patient with a cardiac history may complain of shortness of breath — but is this symptom cased by cancer or heart disease? "It becomes easy to blame everything on the cancer, but we must remember that the patient may have other medical problems," says Lanphear.

• Don't overlook life-threatening emergencies.

Perform a careful physical assessment to avoid missing a potentially life- or limb-threatening disease process, McWilliams says. Here are oncological emergencies you may see in your ED, with assessment tips for each:

— Neutropenic infection. This is the leading cause of death in patients undergoing cancer treatment, and it is imperative to start treatment immediately with broad-spectrum antibiotics, urges Young.

Symptoms can be very subtle, and patients may present only with a low-grade fever or no fever at all, says McWilliams. "Murmurs may be present secondary to

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anemia or intracardiac vegetation," she says. "Your skin assessment must be meticulous, with all sites of recent invasive procedures checked."

Watch for signs of early sepsis, says McWilliams. "When antibiotics are started, vital signs should be monitored frequently in the first hour," she says. "The release of endotoxins can cause refractory hypotension."

— Superior vena cava (SVC) syndrome. This is most often seen with bronchogenic cancers, but any tumor in the mediastinum can compress or invade the SVC, says McWilliams. The most common symptoms are facial, neck, and bilateral upper extremity swelling, dyspnea and cough, but the patient also could present with headache or other signs of increased intracranial pressure, dysphagia, and hoarseness, she says.

— Spinal cord compression. "This is a medical emergency and can cause permanent paralysis if not treated promptly," McWilliams warns. Pain is constant, may increase in the supine position, and may cause the patient to awaken at night, she adds.

"Radicular pain is caused by pressure on the nerve roots, especially in the affected dermatome," McWilliams says. It can be relieved by sitting upright, she says.

"This is the exact opposite of what is seen in patients with a slipped disc," McWilliams says.

— Syndrome of inappropriate antidiuretic hormone secretion. This is an endocrine disorder of water intoxication, most commonly caused by a lung malignancy, says McWilliams. "Look for signs of dehydration or fluid excess," she advises.

— Tumor lysis syndrome. "This emergency is frequently triggered by administration of chemotherapy," says McWillliams. Dehydration, hyperkalemia, hyperuricemia, and hyperphosphatemia with associated hypocalcemia can produce acute renal failure, she warns. "Ask the patient about intake and urine output." ■

Avoid EMTALA violations: Never say these 3 things

Your ED's waiting room is packed with patients, and stress levels are rising fast. A man with an ankle injury asks angrily, "How much longer will I have to wait?" You roll your eyes and tell him it could be hours.

You may not intend this, but the patient may feel you're discouraging him from seeking care — leading to a potential violation of the Emergency Medical Treatment and Labor Act (EMTALA).

"Oftentimes it's body language, the shrugging of shoulders, failing to make eye contact, the rolling of eyes, or just the tone of a curt response, that causes a patient to leave," says **Pamela Rowse**, RN, quality/risk consultant for the ED at Saint Rose Dominican Hospital in Henderson, NV.

These probably are the leading causes of patients determining that they should go elsewhere, she says. "The patient's mindset is, they are treating me this way because I don't have insurance, or I'm homeless, or I'm Hispanic or black or Asian."

What you say and do can trigger a complaint to the Centers for Medicare & Medicaid Services (CMS), says **Jeff Strickler**, RN, clinical director of emergency services at University of North Carolina Hospitals in Chapel Hill. "To avoid this, be particularly cognizant about what you tell a patient prior to the medical screening examination [MSE] occurring," he says.

Never make any statement to patients about wait times, payment, or alternatives to care, especially before a full clinical triage assessment has been done, including history and medications, warns Rowse.

EXECUTIVE SUMMARY

Words and actions that appear discouraging may cause patients to leave without treatment, putting you at risk for Emergency Medical Treatment and Labor Act violations.

- Be aware of your body language, and avoid shrugging shoulders or rolling eyes.
- Don't make any statements about long wait times.
- If patients say they are leaving, offer to reassess their condition.

"When a patient's outcome is bad because they have left without receiving their MSE, then state and CMS surveyors will have red flags when they come in to review the chart," she says.

Here are three things to avoid saying to patients:

• Anything that could be interpreted as encouraging a patient to leave.

Something as simple as telling a patient with a seemingly minor complaint, "The wait could be several hours," could cause the patient to leave without being seen and file a complaint with CMS for a failure or delay in providing an MSE, says Strickler.

Avoid phrases of irritation such as "whatever" or "it's your choice," if patients ask about wait times or tell you they are leaving, says Rowse. "Offer to reassess their condition," she advises. "Explain to them that it is important that they be seen by the physician to determine if there is anything that needs to be treated immediately."

• Complaints about other practitioners or hospitals.

Avoid venting your frustrations about delays or inappropriate staff behavior to patients, advises Strickler. "Comments about another institution refusing to accept a patient's case on transfer, or lack of a timely response from a consultant, also could trigger a complaint to CMS."

The bottom line is to avoid any statements that could be construed as the ED delaying the MSE for any reason, says Strickler. "Especially troublesome are any statements that reflect on financial screening practices, such as 'Before we can get you back, I need you to give your insurance information to registration.'"

• Statements about long wait times.

It's easy to become frustrated when your waiting room is crowded with patients who all want to be seen first, says Rowse. "Both patients and family members become angry and agitated, leading to a confrontational environment," she says. "This sets the arena for potential EMTALA violations with even well-intended and caring health care personnel."

Avoid the following statements, recommends Rowse:

— "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."

— "We've had many ambulance patients that have arrived, and we are very overwhelmed right now. We'll get to you as soon as we can."

These statements often are made before the potential for a medical emergency has been assessed, adds Rowse. "I have even heard triage nurses tell patients that 'the wait at the urgent care would be much less,'" she says. "Those patients routinely were referred back to the ED because the necessary diagnostic capabilities were not available at the urgent care."

If patients do ask about wait times, Rowse recommends saying, "We care about you and want to provide you with the services that you need, but right now there are others that need immediate attention because they are in a potentially life-threatening situation. We will do anything that we can to expedite your being seen by a physician. Please let us know if your condition gets worse while you are waiting."

EMTALA investigations have become a "major heartbreak" for hospitals, particularly when they are unfounded, says Rowse. "However, taking the right steps from the get-go and showing compassion will go a long way to preventing complaints being filed." ■

SOURCES

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Staff incentives help prepare for surveys

Is an unannounced survey from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) topping your "worry list" these days? All Joint Commission surveys will be unannounced as of Jan. 1, 2006, which means that you'll need to be ready for surveyors to walk in at any minute.

To ensure continuous preparedness, the "I'm Rich" program was developed by ED nurses at Wake Forest University Baptist Medical Center in Winston-Salem, NC. "We wanted to find a fun way to educate staff on the current National Patient Safety Goals and our efforts within the ED to meet them," says **James Bryant**, RN, MSN, CEN, director of emergency and transport services.

"I'm Rich" is a mnemonic device:

I = Identification;

EXECUTIVE SUMMARY

Incentives are an effective way to keep staff motivated for continuous preparedness and unannounced accreditation surveys.
- Ask nurses random questions during weekly rounds.
- Reward correct answers with paper money.
- Have a contest where the nurse with the most 'dollars' exchanges them for a gift certificate.

M = Medication safety;
R = Reconcile medication history;
I = Infusion pumps;
C = Communication;
H = Health care-associated infections and Harm from falls.

A bulletin board explaining the program was placed next to the ED's time clock. During weekly rounds, nurses are quizzed randomly by managers, and they are "paid" for correct answers with paper "money. "The amount they are paid is based on the difficulty of the question," says Bryant. **(See list of sample questions, right.)**

At the end of two weeks, nurses tally up their winnings. The staff member with the largest amount receives a gift certificate of their choice for $50, paid for by the ED. "The program helps staff to become more comfortable answering questions on the spot and to be proud of the efforts made by our department and hospital to improve patient safety," says Bryant.

The program has increased the comfort level of nurses who might have been nervous about surveyors "putting them on the spot," says **Ryan Oglesby**, BSN, RN, EMT-P, educator for the ED and transport services. "It has been beneficial to question staff randomly and off guard as the case may be in future JCAHO surveys."

Nurses are enjoying this new way of learning the necessary information, says Oglesby. "Often, presentations and fliers just don't have the desired impact in an physically and emotionally stressful environment where staff are already busy with life-saving interventions and handling urgent patient care needs," he says.

Day, evening, and night shifts are competing with each other to respond with the most correct answers, says Oglesby. "They started the competition on their own, without incentive, as friendly competition," he adds.

The program is not only more enjoyable — it's also more effective, says Bryant. "It is a fun activity to get staff motivated and out of the handout and video world of inservice education we all too often are forced to use." ■

SOURCES

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Here are questions to prepare for JCAHO

Below are questions asked of ED nurses at Wake Forest University Medical Center in Winston-Salem, NC, to prepare for an unannounced survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO):

1. **Question:** How are critical lab or radiology values handled? **Answer:** Nursing documents the critical test results. A read-back of the information is required. The patient's physician then is called with the results within 15 minutes of the report. The nurse is prepared to take a telephone order to act on the results.
2. **Question:** How do you handle an order that was written using an abbreviation identified as dangerous and not appropriate for use? **Answer:** Medication orders with unacceptable abbreviations are not accepted by our pharmacy. The physician will be called and asked to rewrite the order.
3. **Question:** How do you identify your patient when giving medications or doing procedures? **Answer:** Our policy requires the use of two patient identifiers. On the inpatient units, the identifiers are patient medical record number and patient name. The nurse checks the patient's armband with the computer information. In outpatient or ancillary areas, patients may not have armbands. In these cases, the patient's name and birth data and/or picture ID are used.
4. **Questions:** What is an acceptable length of time to answer an equipment alarm? Have audible alarms been set loud enough to be heard over a busy unit? **Answer:** Alarms are responded to immediately,

with prioritization given to patients warranting immediate attention and to critical equipment such as ventilators. All alarms are audible to staff.

5. **Question:** How are medications with a range of doses handled? **Answer:** All orders must be written with a specific dose and frequency. Dose ranges are accepted when a dose and frequency are specific to a quantified monitoring parameter, such as sliding scale insulin for a specific blood glucose value.
6. **Questions:** How do you report a medication error? Is there any recrimination for reporting an error? **Answer:** All clinicians are encouraged to report medication errors, which may be done anonymously. The majority of medication errors involve process issues and not human error. There is no recrimination for reporting medication errors.
7. **Questions:** How often do you have fire drills? Where's the nearest fire extinguisher? Where's the nearest evacuation route? **Answer:** Fire drills occur once per shift per quarter. Staff should know where all the fire extinguishers are on their unit. There is a posted evacuation route on each unit, and staff need to know it. ■

Project gives nurses quick access to patient meds

• A woman found unconscious by co-workers.

• An elderly man who says he takes several medications, but he can't recall the names or dosages.

• A teenage girl critically injured in a motor vehicle accident.

What do all these patients have in common? The lack of ability to obtain an accurate and complete list of all the medications they're taking. As participants in the MedsInfo — ED project program, ED nurses at Emerson Hospital, Boston Medical Center, and Beth Israel Deaconess Medical Center, all in the Boston area, can obtain this information within seconds. The project is a collaboration of health plans, hospitals, pharmacy benefit managers, technology vendors, and Massachusetts state agencies with the goal of improving patient safety.

"In the ED, I see patients on a daily basis who have been prescribed more pills than they could possibly remember," says **Larry A. Nathanson**, MD, director of emergency medicine informatics at Beth Israel. "Given the unplanned nature of emergencies, patients often arrive in the ED without a complete medication history available."

In addition, patients may have altered mental status, ranging from mild confusion to comatose, which makes it impossible to obtain an accurate medication history.

"With ambulance diversion and ED overcrowding reaching critical proportions, it is common to see patients with no previous records immediately available to me," says Nathanson. "Knowing what medications the patient is taking can provide immediate insight into their medical history, as well as allow confidence that any medications I might give them won't cause an interaction."

If patients are unsure of their medications or doses or are unconscious, an encrypted application is used to enter information, so triage nurses can view a list of the patients' prescriptions that have been filled by any pharmacy, based on insurance records.

Special care is taken to protect this and all other types of electronic personal health care data, emphasizes Nathanson. MedsInfo has specific rules governing who may access this information and when: Either the patient must give permission, or the attending physician must certify that a medical emergency exists that prevents the patient from being able to do so, he says. "The information is password protected and encrypted during transmission, and all usage is logged and reviewed," says Nathanson.

The program ensures compliance with one of the National Patient Safety Goals from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that requires you to reconcile a patient's medications across the continuum of care.

"This goal is challenging for EDs because they often lack information about medications a patient is currently taking," notes Nathanson.

Once obtained, the patient's current medication list can be compared to other documentation such as previous discharge summaries. **Duane A. Young-Kershaw**, RN, BSN, clinical nurse educator for the ED at Beth

SOURCES

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Israel, says, "We also can compare the list to medications the patient brings in, and we can look at issues such as compliance and availability of the medication to the patient."

ED nurses know the medication name, date dispensed, dosage form, quantity, class, and prescriber — information that can significantly impact the care a patient would receive, says Young-Kershaw.

The patient may be critically ill and unresponsive, with no one to provide medical information. "Having the medication list would not only tell us what the patient is taking, but also give us a clue to their past medical history," he adds. "Similarly, if a patient is unresponsive, we could look at their meds combined with the date of dispense and find any possible culprits that the patient could have overdosed on." ■

Avoid recording inaccurate respiratory rates at triage

Do you always measure a patient's respiratory rate at triage? Would it surprise you to know that what you're documenting often is inaccurate, according to new research.[1]

"Many of the respiratory rate measurements we write down are meaningless," says **Paris Lovett**, MD, the study's principal investigator and an ED physician at Columbia University Medical Center in New York City. "This has nothing to do with the quality or dedication of triage nurses."

Researchers found that neither triage nurses nor an electronic monitor provided accurate measurements of respiratory rate in the ED. It's difficult to measure respiratory rate accurately, since the patients have to be relaxed, not talking, not moving, unaware that respiratory rate is being measured, and their chest rise and fall has to be visible, says Lovett.

Also, you need a full minute to record it accurately, he says. "Do any of these things sound like working in triage?" he asks.

At best, it's a waste of time to record meaningless information, and in some cases, it's dangerous, Lovett maintains. "We run the risk of mistriaging and misdiagnosing patients if we miss an abnormal respiratory rate — for example, the diabetic who is tachypneic because they have ketoacidosis," he says. "However, we are mandated by many regulators and payers to record vitals. We are unlikely to see respiratory rate abandoned any time soon."

SOURCE

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To improve respiratory rate measurements at triage, Lovett suggests the following:

• Choose between auscultation and observation. "I prefer observation, when sufficiently unclothed, because it is less intrusive and less likely to influence the variable being measured," he says. "However, you do need to have a good view of the chest."

• Use a one-minute counting period. "This is very hard to achieve, but necessary for accuracy," Lovett says. Fifteen seconds is insufficient, he says. "At a minimum we should take 30 seconds," Lovett says.

• Don't record bad data. Triage nurses may be more likely to count respiratory rate carefully and formally in patients who look very sick, but for other patients, they may write down a quick estimate, says Lovett.

Unfortunately, to comply with charting guidelines, they have to state any guesses as numbers, not impressions, he says. "We're constrained by guidelines that aren't likely to change any time soon, but maybe one day we can simply write 'bradypneic,' 'normal,' or 'tachypneic' if there isn't time to formally count out the respiratory rate," Lovett says. "That way, we're not capturing bad data on the chart and misdirecting clinical decisions."

Reference

1. Lovett PB, Buchwald JM, Sturmann K, et al. The vexatious vital: Neither clinical measurements by nurses nor an electronic monitor provides accurate measurements of respiratory rate in triage. *Ann Emerg Med* 2005; 45:68-76. ■

COMING IN FUTURE MONTHS

- Reduce repeat visits for asthma patients
- Foolproof ways to improve 'handoff' communication
- Dramatically improve assessment of acute coronary syndromes
- What the Joint Commission is asking about nursing competencies

CE instructions

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

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

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

CE*questions*

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

- **Identify** clinical, regulatory, or social issues relating to ED nursing. (See *Do physicians comply with verbal orders policy?)*
- **Describe** how those issues affect nursing service delivery. (See *Avoid EMTALA violations: Never say these 3 things.*)
- **Cite** practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. (See *Avoid recording inaccurate respiratory rates at triage* and *Are cancer patients getting inadequate care in your ED?*)

9. Which is required by the Joint Commission on Accreditation of Healthcare Organizations for use of verbal orders?
A. EDs should take steps to reduce use of verbal orders.
B. Verbal orders can only be taken when physicians are physically present.
C. Verbal orders can be written by ED nurses if physicians are busy.
D. Orders must be read back only if they are taken over the telephone.

10. Which is recommended for cancer patients with neutropenic infection, according to Linda Young, RN, MSN?
A. Delay treatment until the patient is admitted.
B. Treat in the ED only if symptoms are severe.
C. Discharge the patient unless fever is present.
D. Start treatment immediately with broad-spectrum antibiotics.

11. To comply with the Emergency Medical Treatment and Labor Act, which is recommended when patients ask about wait times, according to Pamela Rowse, RN?
A. State that the wait could be several hours.
B. Offer to reassess the patient's condition.
C. Explain that the consultant never responded.
D. Tell the patient that the receiving hospital is refusing the transfer.

12. Which is recommended to improve measurement of respiratory rate at triage, according to Paris Lovett, MD?
A. Ask patients to talk while you are measuring.
B. Use a one-minute counting period.
C. Use a 15-second counting period.
D. If you guess at the respiratory rate, document this as a specific number.

Answers: 9. A; 10. D; 11. B; 12. B.