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IN THIS ISSUE

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ED nurses must stop these triage mistakes that could get them sued

Suits against ED nurses may increase due to crowded waiting rooms

A triage nurse tells the ED physician that two young boys have high fevers and rashes, but fails to mention one crucial fact: that two ticks were removed from one of the boys. As a result, the boy was misdiagnosed with measles when he actually had Rocky Mountain spotted fever, and he died as a result. The ED nurse was held liable for negligent conduct.[1]

In another case, a triage nurse failed to tell a man with flu-like symptoms to stop taking over-the-counter acetaminophen, although hydrocodone-acetaminophen was prescribed. The man was sent to X-ray for an outpatient ultrasound, but hours later, he came back to the ED with an altered level of consciousness.

"By the time he arrived back in the ED, his glucose was 21, and he was obviously jaundiced with fulminate hepatic liver failure from an accidental [acetaminophen] overdose," says **Kathryn Eberhart**, BSN, RN, CEN, a Santa Rosa, CA-based legal nurse consultant and ED nurse at Santa Rosa Memorial Hospital. "He subsequently died a few days later from the liver failure."

If a complete triage assessment had been done, the liver failure probably would have been recognized earlier and the man might not have died, says Eberhart. The case settled for an undisclosed amount.

Mary Ann Shea, JD, RN, a St. Louis-based legal nurse consultant, says, "Lawsuits alleging negligent triage arise when the nurse fails to identify and act upon an emergency condition in a timely manner. This can even happen to a well-informed triage nurse who fails to perform the assessment steps necessary to recognize the emergent nature of the patient's condition."

Overcrowding and long wait times are increasing liability risks for ED

EXECUTIVE SUMMARY

Triage nurses are at increased risk for liability risks because of long wait times and ED overcrowding, according to risk management experts.
- Always perform a thorough assessment.
- Have pre-designated nurses help with triage during peak volumes.
- Flag charts with "priority" labels, and list the time of the last reassessment.

nurses, according to Shea. "Nurses might feel pressured to triage faster and fail to complete an adequate examination," she says.

Shea says she would not be surprised to see lawsuits against triage nurses increase. "More patients are being pushed through at a faster pace than some nurses can safely handle," she says.

At Carondelet St. Mary's Hospital, a number of interventions were done to improve safety in triage. "We struggle with the same problem as most EDs, with long waits to be seen," reports **Diana Platt Lopez**, RN, BSN, clinical educator for emergency services. Nurse satisfaction also was an issue, she says. "Who wants to work in triage, if all the patients are upset because of the waits?"

Reassessment of patients waiting to be seen is a major challenge, notes Lopez. "The issue is that the 55 beds you have in the ED are your patients, but so are the other 50 out in the waiting room waiting to get inside," she says. You need to reassess those persons and upgrade them if their condition deteriorates, Lopez warns. "That is a real challenge when your staff is already busy and your triage staff are busy seeing the new 'in-comers' who haven't been looked at yet," she says. **(For more information on this topic, see "Are patients with life-threatening conditions in your waiting room?" *ED Nursing*, August 2005, p. 109.)**

To reduce liability risks, do the following:

• Don't give patients false reassurance.

When frantic parents told a triage nurse that their infant had turned blue at home and seemed very sick, they demanded to see a physician immediately. To calm them, the triage nurse reassured them that the baby would be fine and told them to wait. The parents left the ED, and the child died later that night.

Because the triage nurse failed to take a complete history and didn't bring the baby to the physician's immediate attention, the hospital was ordered to pay almost $2 million for negligence.[2]

"A comprehensive triage needs to be completed, including documentation of that comprehensive triage," says Eberhart. Document the time of contact with the patient, a triage assessment, the conversation that took place, and the specific words you told the patient such as "please don't leave" or "the child needs to be seen," says Eberhart.

Under the Emergency Medical Treatment and Labor Act (EMTALA), any patient who comes to the ED requesting care or treatment needs a medical screening examination performed by a qualified medical person, which in many cases is the emergency department physician on duty, stresses **Sue Dill**, RN, MSN, JD, director of hospital risk management for Columbus, OH-based OHIC Insurance Co. False assurance never should be provided, she adds. "Nurses do not diagnose. Physicians do. Setting accurate and realistic expectations is important."

• Provide frequent inservices.

ED nurses at Carondelet complete an annual self-learning packet on triage protocols that addresses changes to triage such as medication reconciliation or how to manage behavioral health patients when the ED is full.

"We fortunately have not had any mistakes related to under triage for a long time," says Lopez. "All of our staff who are new to ED nursing get a full day of didactic lecture on triage and spend time training with the triage nurses after they have been here about six months."

• Use dedicated triage nurses.

At Carondelet's ED, throughput time was slower when dedicated triage nurses weren't used, because some nurses were unfamiliar with protocols. "Also, dedicated triage nurses were the ones who suggested

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and developed all of our triage protocols in conjunction with our ED physicians," says Lopez. For example, nurses order X-rays at triage based on assessment findings using the Ottawa Ankle Rule criteria. **(See protocol used by the ED's triage nurses, this page.)**

• Add nurses to triage as volume increases.

During peak volumes at Carondelet's ED, Mobile Assistance Team (MAT) nurses assist with procedures and triage. "Our MAT nurses are our more experienced nurses who can see 'the big picture' of what is going on and where they are most needed as helping hands," says Lopez.

The policy is, if the triage nurse has more than six charts in the rack waiting to be triaged, they contact the MAT nurses or charge nurse for help until they catch up. "We have up to three MAT nurses in the department at any given time, based on volume," says Lopez. **(See job description of the ED's MAT, p. 100.)**

• Flag charts with "priority" labels.

Laminated pink-colored sheets labeled "Priority" are used at Carondelet's ED, with a blank space for nurses to write the last time assessed. "They also serve as covers to protect [protected health information]. In case anyone is walking by, they can't see any patient information on the chart in the rack," says Lopez.

• Do sufficient charting.

If a nurse walks by the chart rack to place a patient in a room, they should be able to look at the triage assessment and know what the patient's complaint is and whether that patient needs a specific room for treatment or has any special needs, says Eberhart.

"There is usually too brief of a note that really doesn't

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Protocol to Order Foot X-Rays

PURPOSE

1. To use the Ottawa Ankle Rule to initiate foot X-rays
2. To provide the triage nurse with a tool to appropriately assess and order foot X-rays when necessary.

ASSESSMENT

1. Obtain history form patient to include:
   - A. Mechanism of injury
   - B. Time of injury
   - C. Force of injury
   - D. Pregnancy history of females of child-bearing age (for X-ray purposes)
2. Assess neurovascular status of injured extremity
3. Palpate injured extremity
4. Assess for pain in midfoot zone and bone tenderness at the base of the fifth metatarsal (little toe) or bone tenderness in the navicular zone (refer to Ottawa Ankle diagram)
5. Assess for lacerations and abrasions
6. Assess for deformity
7. Determine range of motion before and after injury
8. Assess for inability to bear weight both immediately and in emergency department
9. Obtain tetanus history in presence of broken skin

INTERVENTIONS

1 Initiate appropriate X-ray order based on assessment findings (refer to Ottawa Ankle Rule diagram)
2. Apply ice pack and elevation to injuries less than 24 hours old
3. Splint any obvious deformity
4. Provide wheelchair or stretcher for safety or comfort when possible, or assist patient into comfortable position
5. Flag chart to indicate to Registration that X-ray is ordered
6. Refer any patient with vague complaints or when soft tissue injury is suspected to a licensed independent practitioner before ordering X-ray

DOCUMENTATION

1. Document assessment and interventions on ED service record
2. Assist patient to appropriate waiting area

Source: Carondelet St. Mary's Hospital, Tucson, AZ.

Mobile Assistance Team (MAT) Nurses

Description

The Emergency Center (EC) MAT is comprised of a Registered Nurse and LPN or Patient Care Technician. MAT(s) work together to facilitate patient flow throughout the Emergency Center. MAT(s) work closely with the EC Charge RN, Triage RNs, Bedside RNs, EC Physicians, as well as ancillary and support staff for provision of patient care throughout the Emergency Center. MAT members will be a highly motivated and self-directed individuals who possesses excellent communication skills.

Roles and responsibilities

1. Assist triage team.
2. Members of PAGE team for newly arrived patients, including disrobing, gowning, monitor hook up, IV starts, blood draws, triage assessment, inventory and securing patient belongings.
3. Responsible for reassessment of all patients in sub waiting areas.
4. Assist bedside nurses with all areas of patient care including care, comfort, hygiene, and toileting.
5. Assist in answering patient call lights.
6. Assist with set up of any trays, as needed.
7. Assist physicians with any procedures, as needed.
8. Assist with answering telemetry calls, as needed.
9. Assist with codes, team 200, moderate sedations, 1:1 patient care, and accompany patients needing to be transported for tests as needed.
10. May accompany critical "ground transports" to another facility.
11. Assist to expedite discharges.
12. During department "down time," covers staff to attend inservices and complete mandatory EC and hospital continuing education.
13. Assist with completion of the medication reconciliation form.
14. Expedite admissions.
    - checks that correct room has been requested;
    - review admit orders;
    - rncourages EC physicians to write admission orders;
    - calls report;
    - transports critical patients to intensive care unit.
15. Cover meal breaks for EC staff.
16. Any other duties as assigned.

Source: Carondelet St. Mary's Hospital, Tuscon, AZ.

tell the reader much," she says. "Many triage nurses do not fill out the history section or don't pull the history out of the patient."

Eberhart points to a recent case in which the triage nurse documented a history of "liver disease" and "many meds." The patient's husband alleged that nurses never asked how severe the liver disease was. The woman subsequently died due to hemorrhage, and a lawsuit was filed. "The patient had been worked up weeks earlier for a possible liver transplant," she recalls. The verdict was for the defense, but if the patient had been triaged appropriately, it's likely the patient would have survived and the case never would have been filed, Eberhart adds.

"Patients don't understand how a separate disease process can affect their injury. It's a nurse's responsibility to elicit the history and dig for those answers to the best of their ability," she says.

• Don't ignore "gut feelings."

Sometimes it's just a "sixth-sense" feeling that a patient is really sick, says Eberhart. She gives the example of an elderly cancer patient who complained of not feeling well after a fall. "I reached over and felt for a pulse, which was weak and thready," she recalls. Eberhart immediately hooked her up to a cardiac monitor. The patient was in ventricular tachycardia, Eberhart says.

"I could have spent much longer in triage trying to discern what was wrong with her," Eberhart says. "It really was a gut feeling and nothing I can absolutely put my finger on."

References

1. *Ramsey v. Physicians Memorial Hospital,* 36 Md. App. 42, 373 A.2d 26 (1977).
2. *South Fulton Medical Center, Inc. v. Poe,* 480 S.E. 2d 40 (Ga. App., 1996). ■

Can you prove you told a physician about symptoms?

If you don't document, you could be held liable

If you tell an ED physician that a patient's condition changed for the worse and the patient later sues, can you prove what you said?

A change in condition always should be communicated to the physician, with the time of notification documented as well as the physician's response, says **Trish Murray**, RN, BN, CEN, ED nurse manager at Houlton (ME) Regional Hospital. "If the nurse doesn't document that they let the physician know, then they have no recourse if the physician doesn't act on the information and the patient condition continues to deteriorate," she says. **(See documentation policy, this page.)**

Murray gives the following example of good documentation: "BP decreased to 90/70, pt now diaphoretic. Pt placed in Trendelenburg position. Dr. Jones notified of change in condition at 0900, order for fluid bolus received. BP increased to 111/80 after fluid bolus, Dr. Jones notified, in to evaluate patient at 0930."

The ED has a "notifying a physician" policy that addresses this specific issue. It is the result of a chart review in which a change in condition was reported to the physician and acted on, but with no documentation that the notification occurred. The policy states that the ED or attending physician will be notified by nursing staff when a patient experiences a change in condition including deterioration in vitals sign, decreased level of consciousness, change in mental status, and increased pain. The policy also states that this verbal notification will be documented in the record by the nurse and will include the time of the notification and the name of the physician notified.

"Sometimes in the busy ED environment, we take things for granted, like our interactions with physicians," says Murray. "Things can happen so fast, so the policy was put in place as a reminder to staff."

Document the patient's vital signs, any associated signs, symptoms, or other clinically important conditions, and any actions that you have carried out, says **Jeff Strickler**, RN, clinical director of emergency services at University of North Carolina Hospitals in Chapel Hill. "Ideally vital signs should be verified, with documentation of what method was used to take them," he says.

When documenting, answer three questions, says Strickler: Who was told, when they were told, and how they were told. For example: "Dr. Smith notified via phone at 1810 that patient BP 80/50, checked x 2 via NIBP."

"Think in bullet points" when conveying a change in a patient's condition to the physician, advises **Jennifer Williams**, RN, BC, CEN, CCRN, clinical nurse specialist for emergency services at Barnes-Jewish Hospital in St. Louis. "Give the physician a one-sentence situation update, one sentence on background, and one sentence on your current assessment. Then ask for the plan," she says.

The ED implemented the "SBAR" approach, which stands for Situation, Background, Assessment, Response, and Recommendation, for communicating critical information between health care providers.

Williams gives the following example to say to the physician: "Dr. Smith, I have a 62-year-old female with chest pain. She has been started on nitro and heparin, aspirin is given, currently chest pain is 7/10 and was a 4/10 on arrival. Vitals are now HR 112, BP 88/50, RR 22, and pulse ox is 95% on 4L Nasal Cannula. This represents a change from initial vitals of HR 88, BP 110/60. I have held the nitro drip due to her blood pressure. What would you like done if her blood pressure and heart rate continue to change? What is your threshold for implementing the plan?"

Include the name of the physician you spoke with, the time, what you communicated, what their plan was, and what actions you have taken, suggests Williams. She gives the following example: "Updated Dr. Smith at 2316 on patients decreasing blood pressure and increased heart rate. Informed nitro drip was on hold. Dr. Smith ordered

Take these steps when notifying ED physicians

Below is the policy used by ED nurses at Houlton (ME) Regional Hospital to notify a physician of a change in a patient's condition:

Purpose: To ensure timely notification by nursing staff to the ED or attending physician when a change in patient condition occurs, and to ensure accurate documentation of such notification.

Procedure: The nursing staff shall timely notify the ED physician or attending physician, as applicable, when a patient being treated in the ED experiences a change in condition.

Such a change in condition includes, but is not limited to: Deterioration in vital signs, change in mental status, decreased level of consciousness, increased pain, or other relevant change related to the patient's symptoms or diagnosis. The nurse shall document this oral notification in the ED record and shall include the name of the physician notified and the time of the notification. ■

SOURCES

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additional IVF and to hold nitro until blood pressure stabilizes above 120 systolic. IVF bolus initiated. If vitals continue to deteriorate, Dr. Smith to be notified for additional treatments."

"After you initiate the actions, document the patient's response and that you communicated the results to the physician," says Williams. "If they do not want to initiate any treatments, this should be noted as well." For example: "IVF Bolus completed, patient now with BP 126/72, HR 88. Nitroglycerin infusion restarted at 3 mcg/min and will monitor vital signs. Patient reports pain is 5/10 at this time. Dr. Smith notified of improvement in patient condition at 0040, and no further treatment ordered at this time." ■

What is policy for 'range' orders? JCAHO will ask

Unclear drug orders can put you at risk

Are nurses in your ED given "range" orders for pain and other medications, without specific dosages and frequency of administration? This prescribing practice puts patients at risk, says **Susan F. Paparella**, RN, MSN, director of consulting services for the Huntingdon Valley, PA-based Institute for Safe Medication Practices.

She gives the example of an order for "Tylenol 325 mg-1,000 mg 2-4 hours PRN for headache, fever, or pain." "We refer to these as 'don't bother me orders' because the prescriber is writing a broad order to cover almost anything," she says. "The nurse is left to decide how much, how often, and for what reason."

Range orders results in variation in care since different nurses will choose different doses and frequencies, says Paparella. "Getting a handle on what the patient actually received and measuring its effectiveness is particularly difficult to do," she says. "There is really no reason for a prescriber to give range orders."

Instead, specific orders should be tied directly to a pain scale or other objective measure, says Paparella. She suggests the following example order: "For a pain scale rating less than X, give Drug A one tablet po prn pain every four hours. For a pain scale rating X-Y, give Drug B mg IV prn pain every four hours. For a pain scale rating of Y or greater, give Drug C mg IV prn pain. For pain unrelieved with Drug C, contact the prescriber."

"That way, the order is not open to interpretation," says Paparella. "Anything else borders on being ambiguous." If range dose orders are written in the ED, the nurse should ask the prescriber for clarification, so the order is clearly understood, she adds.

If an order such as "Morphine 2-4 mg every 3-4 hours prn for pain" is written without a policy in place for guidance, this leaves the criteria for medication administration up to nursing judgment, says **Gail Williams**, RN, CCRN, CEN, clinical nurse specialist for the ED at Shore Health System in Cambridge, MD. "Legally, this could be interpreted as practicing medicine without a license," she says.

If range orders are used in your ED, you need to specify the required elements of that type of order, says **Anita Giuntoli**, associate director of the standards interpretation group at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If those required elements are not present in a range order, then the nurse or pharmacist must clarify with the prescriber exactly what is intended

EXECUTIVE SUMMARY

If medication orders don't give specific dosages and frequencies, they could put patients at risk, according to patient safety experts.

- Dosages should be tied directly to a pain scale or other objective measure.
- Orders should not be vague or left up to nursing judgment.
- Assess the patient's response to medication before and after each dose.

SOURCES

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for that patient, she adds.

"Allowing for too much discretion for those interpreting the order can potentially put a patient at risk and may have nurses practicing outside of their scope of practice," says Giuntoli. "The range order should be written so specifically that every nurse or clinician working with that patient would be able to interpret and implement that order exactly the same way."

At Shore Health System, the ED's policy states the shortest time interval ordered will be the official time increment, with a system for correlating the patient's numerical report of pain with the nursing assessment to determine medication dosage, says Williams.

At Methodist Hospital in Indianapolis, physicians no longer give range orders, reports **Mary J. Ross**, RN, BSN, CEN, charge nurse in the Emergency Medicine Trauma Center. "We made this change over a year ago due to a JCAHO recommendation," she says. "Now the practice in the ED is that a nurse and physician assess the patient's response to all medication before and after each dose." Here are the steps that occur:

• A written order is given for a specific dosage, such as 4 mg of morphine.

• Before the drug is given, the nurse asks the patient to rate their pain, gives the pain medication, and performs a reassessment in 15-30 minutes.

• If the patient has had little result, the nurse then takes the patient chart back to the physician and relays the patient's response, so the physician then will write an order for additional medication.

"Sometimes it is a different medication, sometimes it is a repeat of the same dose of medicine, and sometimes it is a larger dose of the same medication," says Ross. "It all depends on the patient's response to the medication that was given."

In some cases, the physician goes to the room to reassess the patient and writes an order for additional medication, adds Ross. In this case, an assessment of the patient's drug response before and after each dose is documented. "After this assessment, the nurse can get another order for additional medication," she explains.

The pain assessment is done before and after medications are given, by asking patients to rate their pain from 1-10. "We also use nonverbal cues to assess pain," Ross says. "We audit the ED charts every month to assess compliance." ■

Blood poisoning cases on rise: Ask these questions

Patients can deteriorate quickly into septic shock

A 74-year-old woman presents with slight fever, weakness and confusion. Would you suspect septicemia?

"During the first hour in the ED she was hypotensive, tachycardic, and was developing tachypnea," recalls **Linda Young**, RN, MSN, faculty at Montana University College of Nursing-Missoula Campus. "Her chest X-ray showed a small right lower lobe pneumonia."

During the patient's stay in the ED, her blood pressure and oxygen saturation continued to fall and her breathing continued to worsen, so she was admitted to the intensive care unit.

Patients with septicemia, a potentially deadly bacterial infection of the bloodstream also known as blood poisoning, can deteriorate quickly if the condition

EXECUTIVE SUMMARY

Cases of septicemia are increasing in EDs. Treatment delays increase mortality rates, so a thorough assessment is key.

- Antibiotics should be started immediately.
- Patients don't always present with the classic signs such as fever and chills.
- If elderly patients report confusion, suspect septicemia.

progresses into sepsis, says Young. "It can be unusually quick and in some cases virulent," she says. "If antibiotics and fluid resuscitation are started early, it may be helpful in halting progression into septic shock."

The number of septicemia cases increased from 666,000 cases in 1993 to more than 1 million cases in 2003, according to statistics from the Agency for Healthcare Research and Quality. In 2003, almost 75%, of all admissions to the hospital for septicemia came through the ED (290,000 cases).

"In our ED, it isn't uncommon to see septicemia one to two times a month," says **Ken Lanphear**, RN, an ED nurse at Borgess Medical Center in Kalamazoo, MI. "Considering all the problems with antibiotic resistant organisms that are now so prevalent, it's safe to assume that the number is already increasing, or in the near future it will be."

Sepsis can result from local dissemination of infection, via lymph or septicemia, which is widespread dissemination by way of the blood stream, explains Young. "Delay in treatment is associated with a higher mortality rate, so it should be started immediately," she says. "Development of sepsis in a person who has undergone chemotherapy and has a very low white blood cell count is an extremely serious matter and can lead to death."

Although specific risk factors should be identified, sometimes it's more of an overall "look" to the patient that is a red flag, says Lanphear. "They just look 'sick,' — pale and weak," he says. Vital signs may be an indicator, but not always, Lanphear says. The usual questions about fever and chills need to be asked," he says. "But you also need to look for a potential source that would explain why this patient doesn't feel well."

Look for a prior infective process, such as a patient reporting a cold a week or so prior, respiratory infections, skin lesions, a recent urinary tract infection, open skin wounds, recent use of an antibiotic, or use of an immunosuppressant. "Usually, there isn't one thing as so much as a combination of factors," says Lanphear.

In addition, patients don't always present with the classic signs of septicemia, says Young. "Fever, tachypnea and hypotension may not always be present at first," she says. "A person may come in feeling 'sick,' with low-grade or even subnormal temperature. Diagnosis may be difficult until lab work is drawn."

Ask the following questions, recommends Young:

• Have you had any recent infections of any kind, whether treated or not?

• Have you had any recent trauma, lacerations, or severe bruising?

• Do you have any indwelling lines?

• Are you taking any medications that may lower the immune response such as chemotherapy or radiation treatments, use of corticosteroids, or use of immunosuppressants for transplant, rheumatoid arthritis, or multiple sclerosis?

• Do you have any history of intravenous drug use? "This is becoming more prevalent, as persons will wait until the site is abscessed and are sick from it before they will go to the ED," says Young.

Elderly patients often present with nonspecific symptoms, says Young. Many times the families will bring in their elderly family members and are concerned that they have had a stroke, she says. "This is because confusion is a hallmark sign, especially in an otherwise healthy, oriented person," says Young.

Any elderly person who has been doing well who develops confusion and weakness, after stroke is ruled out, should be worked up for possible sepsis, says Young. "Much of the time a urinary tract infection is the culprit," she says. "Patients may present with low-grade fever, with weakness and confusion the only symptoms."

ED nurses should make sure that all labs are done in a timely fashion, says Lanphear. "I draw cultures when I draw other labs and hold them until I receive the order if I suspect septicemia on my initial assessment," he says. "Antibiotics should be started in the ED, before the patient goes to their assigned bed in the hospital."

As soon as the initial complete blood count comes back with an elevated white blood cell count, cultures are drawn if not already done, and a broad spectrum antibiotic usually is ordered and administered, says Lanphear.

Antibiotics should be started even before cultures are drawn, if necessary, emphasizes Young. "Broad-spectrum antibiotics are usually started until blood cultures identify specific organisms," she says. "IV fluids

SOURCES

For more information on septicemia, contact:

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and antibiotics should be started in the ED for certain, especially in the person with neutropenia."

At Edward Hospital in Naperville, IL, antibiotics are started in the ED after cultures are drawn for admitted patients. "We've found that giving antibiotics in the ED vs. the floor prevents a tremendous delay," reports **Sharron Chivari**, RN, APN-CNS, clinical leader for the ED. "The process of admitting patients has become lengthier due to volume, and administering antibiotics in the ED can save up to a four-hour delay." ■

Use standing orders for pain treatments

Don't make children wait for relief

If a child comes to your ED in severe pain but without a life-threatening injury or illness, would that child have to wait for hours before receiving pain medications?

To speed care, ED nurses are using standing orders for pain management at triage. "Our triage nurses are empowered to begin pain management preparation from the start of the child's visit," says **Marianne Hatfield**, RN, BSN, system director of emergency services at Children's Healthcare of Atlanta.

Here are steps taken by ED nurses at triage:

• A topical numbing cream is placed onto common sites for intravenous (IV) lines, such as the back of the hand or the antecubital area of the arm, for any patient they suspect will require a peripheral IV or lab draw based on complaint, such as fever of unknown origin, vomiting, or abdominal pain. "We briefly explain to the parent/guardian the purpose of the cream at that time," says Hatfield. For example, ED nurses say, "Based on your child's current symptoms, it is possible that lab work may be required in order to diagnose and treat them. This cream is placed to numb the skin in preparation for this possibility, so that your child will not be subjected to unnecessary pain."

• Oral pain medications are given to children experiencing pain prior to placement in a treatment room, such as acetaminophen, ibuprofen, or acetaminophen and codeine for more severe pain.

• A topical form of lidocaine with epinephrine and tetracaine is applied to lacerations during the triage process to begin numbing the site in preparation for repair.

At Johns Hopkins Hospital's pediatric ED in Baltimore, children are screened for pain as part of the triage assessment. "The screening tool is selected by the nurse based on the patient's age and communication ability," says **Mary Ellen Wilson**, RN, BSN, nurse clinician III/base station coordinator at the ED. Assessment may include the intensity and location of the pain, alleviating or aggravating factors, effectiveness of the patient's present regimen, pain management history, effects of the pain on the child's daily life, physical examination, observation, and past medical history, says Wilson. "Acetaminophen and ibuprofen may be given for pain relief as a standing order by a nurse at the time of patient triage without a physician order," she says. Here are the indications:

• Pharmacologic management of pain is used for patients 6 months of age or older experiencing pain related to ear infection, sore throat without drooling or respiratory compromise, and orthopedic injury with no

EXECUTIVE SUMMARY

Use standing orders so triage nurses can give pain medications to pediatric patients. This increases comfort and allows children to tolerate interventions more easily.

- Put a topical numbing cream for patients who will need an intravenous line or lab draw.
- Include pain assessment in triage.
- Perform nonpharmacologic interventions.

SOURCES

For more information on pediatric pain management, contact:

- **Marianne Hatfield**, RN, BSN, System Director of Emergency Services, Children's Healthcare of Atlanta, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 785-4968. E-mail: Marianne.Hatfield@choa.org.
- **Mary Ellen Wilson**, RN BSN, Nurse Clinician III/Base Station Coordinator, Johns Hopkins Children's Center, Pediatric Emergency Department, 600 N. Wolfe St., Baltimore, MD 21287. Telephone: (410) 955-5680. E-mail: mewilson @jhmi.edu.

obvious deformity.

• Patient must not have a pre-existing condition that contraindicates the use of analgesics, such as hepatic dysfunction, clotting disorder, oncology patients, thyroid disorder, renal disease, or gastrointestinal bleeding.

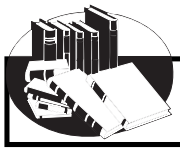
• The patient must not have an allergy to either medication, and the patient must not have received a dose of the medication in the last four hours for acetaminophen or in the last six hours for ibuprofen.

Nonpharmacologic interventions also are initiated early and may be used in conjunction with pharmacologic management, says Wilson. "Physical comfort measures, such as splinting an extremity, cold or warm compresses, positioning, covering wounds, and massage may help minimize pain and are initiated at triage," she says. "For infants, stroking, cooing, or a pacifier can be comforting."

By having a standing order for pain management at triage, the patient may able to tolerate subsequent exams, procedures, or interventions more easily, says Wilson. "Pain can be very distracting to the child and may limit the physical exam and assessment," she explains. "Also, documentation of the patient's response to the intervention may assist with assessment and diagnosis. It also may contribute to a decrease in length of stay in the ED."

Triage nurses may be hesitant to administer medications in fear of masking a more serious illness or injury, notes Wilson. To address this concern, the ED's protocol at Children's Healthcare of Atlanta states, "There is no diagnostic or therapeutic benefit to being in pain. A single dose of oral analgesic rarely, if ever, delays surgical or medical treatment. In fact, reduction of pain sometimes clarifies a diagnosis. Our goal is to not only diagnose and effectively treat the cause of pain, but also to alleviate the symptom as quickly as possible."

Also, if pain relief has been obtained, the parent or caregiver may leave before the child is assessed, diagnosed, and treated. "This obstacle is minimized with good communication with the family, and well as frequent reassessment of the child's condition while in the waiting room or treatment area," says Wilson. ■



JOURNAL REVIEW

Biroscak BJ, Smith PK, Roznowski H, et al. **Intimate partner violence against women: Findings from one state's ED surveillance system.** *J Emerg Nurs* 2006; 32:12-16.

Emergency nurses need to improve documentation of female assault and maltreatment in ED records, says this study from the Michigan Department of Community Health in Lansing.

Researchers looked at 3,111 patient records for female assault and maltreatment victims over two years for the 23 EDs participating in the Michigan Intimate Partner Violence Surveillance system. Chart review confirmed 2,926 incidents of physical and/or sexual violence, with 1,136 involving intimate partner violence. "Clear, complete, and concise documentation is still the crucial factor in effective surveillance," wrote the researchers. They recommend the following to educate ED nurses about documentation requirements:

• inviting them to participate in hospital protocol development;

• having them attend continuing education programs and sessions aimed at improving documentation, familiarizing nurses with the legal requirements of reporting, and helping women create safety plans;

• collaborating with local domestic violence programs.

". . . Emergency nurses are in an excellent position to recognize patients affected by [intimate partner violence] and lead a multidisciplinary approach to intervention," say the researchers. ■

NEWS BRIEF

Pneumatic tubes cut lab turnaround times

Using a pneumatic tube delivery system for transporting blood samples from the ED to the laboratory can reduce turnaround times significantly, says a recently published study.[1]

Researchers compared turnaround times for two EDs, one with a pneumatic tube system and the other using human couriers. Blood samples delivered with a pneumatic tube system took were 33 minutes for hemoglobin and 64 minutes for potassium, compared with 43 minutes for hemoglobin and 72 minutes for potassium when samples were transported by hand.

The study also found that when specimens were hand-carried, they could sit for significant periods of time waiting to be picked up, because delivery was

SOURCE

For more information on use of pneumatic tube systems in the ED, contact:

- **Christopher Fernandes**, MD, Professor and Head of Emergency Medicine, McMaster University, 237 Barton St. E., Hamilton, ON L8L 2X2, Canada. E-mail: christopher_fernandes @sympatico.ca.

dependent on a health care aide being available.

The samples delivered by hand had a trend toward increased hemolysis, though not statistically significant, says **Christopher Fernandes**, MD, the study's lead author and professor and head of emergency medicine at McMaster University in Ontario, Canada. "The study's findings imply that centers without a pneumatic tube system would have significant delays in turnaround time on lab samples, as well as potential redraws due to hemolysis," he says. "The end result is more work for emergency nurses to achieve the same result."

Reference

1. Fernandes CMB, Worster A, Eva K, et al. Pneumatic tube delivery system for blood samples reduces turnaround times without affecting sample quality. *J Emerg Nurs* 2006; 32:139-143. ■

Use fanny pack to store trauma supplies

ED nurses at University of Utah Hospital in Salt Lake City created a fanny pack to use for trauma cases, which puts commonly used drugs at nurses' fingertips. "The trauma pack contains many incidentals that are needed to work a trauma patient," says **Alison Wright**, RN, BSN, nurse educator for the ED. "It is very helpful because frequently we have five minutes or less to prepare for a patient."

Items in fanny pack

The pack is ideal to use when transporting patients to computed tomography and radiology. It is filled by the pharmacy and contains the following items:

- assortment of syringes and needles;
- alcohol wipes;
- medications: promethazine 25 mg vial, cefazolin 1 gm bottle, normal saline 10 cc bottles, and vecuronium bromide 10 mg bottle.

"The routine is for the nurse to check out morphine, [midazolam HCI] and [dolasetron] and add it to the zipper pocket," says Wright. ■

SOURCE

For more information, contact:

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COMING IN FUTURE MONTHS

- ■ Stop dangerous errors during change of shift
- ■ How ED nurses are complying with timeout procedures
- ■ What JCAHO surveyors are asking about medication safety
- ■ Questions to ask if you suspect prescription drug abuse

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 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.

1. Which is recommended to avoid liability risks with triage, according to Diana Platt Lopez, RN, BSN?

A. Do a brief triage assessment when waiting rooms are crowded.
B. Reassess patients waiting to be seen.
C. Reassure worried parents that their child will be fine.
D. Avoid using dedicated nurses for triage.

2. Which should be documented when physicians are told about symptoms, according to Jeff Strickler, RN?

A. Document changes in treatment plan only.
B. Avoid documenting the exact time of your communication.
C. Don't name specific physicians unless inappropriate care is given.
D. Document who was told, when they were told, and how they were told.

3. Which is recommended when accepting orders for medications in the ED, according to Susan F. Paparella, RN, MSN?

A. Nurses should be given a range of dosages when administering pain medications.
B. Dosages should be specified, but frequency should be left up to the discretion of the nurse.
C. Dosages should be determined based on assessment using a pain scale or other objective measure.
D. When range orders are used, the largest dosage should be given first.

4. Which is recommended for patients with blood poisoning, according to Ken Lanphear, RN?

A. Look for risk factors such as recent infections or antibiotic use.
B. Don't consider antibiotics unless hypotension and fever are present.
C. Rule out septicemia if fever is not present.
D. Don't administer antibiotics before cultures are drawn.

Answers:
1. B; 2. D; 3. C; 4. A.