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IN THIS ISSUE

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EDs nurses are key to complying with new JCAHO medication goal

Surveyors will look very closely at this in 2006

Just as you're about to give intravenous penicillin to treat a fungal infection of the lower extremity, the patient mentions being allergic to a certain antibiotic, but can't recall which one.

Do you have a process in place to find out? And do you follow the procedure for every ED patient? If not, you're out of compliance with the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) National Patient Safety Goals requiring all patient medications to be reconciled.

In addition, the Joint Commission has issued a *Sentinel Event Alert* warning that dangerous drug errors are occurring because of lack of information about medications a patient is currently taking. **(To access the *Alert,* go to www.jcaho.org. Click on "Accredited Organizations," "Hospitals," "Sentinel Events," and "Sentinel Event Alert." Click on the Jan. 25, 2006, issue, "Using medication reconciliation to prevent errors.")**

Surveyors are "absolutely looking very closely" at this for 2006 surveys, reports **Richard J. Croteau**, MD, the Joint Commission's executive director for strategic initiatives. "We have ample evidence that a high percentage of medication errors are related to failure to know what a patient has been taking," he says. "If this is a problem in the ED, we'll be looking to see if it is also a problem in other areas, and also explore why it is a problem."

According to data from the U.S. Pharmacopeia, about 100 errors were

EXECUTIVE SUMMARY

During 2006 surveys, the Joint Commission on Accreditation of Healthcare Organizations will want to see that your ED has a consistent process for reconciling a patient's medications. A *Sentinel Event Alert* warns that dangerous drug errors are occurring because patient medications are unknown to caregivers.

- Ask to see prescription bottles when possible.
- Instruct patients to carry a list of their medications.
- Contact pharmacy or physician offices as needed.

reported in 2005 involving the ED's failure to reconcile a patient's medications, including wrong doses, double dosages, and patients given drugs they were allergic to. As a result, one patient was hospitalized after a 10-fold dose of pain medications.

Joint Commission surveyors are finding that many hospitals lack a formal process for medication reconciliation, says Croteau. "This is particularly true in the ED, where there are obvious urgencies competing for the provider's time and attention," he says. "But that doesn't preclude the basic principle that you need to know what medications a patient is currently taking before prescribing new medications."

How to reconcile

To reconcile medications in your ED, do the following:

• Ask patients to show you their medications.

During an assessment of a woman complaining of dizziness, ED nurses at St. Rose Hospital in Hayward, CA, asked to see her prescription bottles — and found she was taking lorazepam, temazepam, and diazepam — all different versions of the same drug. "Each one of the bottles had a different prescribing doctor's name and date of service," says **Bridget Aube**, BSN, RN, TNCC, interim nurse educator for the ED.

The patient told nurses she was taking one for "nerves," one for back pain, and one for sleeping. "I explained that all three medications are essentially the same and told her that this would probably explain her chief complaint — of bumping into objects at home with frequent falls," says Aube.

• Start the process at triage.

When Aube noticed elevated blood pressure in a patient being held waiting for a telemetry bed, she checked his medication list, realized the problem was probably due to missed doses of medications — and promptly got orders to continue the patient's home medications. "Within a half an hour, the patient's blood pressure was 115/82; he was smiling and no longer complaining of shortness of breath or a headache," says Aube.

This situation underscores the importance of starting medication reconciliation at triage — something the ED has implemented since then, says Aube. "If this process had occurred at the patient's point of entry or at least when the admission orders were written, the patient's care could have been more customized to his condition and history sooner," she says.

At University of Massachusetts-Memorial Health Care in Worcester, patients often missed doses while waiting to be seen or were given medications that could have interacted with something they already were taking, says **June Ellis**, RN, the ED's nurse manager.

A form was created to obtain medication history at triage. "We start the medication reconciliation right at the point of entry now and that follows the patient through their entire visit," Ellis says. **(See the ED's Medication Reconciliation Order Form on p. 63.)**

Initially, nurses were resistant because they didn't want to have to document medications twice, but this problem was solved by having nurses write "see attached" on the patient's chart and stapling the form to the chart. "For patients who are taking multiple doses of cardiac medications, nurses can give then their next dose while they are still in the ED," Ellis explains.

• Make sure medication information goes with the patient.

ED nurses at Shore Health System in Cambridge, MD, complete a separate medication reconciliation form for all admitted patients to ensure information

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UMassMemorial

UNIT NUMBER:

MEDICATION RECONCILIATION ORDER FORM

Allergies:

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OTC AND ALTERNATIVE MEDS
(ALTERNATIVE MEDICATIONS WILL NOT BE CONTINUED ON ADMISSION)
NEW MEDICATIONS OR MEDICATION CHANGES SHOULD BE WRITTEN ON ADMISSION ORDERS

PROHIBITED ABBREVIATIONS: qd, qod, U, IU, .X, X.0, MS, MSO4, MgSO4, μg, OD, OS, OU, AD, AS, AU, tiw

Source of Medication list: (check all used)

- ☐ Patient medication list
- ☐ Patient/Family recall
- ☐ Pharmacy _____
- ☐ Primary care physician list / PCHIS
- ☐ Previous discharge paperwork
- ☐ Medication Administration Record from facility
- ☐ Other:

☐ **CHECK HERE IF THIS IS AN ADDENDUM TO OR REVISION OF PREVIOUSLY COMPLETED MEDICATION LIST**

- ☐ Pregnant?
- ☐ Breastfeeding?

CIRCLE C to continue OR DC to discontinue

MEDICATION HISTORY RECORDED/VERIFIED BY: _____
DATE RECORDED: _____

MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg,)	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	PHYSICIAN ORDER CONTINUE ON ADMISSION
1.					C DC
2.					C DC
3.					C DC
4.					C DC
5.					C DC
6.					C DC
7.					C DC
8.					C DC
9.					C DC
10.					C DC
11.					C DC
12.					C DC
13.					C DC

Do not scan or take off orders without MD/NP/PA signature

Signature MD/DO/NP/PA_____ Printed Name_____ Pager #_____ Date_____

Signature RN_____ Printed Name_____ Date_____

Reviewed on Transfer: ☐ By: _____ Date: _____

Reviewed on Discharge: ☐ By: _____ Date: _____

Scan to Pharmacy. File under Orders with the History and Physical.

Source: University of Massachusetts-Memorial Health Care, Worcester.

isn't lost when the patient is "handed off." "If the staff is sure the patient will be admitted, the ED flow sheet is stamped, "See Med Rec Form," which is included in the inpatient record," says **Gail McWilliams** RN, MS, CCRN, CEN, clinical nurse specialist for the ED.

• Check for compliance with chart audits.

At St. Rose's ED, chart audits are being implemented to check that current medications and dosages are documented. "Rather than punitive measures for those that do not fill them out, I will speak with the main offenders to see if they have suggestions for improving the process and go from there," says Aube.

To solve the problem of lack of space to record detailed information, one ED nurse suggested using stickers or stamps with two checkboxes, one saying "patient does not take any medications," and the other saying "see medication reconciliation sheet." "But, with the form being quadruplicate, we would be going through a lot of man-hours for each sheet," Aube says. Instead, nurses came up with the idea of using a separate form for medication reconciliation for lists that will not completely fit on the chart, she adds.

SOURCES

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• Ask patients to carry their own lists.

The Joint Commission recommends instructing patients to bring a list of current medications to the ED. "We would like everybody to keep an up-to-date list," says Croteau. "Patients should be encouraged to do this."

At St. Rose's, ED nurses give wallet-sized business cards to all patients at triage and ask them to write down their medications and primary care physician's name. "If a nurse in the back end wants to give one to their patient, we encourage that as well," says Aube. "They are available to all nurses for distribution."

• Use outside resources.

ED nurses at University of Massachusetts-Memorial were able to find out which antibiotic a cellulitis patient was taking by calling the pharmacy, says Ellis. "We knew that one shouldn't be ordered since it wasn't working," she explains.

At Harney District Hospital in Burns, OR, the ED has an unwritten agreement with local pharmacies to obtain medication lists, refill histories, and allergies without a medical release of information, says **Julie Burri**, RN, ED clinical coordinator.

"I have never had a pharmacy tell me they would not release that information to me without a signed document," she says. EDs need to obtain the most current medication list possible for a patient, Burri notes. "This puzzle may have several pieces that we have to put together."

For example, a patient may have been prescribed 10 days of hydrocodone-acetaminophen, already gotten a refill, and also taken over-the-counter acetaminophen. "This would alert us that the patient may easily have a toxic acetaminophen level, and we would need to draw labs to see if this is influencing the patient's current status," says Burri.

At Missouri Baptist Medical Center's ED, nurses use the patient, the family, medication bottles, and area pharmacies as resources, and they update the list as new information becomes available, says **Sharon Monical**, RN, ED manager.

"When the patient doesn't know their medications, we call their pharmacy or physician office," she says. This information has changed a patient's treatment many times, as with patients taking sildenafil who can't be given nitroglycerin to treat angina pain, says Monical.

In addition, all patients receive an allergy band at triage with either "NKDA" (no known drug allergies) or specific drug allergies listed, says Monical. "All nurses inquire as to allergies, check allergy bands and two patient identifiers prior to any medication administration," she says. "This is done so that staff is constantly checking potential allergies on every patient, every time." ■

Expect a surge in drug-resistant bacteria

EDs are braced for an influx of these patients

Do you know the risk factors for community-associated methicillin-resistant *Staphylococcus aureus* CA-MRSA), *Clostridium difficile* (*C. difficile),* and other drug-resistant bacteria? ED nurses across the nation are reporting a dramatic surge in these cases.

"Emerging infections and antibiotic-resistant bacterial infections are a problem for every emergency department," says **Jeffrey A. Murphy**, RN, BSN, ED nurse at HealthEast St. John's Hospital in Maplewood, MN. "We are braced for an influx of these patients."

Since his ED's population of uninsured, underinsured, and homeless patients is increasing, Murphy expects to see many more cases of antibiotic-resistant infections.

A recent study found that CA-MRSA is the most common pathogen among patients with skin and soft-tissue infections at a Los Angeles ED,[1] and another study reports that *C. difficile* is causing significant increases in morbidity and mortality in 16 states.[2]

"This could have tremendous implications to ED nurses," says **Reneé Holleran**, RN, PhD, CEN, CCRN, CFRN, nurse manager for adult transport service at Intermountain Health Care LifeFlight in Salt Lake City. *"C. difficile* is a bacterium that is normally in our guts, but because of antibiotic overuse, people have been getting very ill with it." It causes profuse diarrhea and has been attributed with deaths, she adds.

To improve care of patients with drug-resistant bacteria, take the following steps:

• Obtain a detailed patient history.

The Centers for Disease Control and Prevention (CDC) recommends flagging patients with a history of antibiotic-resistant infections, notes Murphy. In his ED, all patients with previous diagnoses as "isolatable" are identified in registration, Murphy says. "We have a practice of coding the admit face sheet if the patient has a history of a resistant organism," he says. "This can alert the admit nurse to place in isolation in a timely manner."

If a patient recently was hospitalized and reports a recent infection, ask whether it was resistant to antibiotics, says **Jeffrey Brown**, RN, administrative manager for the emergency center at William Beaumont Hospital in Royal Oak, MI.

• Put patients in contact isolation and practice hand hygiene.

Wear gloves and gown and use universal precautions when caring for these patients, Brown advises. "The patient should be in a private room for their own safety and for other patients in the ED," he adds.

Brown's ED created isolation carts with all personal protective equipment in one spot, including disposable blood pressure cuffs, stethoscopes, masks, and gowns. It is kept in a central area to move outside the patient's room as needed, says Brown. "If we make staff run around to too many places, they are likely to skip a step to expedite patient care," he says.

Murphy says because most of these germs are spread by physical contact, often on environmental surfaces and bed linens, it is important that providers perform hand hygiene and that environmental surfaces be disinfected after these patients have occupied care areas. This will protect other immunocompromised patients and staff, he advises. "There may be patients with these germs that have not been identified," Murphy notes. "Consistent practices of good hand hygiene, and disinfecting the environment and items shared between patients, can control transmission between those we know about and those we do not."

• Err on the side of caution.

If a nursing home patient presents to the ED with dehydration, they usually are admitted under the assumption that they are positive for *C. difficile*, says Brown.

"If a patient came in from an extended care facility with diarrhea and was on long-term antibiotics, we put them in precautionary measures for *C. diff* before we rule it out via lab," he adds.

• Know risk factors.

The CDC has identified a broad range of risk factors for CA-MRSA, including athletes, military recruits, children, Pacific Islanders, Alaskan Natives, Native Americans, men who have sex with men, and prisoners. Factors associated with the spread of MRSA skin infections include close skin-to-skin contact, openings in the skin such as cuts or abrasions, contaminated items and surfaces, crowded living conditions, and poor hygiene.[3]

EXECUTIVE SUMMARY

ED nurses are reporting a dramatic increase in patients with drug-resistant bacteria, which can be life-threatening.

- Keep equipment for isolated patients in a single cart.
- Ask whether recent infections were resistant to antibiotics.
- Identify patients at high risk, including chronically ill individuals and nursing home residents.

SOURCES

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"These risk factors are very broad and don't seem to be too specific, but that is also the characteristic of this disease," says Murphy. "One of the most important factors is that the triage nurse conveys information regarding known antibiotic-resistant infection or risk factors and initiates isolation precautions immediately."

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Tips for improving your trauma care

It's a team effort

When mistakes are made during a trauma case, are these identified and discussed? Do nurses in your ED feel comfortable bringing their concerns to the attention of others during a resuscitation? Are new nurses given a chance to ask questions about trauma care?

These are all effective strategies for improving trauma care in your ED, says **Margot Daugherty**, MSN, MEd., RN, education specialist for trauma services at Cincinnati Children's Hospital Medical Center in Cincinnati.

Here are ways to improve trauma education of ED nurses:

• Make trauma education mandatory.

ED nurses at Cincinnati Children's are encouraged to participate in trauma rounds, attend trauma morbidity and mortality meetings, and become involved in the trauma performance improvement committee, says Daugherty.

In addition, nurses must obtain Trauma Nursing Core Course (TNCC) certification within a year of employment, and are paid to attend the classes, says Daugherty. "TNCC provides a systematic approach to the care of a trauma patient," she says. **(To find a course near you, go to www.ena.org and click on "CATN II/ENPC/TNCC.")**

An all-day trauma workshop is held annually that covers all phases of resuscitation. "We set up stations in the ED to orient nurses to the trauma bay, so they learn which equipment is located on the right and left side of the bed and what the role of each team member includes," says Daugherty.

• Focus on communication during codes.

Knowing the roles of each team member during a resuscitation is of the utmost importance to reduce errors, says Daugherty. "In a resuscitation bay, things can quickly become chaotic and confusing," she explains. "We respect that each team member has equal input, but there is only one conversation in the bay, with one team leader."

However, ED nurses are encouraged to point out concerns such as trends in vital signs that other team members might not notice in the flurry of activity, says Daugherty. It's OK to say, "I can't start this IV. You need to start a central line," she says. "It's a team, and no one should be intimidated by the senior surgical attending physicians. If a team member notices something that isn't quite right, it's the team member's

EXECUTIVE SUMMARY

Requiring certifications, attending trauma workshops, having experienced nurses act as mentors, and videotaping of trauma cases are all effective ways to improve care of trauma patients.

- During resuscitations, call out trends in vital signs or concerns immediately.
- Complete debriefings immediately after trauma cases to identify errors.
- Before patients arrive, nurses should warm the bay and prepare equipment.

Check these things after trauma cases

The following checklist is completed by ED nurses after trauma cases at OSF St. Joseph Medical Center in Bloomington, IL:

- ☐ Was a briefing with the entire team completed prior to patient arrival?
- ☐ Was the secondary and primary nurse assigned prior to arrival?
- ☐ Was all appropriate equipment in the room prior to patient arrival?
- ☐ Were call-outs completed during resuscitation?
- ☐ Were read-backs performed during resuscitation?
- ☐ Was the primary/secondary assessment called out to the entire team by the primary nurse?
- ☐ Did respiratory call out airway information to the entire team?
- ☐ Was the recording erased within five days?
- ☐ Did the staff involved do a debriefing afterward? ■

responsibility to point it out."

• Pair new nurses with experienced trauma nurses.

"In our ED, we have a team of core trauma nurses who are present at every resuscitation," says Daugherty. These nurses are required to attend higher-level inservices such as running simulated resuscitations, and they act as mentors to new ED nurses.

"This provides a steady source of information from a single individual, which is less overwhelming to a new nurse," says Daugherty. "Sometimes it's easier to ask questions when you have an established relationship with one particular nurse."

Real-life learning

• Videotape actual codes.

At OSF St. Joseph Medical Center in Bloomington, IL, traumas are digitally taped and reviewed by the ED team so nurses can identify mistakes and why they occurred, reports **Staci Sutton**, RN, BSN, TNS, emergency services manager. For example, nurses check to see that medication orders were read back and that nurses called out to the team after giving medications.

At first, nurses were resistant to the videotaping of resuscitations, says Sutton. "Many didn't feel comfortable because they felt like they were being watched," she says. "We had to do a lot of education with the staff to explain that the only people who view the tape are the team members who were actually involved."

If possible, the debriefing occurs right after the case, and at minimum, staff are required to do a verbal debriefing, says Sutton. "Debriefing sheets are completed and turned into the ED manager or trauma coordinator for review," she adds. **(See checklist used by ED nurses, this page.)**

Commonly observed mistakes include call outs that don't get heard or information that is not relayed, says Sutton. "A patient may be getting intubated, but that information isn't shared with the group, or a nurse didn't yell out the vital signs so we don't know the pulse oximetry, or the patient may fibrillate but no one calls it out," she says.

These errors are very easy to spot when watching the recordings, says Sutton. "It's very easy to get caught up in doing your own task and fail to see the bigger picture, so it's very important that debriefings are held," she says.

During debriefings after trauma cases at Children's, one area of focus is preparation before the patient arrives in the ED, says Daugherty. "When we have notification and the team arrives, the expectation is that the nurses have the bay warmed up, checked all of the equipment, and any equipment is opened that they anticipate needing, such as a chest tube drainage system," she explains.

ED nurses also are asked to watch for instances of poor communication, says Daugherty. "What we are listening for is who is calling out the orders."

If orders are coming from the anesthesiologist, the ED physician, and the team leader, the tape is stopped to point out that three people are giving orders. "That increases the chance of a mistake," she says. ■

SOURCES

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What do you do when a physician's order is unsafe?

ED nurses may be held liable

What would you do if a pulmonologist asked you to give a medication subcutaneously when it was approved only for intramuscular injection (IM)?

"I told him I was not comfortable doing this, but he tried to persuade me to do so by explaining why it was safe," says **Kathryn Eberhart**, BSN, RN, CEN, a Santa Rosa, CA-based legal nurse consultant and ED nurse at Santa Rosa Memorial Hospital.

"I elicited the help of one of the ED physicians who agreed with me, and together we discussed it with the pulmonologist," she recalls. The medication eventually was given IM, and Eberhart documented this in an incident report.

ED nurses often hesitate to question a physician's order, but nurses are liable in a malpractice suit if adverse outcomes occur as a result, warns **Jackie Ross**, RN, a Chagrin-Falls, OH-based ED nurse and risk management expert. "Several claims have involved nurses failing to question an order, either a medical treatment or medications," she reports. "Nurses are professionals and will be held accountable for their actions and inactions in a court of law."

Follow these steps if you feel a physician's order is not safe:

• Use the chain of command.

"If there is an order that a nurse is not comfortable completing, then don't do it," says Eberhart. "Seek the advice of the charge nurse, and if you are still not satisfied, go up the chain of command."

As an ED nurse, you are the patient's advocate — and that includes questioning orders that are unsafe or unfamiliar, says **Darlene Bradley**, RN, MSN, CCRN, CEN, director of emergency and trauma services at the University of California-Irvine Medical Center in Orange.

EXECUTIVE SUMMARY

If an ED nurse follows a physician's order and a patient is harmed as a result, nurses can be held liable in a malpractice lawsuit.

- If you feel an order is unsafe, don't follow it.
- Consult with your charge nurse, and then follow the chain of command.
- Don't document disagreements in the patient's chart.

Say this when you feel orders are unsafe

Use the following as examples of what to say when you feel a physician's order is unsafe, recommends **Pamela S. Rowse**, RN, quality/risk consultant for the ED at St. Rose Dominican Hospital in Henderson, NV:

- "Dr. Smith, I have an order from you related to Patient X, and it doesn't appear to be appropriate for this patient's care and presentation."
- "Dr. Smith, You have given an order for this medication in this dosage, and it is outside of the parameters for administration dosage or route."
- "Dr. Smith, I can't in good conscience follow this order because of the potential danger. I have contacted my supervisor who is going to be contacting your department chairman." ■

"If the nurse still feels the order is unsafe, she should refuse to follow-through and let her manager and the physician know why," says Bradley. "If the issue cannot be resolved for instance by an attending physician, the nurse would go up the chain of command and if necessary involve the nursing leadership to mediate."

• Document the incident.

A confidential incident report should be completed if appropriate, but the details of conflicting opinions shouldn't be included in the patient's chart, says Eberhart.

After the issue is resolved, the medical record should simply reflect that the previous order was cancelled and a new order was given, says **Patricia Iyer**, RN, MSN, LNCC, president of Flemington, NJ-based Med League Support Services, a legal nurse consulting firm specializing in malpractice and personal injury cases. "It is not necessary to highlight in detail your concerns after the order is rescinded," she advises.

• Don't hesitate to speak up.

Research shows that health care professionals are reluctant to voice concerns, even when patient safety is at stake, Iyer notes. "The ED nurse must always remember the responsibility to speak for the patient who cannot speak for himself or herself," she says. "The prescriber needs a safety net — an individual who will detect an error. The nurse is in the position to be that safety net."

She gives the example of a physician about to discharge a man complaining of chest pain, when a nurse

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intervened by suggesting that he be held in the ED evaluate his cardiac enzymes. "During this observation, the patient's chest pain worsened, and a decision was made to admit him to the CCU," says Iyer.

When in doubt, research

Remember that distraction, fatigue, and a host of other factors interfere with providing safe orders, says Iyer. "Then you will be able to diplomatically but firmly question an inappropriate order," she says.

If there is any doubt in your mind, seek verification that you are correct, recommends Iyer. "Check a drug dosage using the resources available to you or do a quick Internet search to verify that your concerns are valid, or speak to a more experienced colleague," she says.

Armed with the knowledge that your concern is valid, approach the physician with what Iyer calls an "I" message. For instance, use the following wording:

"I have concerns about administering 10 mg of morphine to this infant. The *PDR* recommends not exceeding 0.3-0.6 mg/kg per dose. Can we rethink this?" **(See box on p. 68 for more examples.)**

"This is better than saying, 'I can't give this. You give it!'" Iyer says. "Some prescribers may blunder ahead, even in the face of that kind of warning." ■

New psychiatric guidelines: What ED nurses must know

Many diagnostic tests are unnecessary

New guidelines from the American College of Emergency Physicians will affect the way you care for adult psychiatric patients in your ED, according to **Stephen J. Wolf**, MD, a member of the panel that authored the guidelines and director of the emergency medicine residency program at Denver Health Medical Center.

"The implications of this policy are pretty profound," he says. "It hopefully will change the culture of EDs across the country." **(To access the guidelines, go to www.acep.org. Under "Practice Resources," click on "Clinical Policies," "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department.")**

When patients present to an ED with a psychiatric complaint, many diagnostic tests usually are ordered up front, including a complete blood count, CHEM-7, liver function tests, and urine toxicology screen.

"ED nurses should be aware that a lot of these tests that are ordered in almost knee-jerk fashion. Our policy says they are not necessarily needed," says Wolf. "What should be ordered are only those tests driven by medical complaints that will result in a change in medical management."

Many psychiatric facilities will insist that certain tests be ordered to ensure that there are no medical issues that might arise while the patient is in their care, notes Wolf. "The thought is that extensive testing can ensure this. In fact, our review found that testing does not provided additional information over a thorough history and physical," says Wolf.

However, it is important for ED nurses to recognize that a psychiatric patient can have medical issues and that many psychiatric symptoms can be caused by medical illnesses, says **Carol A. Ziolo**, RN, LCPC, a mental health liaison specialist for the ED at Northwest Community Hospital at Arlington Heights, IL. "Medical clearance is crucial to a psychiatric patient's treatment plan," she adds.

For example, Ziolo cared for one patient who complained of confusion and sadness, with a history of bipolar disorder. "We were ready to admit her to our mental health unit until her blood results showed she was in kidney failure," she recalls. "She want to a medical floor, and her mental status improved when her kidney function improved."

Another man came to the ED psychotic and

SOURCES

For more information on care of psychiatric patients in the ED, contact:

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- **Carol A. Ziolo**, RN, MA, LCPC, Northwest Community Hospital, 800 W. Central Road, Arlington Heights, IL 60005. Telephone: (847) 618-4145. Fax: (847) 618-3996. E-mail: CZiolo @NCH.org.

disoriented with a history of a depression. "Everyone thought he was experiencing a psychiatric psychosis until a CAT scan showed he had bleeding in his brain that required surgery," says Ziolo.

At Northwest Community, the ED nursing director met with the psychiatric hospitalist and ED medical director to discuss the medical needs of psychiatric patients, and a decision was made to give psychiatric patients a "mental health panel" consisting of a complete blood count, comprehensive metabolic panel, urine drug screen, blood alcohol levels for patients with a history of alcohol abuse, and pregnancy test for all women of childbearing age.

Intoxicated patients are seen by a psychiatrist on a medical unit if they have taken a supratherapeutic ingestion of medication or harmful substance, says Ziolo. "We will also ask that a CAT scan of the brain be done in the ED if the patient has an altered mental status and no history of mental health issues," she adds.

Drug screens are important to determine if you need to watch for any type of withdrawal or the patient is in a substance-induced psychosis, says Ziolo. "Also, the drug screen can help determine disposition, mental health vs. substance abuse treatment, especially in adolescents," she says.

Agitated patients usually are medicated with haloperidol and lorazepam IM, says Ziolo. **(For more information on this topic, see "Are you sedating agitated psychiatric patients safely? *ED Nursing*, July 2005, p. 106.)**

"We offer PO [lorazepam] to people who are anxious, agitated, but cooperative," says Ziolo. They haven't been using ziprasidone as often because it is not as effective as haloperidol in chronic patients, she adds.

To keep staff current on pharmacological management of agitated patients, Ziolo and other mental health liaisons attend inservices from drug companies and educate ED nurses. "Also, we suggest the drug company representatives talk with the medical director of the ED so she can educate the ED physicians during their monthly meetings," she says. ■

Are children unsupervised in your ED? Know the risks

You could be at risk for a lawsuit

A baby girl is unhurt in a motor vehicle accident, but her mother needs X-rays. An unconscious man is about to be admitted, and his two small children tell you that all their family members live out of state.

Both cases result in unattended children spending time in your ED. It's a frustrating problem, but you may not realize that this also is legally risky, warns **Stephen A. Frew**, JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals.

"Unless there are dedicated personnel assigned to watching children, I recommend against separating the parents and children except in serious injury cases," he advises. In those cases, social services personnel should be contacted to come to the ED to provide supervision and make efforts to secure family care or other protective services, says Frew.

"Separating the children from the parent typically results in more problems and disruptions than tolerating the children in the treatment area, unless family members are available to watch the child or children in the waiting area," says Frew.

EDs should have policies and protocols that assign

EXECUTIVE SUMMARY

Unattended children can pose legal and risk management risks for emergency nurses. If you are aware of risks and fail to protect a child, you could be held liable.

- If a parent is being admitted, contact social services to make arrangements if necessary.
- Don't use videotapes or enclosed play areas as substitutes for adult supervision.
- Assign specific staff members the job of contacting family members.

SOURCES

For more information on unsupervised children in the ED, contact:

- **Stephen A. Frew**, JD, Vice President-Risk Consultant, Johnson Insurance Services, 525 Junction Road, Suite 2000, Madison, WI 53717. Telephone: (608) 245-6560. Fax: (608) 245-6585. E-mail: sfrew@johnsonins.com.
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responsibility to specific staff members to follow up on family contacts, advises Frew.

At Gwinnett Medical Center in Lawrenceville, GA, if the patient is in the ED being treated and child care is needed for a short period of time, an ED technician is assigned to care for that child, says **Denise Proto**, RN, MS, CEN, nurse educator for emergency services. However, if the patient needs admission, the ED nurse contacts social services to make arrangements if necessary, says Proto.

"Of course, our optimal hope would be that a family member would be contacted. But if not, other arrangements — including possible intervention from the Department of Children and Family Services — would take place," she says.

Whenever possible, children are kept with their parent, and family members are contacted as needed, says **Kathy Hendershot**, RN, director of clinical operations for the ED at Clarian Health Partners in Indianapolis. "We are very fortunate to have child-life specialists for 12 hours a day from the pediatric area," she says. "They have been very supportive when called to help watch children until we can get someone else in here."

Social workers, chaplains, and secretarial staff are other possibilities, depending on the situation, says Hendershot. "We get very creative," she says. "I have had children in my office until we can get help."

Providing entertainment such as videotapes and an enclosed play area can be helpful, but are not a substitute for adult supervision, notes Frew. "State laws may vary on what constitutes a child care facility," he says. "Also, safety and infection control must be considered for any toys provided."

Staff supervision needed

Even when the children are with the parent, some degree of staff supervision may be required for safety reasons and also to ensure that treatment of the patient isn't hindered, says Frew.

He points to a lawsuit involving a 3-year-old boy who ran around an ED unsupervised, collided with a treatment table, and ended up with a gash on his forehead. "The child was promptly and effectively treated, but the mother filed a claim on a theory of malpractice by the nurse in failing to contain the patient's child," says Frew. The matter was denied as a malpractice claim by the professional liability insurer and settled for a waiver of the child's bill and parent's copay through the general liability carrier, reports Frew.

"This type of case is often handled through the risk

CE instructions

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

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

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

COMING IN FUTURE MONTHS

- How EDs are handling a surge in meth overdoses
- Proven ways to cut delays at triage
- What Joint Commission wants to see for stroke patients
- Dramatically improve cardiac care with point-of-care testing

management department without ever involving an insurer, but points out that hospitals are potentially dangerous places for unsupervised children," he says.

An ED may be potentially liable for failing to protect a child if staff are aware of a risk, says Frew. "Obviously allowing a child to handle dangerous instruments, hang on equipment that might fall over, or ingest drugs awaiting use would represent serious risk of suit if the nurse were aware of the risk and fails to act," he says. ■

Our Condolences

Nancy Eckle, RN, MSN, longtime board member for *ED Nursing* and *ED Management*, has died after an extended illness. We send our condolences to Eckle's family and her co-workers. ■

CE*objectives/questions*

Participants who complete this activity will be able to:
- **identify** clinical, regulatory, or social issues relating to ED nursing;
- **describe** how those issues affect nursing service delivery;
- **integrate** practical solutions to problems and information into the ED nurse's daily practices, according to advice from nationally recognized experts.

13. Which of the following is recommended to reconcile medications in the ED, according to Julie Burri, RN, ED clinical coordinator at Harney District Hospital?
A. Avoid contacting the primary care physician's office.
B. Obtain a list of prescriptions and allergies from the patient's pharmacy.
C. Do medication reconciliation for inpatients only.
D. Contact pharmacies only during life-threatening emergencies.

14. Which of the following is recommended for drug-resistant bacteria cases, according to Jeffrey Brown, RN, administrative manager for the emergency center at Beaumont Hospitals?
A. To avoid patient flow problems, don't isolate patients unless infections are confirmed.
B. Use standard precautions only for nursing home patients.
C. Ask patients whether previous infections were resistant to antibiotics.
D. Isolate patients only if they report specific risk factors.

15. Which is recommended to improve care of trauma patients during resuscitations, according to Margot Daugherty, MSN, MEd., RN, education specialist for trauma services at Children's Hospital Medical Center?
A. Having a single team leader giving orders.
B. Asking all team leaders to give orders as needed.
C. Avoiding interruptions to note trends in vital signs.
D. Never calling out concerns unless life-threatening.

16. Which is recommended if you feel a physician's order may be unsafe, according to Kathryn Eberhart, BSN, RN, CEN?
A. Follow the order and consult with the physician afterward.
B. Document your concerns in the patient's chart.
C. After completing the order, file an incident report.
D. Follow the chain of command to report your concerns.

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