ED Management®
The monthly update on Emergency Department Management

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IN THIS ISSUE

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CPOE: It's not a matter of if, but when, say the experts, so the time to prepare is *now*

Get involved in your hospital's decision-making process

(Editors' note: In this first part of a two-part series on computerized physician order entry [CPOE] we tell you how to plan for such a system. In next month's issue, we'll cover how to pick a CPOE that's right for your ED and hospital.)

It's going to come to every ED, warns **Sarah Vogel**, MD, FACEP, ED director at Albany (NY) Memorial Hospital. "You have two choices," Vogel says. "You can get proactively involved with [information systems] and administration and choose the best system for you, or you can hide under your protocols."

"It" is Computerized Physician Order Entry, or CPOE, which refers to computer-based systems for ordering diagnostic and treatment services, including medications. Some of these systems are ED-specific, while others are hospitalwide systems that incorporate an ED module.

Vogel is not alone in her belief that CPOE will one day be a part of every ED. "It's definitely the future," says **Brian Decker**, RN, CEN, systems administrator and emergency preparedness coordinator in the ED at Robert Wood Johnson University Hospital in Hamilton, NJ.

And **Brian F. Keaton**, MD, FACEP, attending physician/emergency medicine informatics director at Summa Health System, Akron, OH, and president-elect of the American College of Emergency Physicians, is even more emphatic about the future of CPOE when he says, "There's no question."

Several groups are pushing it as the best chance to improve quality and safety of care, especially in terms of medication errors, he says. The most prominent proponent

Executive Summary

The implementation of Computerized Physician Order Entry can be challenging and complicated, but you can make the process much smoother with careful planning.

- Staff up before going live. The first several weeks will slow down the department.
- Have enough computers for all staff, including residents and attendings.
- Take a "go-slow" attitude when it comes to installing medication allergy alarms.

is the Leapfrog Group, a Washington, DC-based health care safety organization, he says. The Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare and Medicaid Services also are pushing CPOE, he says.

"The reality is if you want to get paid in the future, you will have to have these systems," Keaton says.

The potential benefits of CPOE are readily apparent. For one, because physicians directly enter their orders into a computer, the issue of poor handwriting is nonexistent. Since department secretaries no longer have to transcribe doctors' orders, the potential for transcription errors also is eliminated. In addition, such systems can be programmed to provide alarms if an improper order has been entered.

Despite these clear benefits, sources tell *ED Management* that the adoption of CPOE can be fraught with pitfalls. The initial learning curve can be quite steep, physicians complain it does not save them time, and the first few months after going live can create problems the ED manager may never have anticipated.

Bumps in the road inevitable

As with any new computer system, it is inevitable that a new CPOE system will present challenges — some of which can be daunting.

"The initial learning curve was very steep, and it slowed us down significantly," says Vogel, whose facility is installing a hospitalwide system from Meditech in Westwood, MA, but is using the ED as its "guinea pig." They went live in November 2004. "It saves time for clerks who used to enter orders, but docs are doing things they would not have done previously," Vogel says.

The other challenge Vogel faced was per diem physicians. "It's really tough for them to come in once or twice a month and remember the nuances of the system," she says.

Also using a Meditech system is Stamford (CT) Hospital, which went live a couple of months ago. "There's resistance any time you have enormous change," notes **Kristin Winbigler**, administrative director of the ED. "We've worked hard to win the staff over." In order to do that, she says, coaching had to be tailored to individual needs. "Some staff needed a one-on-one approach," she adds.

Keaton, whose facility began implementation of its enterprisewide order entry system from Boca Raton, FL-based Eclipsys about four weeks ago, also notes frustrations because of the culture change. "The doctors had less trouble than the nurses, because many have been using computers for years, while nursing has gone from being pretty much paper-based," he observes.

There are potential kinks in the system that managers don't think about ahead of time, Keaton warns. For example, his system uses fingerprint biometrics to identify users. So, if one physician user had been on a computer and left, but did not log off, the next physician user would have his order denied and would have to go back and sign in.

Then, there's the whole issue of verbal orders, Keaton says. "It's easy for me in a verbal order to say

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Editor: Steve Lewis (steve@wordmaniac.com).
Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: Glen Harris, (404) 262-5461, (glen.harris@thomson.com).
Senior Managing Editor: Joy Daughtery Dickinson, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: Nancy McCreary.

Editorial Questions
For questions or comments, call Joy Daughtery Dickinson, (229) 551-9195.

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Sources/Resources

For more information on Computerized Physician Order Entry (CPOE) systems, contact:

- **Brian Decker**, RN, CEN, Systems Administrator, Emergency Preparedness Coordinator, Emergency Department, Robert Wood Johnson University Hospital, One Hamilton Health Place, Hamilton, NJ 08690. Phone: (609) 584-2882. Fax: (609) 584-5919. E-mail: bdecker@rwjuhh.edu.
- **Brian F. Keaton**, MD, FACEP, Attending Physician/Emergency Medicine Informatics Director, Summa Health System, 525 E. Market St., Akron, OH 44310. E-mail: bfkeaton@earthlink.net.
- **Sarah Vogel**, MD, FACEP, Emergency Department Director, Albany Memorial Hospital, 600 Northern Blvd., Albany, NY 12204. Phone: (518) 417-3266.
- **Kristin Winbigler**, Emergency Department Administrative Director, Mary Nielsen, APRN, Emergency Department Clinical Educator, Stamford (CT) Hospital. Phone: (203) 276-7598.

For a free CPOE evaluation tool and a free copy of the report, *Computerized Physician Order Entry: A Look at the Vendor Marketplace and Getting Started,* visit the Leapfrog Group's web site at www.leapfroggroup.org/media/file/Leapfrog-CPOE_Guide. pdf.

For more information about CPOE products, contact:

- **Eclipsys Corp**., 1750 Clint Moore Road, Boca Raton, FL 33487. Phone: (561) 322-4321. Fax: (561) 322-4320.
- **Medical Information Technology (Meditech)**, Meditech Circle, Westwood, MA 02090. Phone: (781) 821-3000. E-mail: info@meditech.com.
- **Picis**, 100 Quannapowitt Parkway, Suite 405, Wakefield, MA 01880. Phone: (781) 557-3000. Fax: (781) 557-3140.

it was issued half an hour ago, but the computer has a hard time with me predating stuff, so you get into issues of when something really did happen," he says.

While training staff was time-consuming, Decker says it was not difficult at all — perhaps because of his experience as systems administrator. Another advantage he has was that the staff was already accustomed to using its IBEX Pulse Check system (from Picis, of Wakefield, MA).

By going through the implementation process, each of the managers learned valuable lessons about how to implement CPOE successfully.

"During the first three weeks of our go-live period, we had an extra nurse from the team on 24/7," says Winbigler. As with all CPOE systems, the manufacturer first trains a select group of staff, who then train the rest in-house. They were taken out of patient care flow and were called "super-users," she says.

"We knew no matter how much we trained, that when you go to a live situation you have problems," Winbigler notes. For example, many different screens need to be reviewed. "Perhaps you don't remember where you need to indicate an assessment of oxygen units or whether something must be put in the notes," she says. "The super-users are there to provide support and assistance while the staff is still on a learning curve."

The facility also had a command center on-call for the first two weeks, manned by hospital information technology personnel.

"You also need to make sure you have enough computers for all the employees — not just nurses, but doctors, residents and attendings," adds **Mary Nielsen**, APRN, clinical educator for the Stamford ED.

One of the most impressive aspects of a CPOE system also can be one of the most challenging, notes Keaton. "If someone has a listed allergy for a medication, you can [program the system to] stop the process and avoid error," he explains. "But one of your key decisions is where to put the alarms."

In conversations with another facility manager who had implemented a system a year ago, Keaton learned that they had so many alarms programmed in their system that it "dragged the place to a stop," because the system required multiple clicks for so many medications. "You have to be very careful in how you implement this very valuable, strong feature," warns Keaton, who says that in his own ED, they decided not to turn on any alarms until the staff became more comfortable with the system.

Despite these challenges, users agree the benefits of CPOE are undeniable. The greatest benefit is patient safety, Decker says. "You can read the orders, the docs put in what *they* want, not what the secretary *thinks* they want, and you have an automatic cross-reference of drug allergies before the patient gets the medication," he says. "You can also program in your own order sets, so, for example, if you have an ankle, you can do an order set that says, 'X-ray, icepack, crutches, splint, ibuprofen,'" adds Vogel. ■

Atypical patient profiles common after disasters

Be prepared for psych casualties

ED managers recognize the need to prepare their departments for a huge surge of patients in the wake of a disaster in the community. What some of them may not be as well prepared for is the very

Executive Summary

Follow the "surge, sort, support" triage model to ensure a higher quality of care for victims of communitywide disasters.

- Alert your staff that up to 80% of your patients will be self-referred.
- A large number of patients will have unexplained physical symptoms.
- Have a separate space available to function as a support center.

unique distribution of complaints and patient types that will present in such situations, experts warn.

For example, in the wake of disasters such as hurricanes Katrina, Rita, and Wilma, it's important for ED managers to not only treat the physical problems of their patients, but to also understand there may be behavioral health problems related to their experiences, says **James Shultz**, PhD, director of the Center for Disaster Epidemiology and Emergency Preparedness (DEEP) at the University of Miami School of Medicine. Accordingly, he says, behavioral health consideration should be part of disaster planning.

"We ask people to think behaviorally," says Shultz, who follows a "Surge, Sort, Support" model of disaster response. "There may be psychological casualties: people who are fearful and in distress, but who may as a result of that fear generate physical symptoms," says Shultz. "In situations where there is advance warning, such as with hurricanes, there will also be a considerable surge of people trying to gain admission who are oxygen dependent, homeless, or who have special needs."

Another aspect of surge ED managers should consider involves family members, says Shultz. "While many people are self-referred on evacuation, some may be brought in by family members," he notes. "You may also have a big influx of people looking for missing loved ones, as the ED is a main access point to the hospital. Again, this is not typically something we make part of our disaster preparation drills."

Shultz suggests the ED have a place available that can function as a support center. "It's good to have a place for observation and information where you can treat psych casualties, provide psychological first aid, and do behavioral triage," he says. This triage involves distinguishing the many patients who are distressed but who could be helped by being brought out of the ED to a more calming place, such as a classroom, from those who are inconsolable, agitated, or disruptive — those who have to be referred for further evaluation. "The majority will regain control and be ready for discharge," says Shultz. The treatment might be provided by behavioral health professionals, but could also include nurses, medical staff, or chaplains, he adds.

Triage is 'upside down'

In disasters that involve evacuations, such as hurricanes, the normal rate of emergency medical services (EMS) vs. self-referred patients is nearly reversed, which impacts the "sorting" aspect of your response, says Shultz.

Historically, about 88% of your patients are EMS transports, he says. In communitywide disasters, 80% are self-referred, Shultz says, and the first time a patient is seen by any medical professional is in the ED. "This leads to upside-down triage," he says. "You may be full up in the ED before the first emergency vehicles arrive."

Given this reality, it's important to prepare for the different types of patients you will see, Shultz says. "You will have a complex blend of medical casualties, more minor injuries, and if they have been at the scene, the patient is more likely to be psychologically traumatized," he says. A lot of patients will have unexplained physical symptoms, Shultz says. "During disasters, you will have more of that [due to stress and trauma]." You may see mass psychogenic illness, Shultz says. In Israel, for example, when the Iraqi SCUDs fell, most patients had respiratory complaints, but there was no gas onboard the missiles, he says. "These patients need to be worked up in the ED until you find no physical basis for the complaints," Shultz says.

Staff are victims, too

In considering the behavioral health issues that often result from disasters, it's important to include your ED staff, says **Joseph A. Barbera**, MD, co-director of the George Washington University Institute for Crisis, Disaster, and Risk Management in Washington, DC.

"Your staff can definitely be impacted," he says. "So, when you are creating your ED disaster plan, you have to ask if it makes sense from a behavioral point of view." In other words, he poses, do you have people "assigned to do 10 things at once, three of which are life-critical? If that can't be done, what does it do to your people?"

When you add extraordinary circumstances, involving more victims than normal, with a totally different profile from everyday ED patients, this puts a huge amount of professional stress on your staff. "You must also consider the fact that they are victims as well," Barbera advises.

Make sure they have ample food and rest, and respect their need to find out if their family members

Sources

For more information on behavioral triage, contact:

- **Joseph A. Barbera**, MD, Co-Director, George Washington University Institute for Crisis, Disaster, and Risk Management, The George Washington University, 1776 G St. N.W., Suite 110, Washington, DC 20052. Phone: (202) 994-8424. E-mail: jbarbera@gwu.edu.
- **James Shultz**, PhD, Director, Center for Disaster Epidemiology and Emergency Preparedness, University of Miami School of Medicine, Highland Professional Building D-93, 1801 NW Ninth Ave., Miami, FL 33136. E.-mail: jshultz1@med.miami.edu.

are OK, emergency management experts advise. Your role can include items as simple as getting them food at the appropriate time. As an ED manager, observe them for signs of stress on an ongoing basis — especially those with young children. If need be, offer them a comfortable, quiet lounge to sit for a little while. Near the end of the incident, offer them critical incident stress debriefing with staff behavioral health professionals, they add. **(To learn how to access tips for facilities preparing for and responding to emergency situations, see the story, below.)** ■

JCAHO offers emergency management suggestions

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has published a series of tips for facilities preparing for and responding to emergency situations. The tips include:

• how to conduct an emergency management drill that stresses an organization's systems and facilities;

• guidelines for staging effective drills, including planning for surge capacity, staffing considerations such as shift changes, security issues such as crowd control, communications, and how to evaluate the drill;

• tips for communitywide emergency planning from a facility management perspective;

• how to protect and prepare first receivers during a mass casualty incident;

• tips to address emergency management and ensure the continued provision of safe, quality care and services during a disaster;

• a checklist to ensure organizations cover the key aspects of emergency management planning;

• a step-by-step guide for small, rural, and suburban communities to prepare for and successfully respond to major local and regional emergencies.

To download a free copy, go to www.jcrinc.com. In the "search" box, type "Emergency Management Tips." Then, scroll down and click on "Free Emergency Management Tips Now Available Online!" ■

To cut diversions, get other units involved

ED achieves 72% reduction

By addressing ED problems as hospitalwide problems, the ED leadership at Shady Grove Adventist Hospital in Rockville, MD, has reduced ambulance diversions by 72%, reduced average length of stay by 25 minutes (from 397 to 372), and boosted patient satisfaction from 3.96 to 4.11 on a scale of 1-5. Also, the number of patients boarded in the ED has dropped from an average of 190 per month to 120 per month.

At the same time, Shady Gove has earned its facility national recognition. The Joint Commission on Accreditation of Healthcare Organizations has named Shady Grove a 2005 winner of the ninth annual Ernest Amory Codman Award, which recognizes excellence in the use of outcomes measurement by health care organizations to achieve improvements in the quality and safety of health care. The Joint Commission noted that the facility was specifically being recognized for its initiative to relieve ED overcrowding and move patients through the hospital process more efficiently, thereby ensuring community access to care.

"One of the main reasons for our success is that we actually coordinated the effort [among several departments]," says **David Klein**, MD, vice chair of Shady Grove's ED.

Executive Summary

Integrate your own internal solutions for reducing diversions with process improvements developed in concert with other departments. This approached helped one ED reduce diversions by 72%, reduce length of stay from 397 to 372 minutes, and increase patient satisfaction from 3.96 to 4.11 on a five-point scale.

- Show radiology, lab, inpatient staff how unavailable beds or slow test result times can cause a patient logjam in the ED.
- Seek opportunities to move testing done in other departments directly into the ED.
- Give your nurses the authority to order certain treatment on their own.

Source

For more information on working with other departments, contact:

- **Debbie Foshee**, Vice President, Quality and Medical Staff Services; **David Klein**, MD, Vice Chairman, Emergency Department, Shady Grove Adventist Hospital, 9901 Medical Center Drive, Rockville, MD 20850. Phone: (301) 279-6000.

The hospital put together three teams representing various groups within the hospital, says **Debbie Foshee**, vice president of quality and medical staff services. These teams, all of which had ED reps, included:

- AM Discharge Team ("backdoor" of the hospital);
- Patient Throughput Team ("middle");
- ED Admission Team ("front door" of the hospital).

"We also made sure that we avoided focusing on whom or what was to blame for problems and kept our focus on finding a solution that improved access to care," says Foshee.

Seeking solutions

The initiative began in 2003, when rapid growth in the state impacted diversion hours.

"We are the second-busiest ED in the state, and our diversion hours had become much higher than in the past," says Klein, who says the ED had 87,000 visits in 2004.

Every time the department goes on diversion, he continues, the charge nurse and physicians meet together and determine what can be done to relieve the situation. In examining the root causes of these diversions, they realized how interrelated the ED and other hospital departments were and that they all had to take responsibility for their role in overcrowding.

"Lab or radiology may believe the amount of time they take to do their tests doesn't affect the ambulances, but it does," says Klein, "Just like the inpatient side impacts whether we can get our admitted patients a bed."

So Klein participated in meetings with radiology, the lab, and the facility's hospitalists. "I started at the joint Radiology/ED Quality Committee and made them understand that if we could get our patients to radiology quicker, it could help stop diversions," he says.

For example, because of the increased use of abdominal scans, some patients were being kept in the ED for more than six hours, Klein recalls. Through joint meetings with radiology, 40-50 minutes were cut off the process.

The solution? "We now keep contrast in the ED, and have the doc or nurse mix it up and give it to the patient," says Klein. "In the past, I would come out of the room, write an order for the scan, give it to the secretary, then the radiology tech would see the order, mix up the contrast, and go to the ED and give it."

A different approach was used with the hospitalists. Klein approached them with the following argument: "We know you never want to discharge a patient when they're not ready, but if you are going to do it today, and it doesn't make a difference if it's 8 a.m. or 2 p.m., then let's work on discharging them sooner." A "think noon, bed ahead" policy was initiated, and inpatient and discharge nurses now meet every morning to discuss who can go home that day.

Internal changes effective

Of course, says Klein, changes had to be made within the ED itself as well. To start treatment earlier, he initiated an Advanced Triage Protocol, which enabled nurses to start ordering X-rays and labs to facilitate appropriate evaluation and rapid treatment of patients presenting with conditions that include abdominal pain/vaginal bleeding, asthma, chest pain, extremity injuries, fever, seizures, and wound care. "We also added an extra nurse, when available, in triage," he says.

In the past, when patients needed to be admitted, inpatient physicians would come down to the ED and write the orders. "Now, I call them on the phone, talk about the patient, agree on where they should go, and write the initial orders to get the bed moving," Klein notes.

Instead of taking patients from the minor injury treatment (fast-track) unit to the radiology department, the ED purchased a portable X-ray machine and hired a tech who was solely based in the ED. That alone saved 10-15 minutes per patient, Klein notes.

"The most important thing for me was to get everyone on board, to let them know they have a piece of this," says Klein. "It has become a culture change." ■

Tiered structure helps ED improve flow, satisfaction

Department cuts LOS 40 minutes

Between 2001 and 2005, average length of stay in the ED at Northwestern Memorial Hospital in Chicago has dropped from 85 minutes to 45 minutes. Throughput has fallen from 308 minutes to 230 minutes during the same period. In addition, patient satisfaction (Press Ganey Associates, South Bend, IN) scores have increased from 74.6% to 84%.

This improvement was due to a number of factors,

Executive Summary

Subdividing the major management tasks of one ED lightened the manager's load and gave staff a clearer idea of where to take their problems, helping to drop average length of stay from 85 minutes to 45 minutes, reduce throughput from 308 minutes to 230 minutes, and improve patient satisfaction from 74.6% to 84%.

- Where possible, divide responsibilities according to the talents of the individual nurse managers.
- A manager with ED and observation unit responsibilities improves communication between the units.
- Tiered staffing structure creates ready-made "team leaders" for departmentwide initiatives.

notes **James Adams**, MD, chairman of the department of emergency medicine. For one, the department instituted a comprehensive Six Sigma initiative during that time period. But perhaps one of the most unique strategies, and one that has clearly had an impact on the aforementioned improvement, was the redesign of the ED management structure.

"We have four nurse managers, and each has a subsegment of staff and shifts," Adams explains. The new structure, he adds, was adopted in fall 2003. The nurse managers are assigned as follows:

• There is a night manager who works 11 p.m.-9 a.m. four days a week.

• There is another evening manager who works from 2 p.m.-midnight four days a week.

• There are two 'day' managers, one of whom manages the observation unit (OU) and also has ED staff, while the other works entirely in the ED. Both of these managers work 8 a.m.-5 p.m., five days a week.

Managers split responsibilities

Their managerial responsibilities are further divided, explains **Deborah Livingston**, RN, MS, director of emergency services. "We've taken major pieces of what managers do, like staffing, salary and budget, quality management, and equipment, and assigned those responsibilities to each of them," she says.

Salary, budget, and staffing are assigned to the night manager. Quality management has been assigned to the evening manager. Equipment is assigned to the day manager who doesn't have the observation unit. The person who is upstairs with the observation unit and downstairs with the ED also manages staff educators, Livingston says.

They want to take advantage of efficiency in educational and orientation opportunities upstairs and downstairs, she adds. 'Why run two programs when you only need one?"

These responsibilities were assigned based on expertise, Livingston says. "We put a person who was incredibly meticulous with salary, budget, and staffing," she says. She also has a scheduler who works with her, Livingston notes. "We have quality nurses in the department who work with the quality manager," she says. They do all the callbacks for left without being seen (LWBS), radiology callbacks, and nurse quality data collection.

'Double-duty' valuable

The assignment of a single manager for the observation unit and part of the ED staff was an extremely important part of the improvement process, says Livingston. "It really helped us make initiatives between the two areas flow better, as she has staff and influence in both areas," she says. "It's a big part of why we have been so successful."

Once example is the "orange," or middle triage patients. (Northwestern has a five-level, color-coded triage protocol.) "These are mostly young, otherwise healthy patients with abdominal pain who would normally wait the longest," says Livingston. They often need a lot of tests and scans, she says.

The patients who go from the ED waiting room to the observation unit go there for their ED care, Livingston explains. "We call it 'ED2,' she says. "We have an emergency room attending up there at all times these patients are up there. They are registered as ED patients with a special code that denotes their different location." This change starts to drive the culture that patients should not wait, Adams says.

After they have received their ED evaluation and care, if they need observation care, they then are admitted to the observation unit for outpatient observation. They stay in the same room and bed. The patients are happy, as they avoid long waits in the ED and they have a bed and a TV, says Livingston.

Inpatient holding patients (select admitted patients waiting for an inpatient bed) are also placed up in the observation unit. "This unloads the ED and improves throughput, so patients don't wait as long to be seen," she explains, "With inpatient beds very tight, the [observation unit] is our most consistent outflow opportunity for the ED. We are creatively maximizing its use."

All programs affected

Livingston notes that the tiered structure not only directly impacts performance in the ED, but also contributes to the success of specific Six Sigma initiatives.

"It's great to have more than one manager to work on these initiatives we are making," she says. "We

Source

For more information on a tiered ED staff structure, contact:
- **James Adams**, MD, Chairman, Department of Emergency Medicine; **Deborah Livingston**, RN, MS, Director, Emergency Services, Northwestern Memorial Hospital, 251 E. Huron, Chicago, IL 60611. Phone: (312) 926-2000.

always team a nurse manager with a physician, and this gives us more people to go around."

Personally, Livingston is extremely thankful for the new structure. "This would be a lot of work for one manager to be doing," she concedes. "It also helps the staff because they have a go-to person for whatever they need. It creates much less confusion about who is doing what."

Of all the improvements engendered by the new structure, the most important are those that impact wait times and throughput, Adam asserts. "Quality in the ED is time-based," he says. ■

2-pronged approach improves pain recording

From 7.4% to 38.2% documentation

An intensive staff education program and a targeted revision of medical charting has enabled the pediatric ED at New York Presbyterian Hospital/Weill-Cornell Medical Center in New York City to boost pain score documentation from 7.4% before the intervention to 38.2% after its implementation.

While noting that "we expect *everybody* to have a pain assessment — it could be a zero," **Shari Platt**, MD, director of the pediatric ED, says her facility's performance is relatively good in an area of emergency medicine that clearly needs improvement. "In the literature, I've seen nothing above 50%," she says.

Only 45% of children scored

This statistic squares with the findings of a 2005 presentation at the American Academy of Pediatrics National Conference and Exhibition by **Amy Drendel**, DO, MS, assistant professor of pediatrics, Emergency Medicine Section, Department of Pediatrics at the Medical College of Wisconsin, Milwaukee. Drendel reported that from 1997 to 2000, only 45% of children nationally were receiving a pain score in the ED, based on statistics from the Centers for Disease Control and Prevention's *National Hospital Ambulatory Medical Care Survey* database.

A two-pronged effort

The NY Presbyterian/Weill-Cornell initiative, which grew out of a March 2004 project by **Carl Caplan**, MD, a fellow in the department of pediatrics, had two interrelated components. The first, involving staff education, included an introduction to the second component: a new way of charting.

For several years, the department had been using the Wong-Baker FACES Pain Scale,[1] a popular assessment tool that asks children to evaluate their pain along a continuum of "smiley" faces showing different levels of pain. "The triage nurse was using it in her initial assessment, the scale was posted on the wall, and the score was documented in the nursing notes," Platt recalls. "Where it *didn't* exist was in the physician notes, so we actually added the scale to the medical record."

Becoming more aware

Having the physicians documenting the pain scores is important, she explains, "because it makes you more aware of it, and I believe it makes you more conscious to go forward and treat the pain."

The education program involved a 10-minute computerized presentation, which was offered to individuals and small groups, notes Caplan. "Each of the physicians who were rotating through the ED during the study period was given an inservice," he reports. "This included a picture of the new chart design, an introduction to medical charting, as well as the scale and original instructions on using it."

Toward the end of the presentation, the residents and attendings were informed that traditionally pediatric pain has been undertreated and that they should pay

Executive Summary

Take a proactive approach towards staff education and charting procedures to improve staff performance in documenting pain in children.
- Hold regular inservices on an individual or small-group basis. Review importance of pain documentation and most common meds used.
- Make sure that physicians, as well as nurses, are encouraged to document pain in the medical record.
- Adjust your chart design so that commonly overlooked areas are more likely to catch the eye of staff members.

Source

For more information on pediatric pain documentation, contact:

- **Shari Platt**, MD, Pediatric ED Director, New York Presbyterian Hospital/Weill-Cornell Medical Center, 525 E. 68th St., New York, NY 10021. Phone: (212) 746-5454. E-mail: slp9001@med.cornell.edu.

specific attention to the children and their parents. "We also went over the different medications that might be used to treat pain, such as morphine and nonsteroidal anti-inflammatories like Tylenol," Caplan adds.

Following the presentations, charts were reviewed to see how often the physicians' notes made any reference whatever to the pain score, and the aforementioned increases were noted.

Treatment unaffected?

Interestingly, Caplan's study, also presented at the 2005 American Academy of Pediatrics National Conference and Exhibition, did not find any difference in *treating* pain, Platt says. However, the study looked only at pre- and post-treatment of pain in kids who had gotten scores of 6 or greater on a scale of 10, she says.

"At that point we were only looking at a small subset," says Platt, indicating that the scale is probably more valuable where lower levels of pain are involved, since children who are clearly in great pain naturally would be treated.

Still, says Caplan, the physicians' performance improvement in documenting pain probably was an accurate reading of the impact of the scale for those patients. "During the time of the study, they were only aware of being inserviced on a new medical record and charting — *not* that their behavior was being studied," he notes.

Increasing awareness

Still, Platt is eager to see more improvement. "I think we need to increase our awareness of measuring pain and treating pain," she says. "It's a big initiative in pediatric emergency medicine, and [the Joint Commission on Accreditation of Healthcare Organizations] requires pain assessment on everybody." The Joint Commission introduced pain standards in 2001, which included the requirement to conduct pain assessments.

"Using FACES is a great thing — it does help — but we need ongoing [continuing medical education]," Platt insists. "We have residents rotating through here, so every month we should re-emphasize how important pain scoring is. But in reality, the same person should go through [the inservice] on a regular basis."

Caplan agrees. "I think we need continuous presentations and medical education on a regular basis — and/or implementing some kind of lecture series or training in medical school or early on in residency," he says. "There's really not a lot of formal training in most institutions on how to treat pain in the acute setting."

Reference

1. Wong DL, Hockenberry-Eaton M, Wilson D, et al. *Wong's Essentials of Pediatric Nursing*, 6th ed. St. Louis: Mosby; 2001. ■

EMTALA Q & A

Inpatients in the ED: Caught between two worlds

[Editor's note: This column addresses readers' questions about the Emergency Medical Treatment and Labor Act. If you have a question you'd like answered, contact Steve Lewis, Editor, ED Management*, 215 Tawneywood Way, Alpharetta, GA 30022. Phone: (770) 442-9805. Fax: (770) 664-8557. E-mail: steve@wordmaninc.com.]*

Question: The ED is the melting pot of the hospital, treating all clinical needs and all society strata. In the midst of this mixture are patients transitioning from outpatient status to the inpatient setting, many of whom stay in the ED for hours waiting for an available bed. Does EMTALA apply to these admitted emergency patients? If not, what laws apply? Who is responsible for their medical care?

Answer: Before 2003, the Centers for Medicare & Medicaid Services (CMS) was undecided whether inpatients were covered by EMTALA, notes **M. Steven Lipton**, JD, an attorney with Davis Wright Tremaine in San Francisco who specializes in EMTALA.

The courts also were split. Two judicial circuits held that EMTALA did not apply to inpatients. One circuit applied EMTALA twice to inpatients who

were discharged in allegedly unstable conditions after hospital stays. One circuit applied EMTALA to a newborn waiting for neonatal transport. **(See more on this case below.)**

In the 2003 EMTALA regulations, the Centers for Medicare and Medicaid Services (CMS) decided that EMTALA did *not* apply to inpatients, Lipton says. CMS defined an inpatient as an individual who is admitted for bed occupancy with the expectation of remaining overnight and occupying a bed. In 2004, CMS reinforced this interpretation and stated that inpatients boarded in the ED awaiting a bed were not covered by EMTALA. Rather, their care was covered by the Medicare conditions of participation. Although the inpatient issue is settled for EMTALA enforcement purposes, Lipton says that only time will tell whether the courts that extended EMTALA to inpatients will change their views.

One ramification of inpatient status is the impact on the EMTALA obligation of hospitals to accept the transfer of patients with unstabilized emergency medical conditions who require a higher level of care.

For EDs, having EMTALA patients and non-EMTALA inpatients in the same department may be an odd match, says Lipton. Although the level and continuity of care must be consistent between patients with similar clinical needs, the regulations and typical hospital policies may vary.

As a first step, he advises, emergency and other hospital personnel must recognize who is an emergency patient and who is an inpatient. For example, is a patient comes to the ED with physician orders for admission an inpatient or emergency patient? Although admitting orders are necessary for inpatient status, many hospitals patients do not consider patients to be admitted until accepted by the hospital. Despite the admitting orders, Lipton advises that it is best practice to treat the individual presenting directly to the ED as an emergency patient. Perform a medical screening and initiate stabilizing treatment as clinically indicated, pending acceptance for inpatient status by the hospital.

Once the patient is admitted and waiting for a bed, the emergency and admitting physicians must have clear lines of responsibility for monitoring the medical status of the patient, he continues. Which physician is in charge? Who is responsible to monitor the status of the patient? Who writes the treatment orders? Who is responsible for staffing the patient? Does the staff assigned to the patient meet the patient's needs and acuity level (including hospital policies for inpatient staffing)? The answers to these questions should be addressed by the medical and nursing staffs, and reflected in policies and procedures, Lipson says.

One ramification of inpatient status is the impact on the EMTALA obligation of hospitals to accept the transfer of patients with unstabilized emergency medical conditions who require a higher level of care, Lipton says. If the individual is an inpatient, whether boarded in the ED or occupying an available bed, the EMTALA obligation to accept the patient does not apply (although state laws and contractual obligations may apply).

Another area of recent interest by CMS is the status of newborns delivered in the emergency setting. In 1999, a federal court applied EMTALA to a newborn waiting transport to a neonatal facility when the transferring hospital allegedly failed to treat or stabilize the infant before the transport. In May 2005, CMS released a policy memorandum addressing the application of EMTALA to newborns. The reason for the guidance was the 2002 enactment of the Born-Alive Infant Protection Act. That law requires that an infant born alive (whether by vaginal or cesarean delivery or by abortion) be considered a person under federal law, regardless of the prognosis for long-term survival, Lipton says.

In the memorandum, CMS stated that EMTALA applies to an infant born alive, and the hospital must provide a medical screening examination in two instances:

The infant is born alive in a dedicated ED (including most labor and delivery units), and there is a request by a parent for, or the infant needs, examination or treatment for a medical condition.

The infant born alive on hospital property outside of the dedicated ED, and there is a request by a parent for, or the infant needs, examination or treatment for a potential emergency medical condition.

However, Lipton adds, EMTALA does not apply when an infant born alive is an inpatient. Rather, the Medicare conditions of participation apply to the care and treatment of the infant after an inpatient admission. The Medicare conditions, he explains, require the

Source

For more information on the Emergency Medical Treatment and Labor act, contact:

- **M. Steven Lipton**, JD, Davis Wright Tremaine, Suite 600, One Embarcadero Center, San Francisco, CA 94111-3611. Phone: (415) 276-6500.

hospital to have policies and procedures for appraisal of inpatients who develop an acute medical condition. He adds that CMS is in the process of clarifying whether infants treated as inpatients from the time of delivery, the practice in most hospitals, are ever covered by EMTALA. ■

JCAHO unveils 2006 fixed performance areas

The Joint Commission on Accreditation of Healthcare Organizations has announced that for random unannounced surveys conducted in 2006, the fixed performance areas for hospitals are: assessment and care/service, medication management; patient safety; and the 2006 National Patient Safety Goals that are applicable to the services provided by the hospital.

Random unannounced surveys will continue to be performed, even after January 2006, when all accreditation surveys will become unannounced. In fact, the Joint Commission will continue the random unannounced surveys at least through 2008, says **Charlene Hill**, a spokeswoman for the Joint Commission.

5% receive random surveys

Since 1993, the Joint Commission has conducted one-day unannounced surveys on a 5% percent random sample of organizations in the ambulatory care, behavioral health care, home care, hospital, and long-term care accreditation programs. The surveys are conducted nine to 30 months following the accreditation date.

According to Hill, the key areas of focus for EDs should be:

- assessment and care;
- medication management;
- patient safety;
- leadership standard LD.3.15, which require leaders to develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital;
- applicable National Patient Safety Goals. For more information on the 2006 safety goals, go to the following web site: www.jcaho.org/accredited+organizations/hospitals/npsg/06_npsg_cah_hap.htm. ■

CE/CME instructions

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

CE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Explain** developments in the regulatory arena and how they apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CE/CME *questions*

19. According to Brian Decker, RN, CEN, the benefits of Computerized Physician Order Entry include:

A. Legibility of orders is ensured.
B. The order accurately reflects the medication chosen by the physician.
C. There is an automatic cross-reference of drug allergies.
D. All of the above

COMING IN FUTURE MONTHS

■ Infection control in the ED: How you can better handle it

■ 'Crowd risk' protocol a boon for pediatric leukemia patients

■ ACEP unveils first-ever state-by-state emergency medicine report card

■ Are we overprescribing antibiotics for children?

20. According to James Shultz, PhD, what percentage of patients are self-referred in disasters that involve evacuation?
A. 70%
B. 75%
C. 80%
D. 85%

21. According to David Klein, MD, his department formed a joint quality committee with all of the following departments except:
A. surgery.
B. radiology.
C. inpatient.
D. laboratory.

22. According to Deborah Livingston, RN, MS, the assignment of a single manager for the observation unit and part of the ED is beneficial because:
A. It improves flow between the two areas.
B. It lightens the load of the ED manager.
C. It avoids duplication of effort in educational programs.
D. All of the above

23. According to the *National Hospital Ambulatory Medical Care Survey* database, what percentage of pediatric patients receive a pain score?
A. 40%
B. 45%
C. 50%
D. 55%

24. According to M. Steven Lipton, JD, EMTALA does *not* apply to a newborn infant when:
A. The infant is an inpatient.
B. The infant is born alive in a dedicated ED and there is a request by a parent for examination or treatment for a medical condition.
C. The infant is born alive in a dedicated ED and the infant needs examination or treatment for a medical condition.
D. The infant born alive on hospital property outside of the dedicated ED, and there is a request by a parent for, or the infant needs, examination or treatment for a potential emergency medical condition.

Answers: 19. D; 20. C; 21. A; 22. D; 23. B; 24. A.