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IN THIS ISSUE

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Joint Commission's 2007 safety goals will revamp ED nursing practice

New goals require you to involve patients in their care

Do you identify patients at risk for suicide? Do you give patients a list of their medications? And do you encourage patients to report safety risks? These are some of the changes you'll need to make to comply with the 2007 National Patient Safety Goals from the Joint Commission on Accreditation of Healthcare Organizations.

"To be safe, health care has to be done as a team activity, and the patient is arguably the most important member of the team," says **Richard J. Croteau**, MD, the Joint Commission's executive director for strategic initiatives.

Here are the new requirements with strategies for each:

• Encourage patients to report concerns about safety.

At McKay-Dee Hospital Center in Ogden, UT, "We urge patients to be involved with their own care and to report safety concerns by statements in their discharge instructions, which are reviewed with them," says **Kayleen L. Paul**, RN, CEN, care center director for emergency, critical care, and trauma services. "We also include the name and phone number of our care manager on every discharge instruction and urge them to give us feedback about any issue they might have."

The statement invites questions about ED care, medications, follow-up instructions, or aftercare. "We are considering adding the specific word 'safety,'" she says. For example, the statement may be changed to read, "If you have any questions or concerns about your care or safety in the ED or about your follow-up care, please call . . ."

Patients have called the ED to confirm that they received the correct medication, says Paul. "The prescription medication may look different in size and

EXECUTIVE SUMMARY

The Joint Commission's National Patient Safety Goals for 2007 will require ED nurses to identify patients at risk for suicide, give patients a list of medications on discharge, and encourage patients to report safety concerns.
- Add a statement to discharge instructions asking patients to report concerns.
- Update patient medication lists electronically.
- Ask patients to give feedback about their care.

color than the dose we gave, and patients have called to clarify that it's the right medicine," she says. "It's always been a case of the pharmacy using a generic and not a medication error, but I always praise people for their attention to important details."

Invite patients to report safety concerns by handing out a brochure, posting a sign, or discussing this at triage, recommends **Darlene Bradley**, RN, CNS, CCRN, CEN, MICN, FAEN, director of emergency/trauma services at University of California-Irvine Medical Center in Orange.

"Inform the patient that health care staff are interested in safety and will listen to any concern the patient would like to address," she says. "Letting the patient know that the organization wants to provide a safe and secure environment opens the door for that discussion to continue."

Patients have voiced safety concerns about wet floors and the risk of infection if an infiltration occurs with intravenous infusion, says Bradley. "Patients also question blood transfusions, disease transmission, and fear of receiving the wrong blood," she adds. "When patients witness caregivers complete the double-check to validate the right blood for the right patient, the anxiety subsides."

• Involve patients in their care.

At Barnes-Jewish Hospital in St. Louis, ED nurses explain that they need to ensure that the correct patient is getting the correct treatment, says **Jennifer Williams**, MSN, RN, BC, M-S CNS, CEN, CCRN, clinical nurse specialist for emergency services. "We inform the patients on arrival that care providers will ask them their name and date of birth while confirming it with their armband many times, specifically before medications and procedures," she explains. **(See article on p. 111 for other ways to involve patients in their care.)**

• Identify patients at risk for suicide.

If your ED is caring for psychiatric patients, surveyors will expect to see that patients are assessed for risk of suicide, says Croteau. "The fact is that patients sometimes do commit suicide in the ED itself." In addition, if patients aren't admitted, there is a risk of suicide after they leave the ED, he adds.

Many EDs are reporting significant increases in the number of psychiatric patients, notes Croteau. "Any time the volume goes up, it puts pressure on available resources, but that is not a reason to do the right thing," he says.

Don't miss suicide risk

Assessment of suicide risk may be a major challenge for many EDs, says **Kathleen A. Catalano**, RN, JD, director of health care transformation support for Perot Systems, a Plano, TX-based provider of information technology services and business solutions.

"EDs are prepared for that if they are one of the behavioral health receiving centers, but otherwise, they may not know how to deal effectively with the issue."

At McKay Dee, the ED collaborated with the psychiatry department to put crisis workers in the ED to help with assessment of psychiatric patients. "Some patients are clearly brought in for a crisis evaluation by family, police, or themselves," says Paul. "For other patients, especially trauma and those involving medication 'mistakes,' the nurses are trained to have a high index of suspicion and frequently consult the crisis worker."

Suicide risks often are identified by the person accompanying the patient, says Bradley.

To assess suicide risk, she suggests using quick assessment tools such as "SAD," an acronym standing for:

— **S**ex, because women attempt suicide three times more often than men;

— **A**ge, because individuals 19 years or younger

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and 45 years or older are at greater risk;

— **D**epression, which is a good indicator of suicide risk.

"The presence of the three criteria may warrant a closer assessment by the nurse," says Bradley. She also recommends the "PERSONS" assessment:

— P, previous attempts at suicide;
— E, ETOH (alcohol abuse);
— R, an inability to think rationally;
— S, a lack of social support;
— O, an organized plan for the suicide;
— N, no spouse;
— S, a chronic or disabling sickness. **(For more information on assessment of potentially suicidal patients, see "Use these tips if you suspect a suicidal patient," *ED Nursing*, June 2005, p. 92.)**

ED nurses routinely screen patients for violence and abuse at Barnes-Jewish Hospital, says Williams. "Perhaps the biggest challenge is continuing to ensure consistency in screening our patients," she says. "We need to ensure that every patient is provided the same level of screening from every ED nurse."

• Give patients a complete list of medications on discharge.

"Provisions for listing all medications at discharge may be a challenge for many EDs," says Bradley. Give patients a wallet-size card with the medications, dose, frequency, and purpose for each medication listed, she recommends. "All patients should be encouraged to carry such tools," Bradley says.

A medication list could be given to patients with discharge instructions or as a wallet-sized card, says Paul. "If given as a pocket card, there needs to be some way to change doses, or add and subtract medications," says Paul. **(To download a wallet-sized medication card at no charge, go to the Utah Department of Health web site: health.utah.gov. Click on "Patient Safety." Under "Consumer Information," click on "Patient safety materials you can use in your facility." Under "Using Your Medication Safely — a Guide to Prescription health," choose English or Spanish version.)**

Having an electronic medical record that can update medication lists with each visit is key to doing this list effectively, says Bradley. The University of California-Irvine's ED uses a "problem list" in which care problems and medications are listed.

Upon arrival to the ED, the listing is updated and verified with the patient. At registration, the list is automatically printed for every patient. As the care is completed, changes to the list are entered and validated.

"The list is available to all health care providers in the hospital and the clinics who are caring for the patient," says Bradley. "The printout at discharge is then used to evaluate the drugs, review side effects, and analyze for drug interactions." Errors, potentially harmful drug interactions, and discrepancies are identified through this process, she says.

Patients don't realize that vitamins, minerals, and herbal supplements can interact with other medications and can be hazardous, and these often are not reported to ED nurses, says Bradley. "Patients that frequent multiple institutions including doctor's offices and hospitals generally get a medication for each complaint," she says. "The failure to report these and document the types, doses, and frequency of use can be a significant hazard to the health of the individual." ■

5 ways to involve ED patients in care

The 2007 National Patient Safety Goals will require you to involve patients in their care. Here are some ways to do this in the ED, says **Darlene Bradley**, RN, CNS, CCRN, CEN. MICN, FAEN, director of emergency/trauma services at University of California-Irvine

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Medical Center in Orange:

• Allow patients to choose the method of pain relief they are given.

• If a surgical procedure is performed, have the patients participate in the identification of the correct site.

• Ask the patients if they would like to read or watch television when wait times are lengthy.

• Ask patients to participate in minor procedures, such as applying pressure over a bleeding site or holding a dressing as tape is applied to secure the site.

• Give choices about the treatment plan, such as having the labs drawn before going to radiology. ■

Flu shot requirement adopted by JCAHO

JCAHO will require shots to be given on-site

Does your ED offer influenza vaccine to staff? This will be a requirement from the Joint Commission on Accreditation of Healthcare Organizations, effective Jan. 1, 2007.

The Joint Commission developed the standard in response to recommendations by the Centers for Disease Control and Prevention (CDC) making the reduction of influenza transmission from health care professionals to patients a top priority in the United States.

Currently, less than 40% of health care workers are immunized each year, according to the CDC. Health care-associated transmission of influenza has been documented among many patient populations in a variety of clinical settings, and infections have been linked to unvaccinated health care workers.

The standard requires you to establish an annual influenza vaccination program for staff with flu vaccine given on-site. In addition, staff must be educated about the flu vaccination; nonvaccine control measures such as the use of appropriate precautions; and diagnosis, transmission, and potential impact of influenza.

At Clarian Health Partners in Indianapolis, "we currently have a vaccination program in place for all employees," reports **Kathy Hendershot**, RN, director of clinical operations for the ED. "When vaccines are in short demand, the ED direct caregivers are identified as high risk and get priority vaccine." Last year, 64% of staff received the vaccine in the ED, she reports.

All ED staff are inserviced every year about the vaccine and the illness, and they have to sign a refusal if they are unwilling or unable to take the vaccine. "Once the season hits us, we have guidelines as to when you cannot work, vaccinated or not," says Hendershot. "Of course, we educate all our staff about cough etiquette, hand washing, and mode of transmission."

A new system is needed to track which staff have been vaccinated, she says. "Right now, I only track how many I vaccinate," she says. "This does not account for those who are unable to receive the vaccine or receive the vaccine elsewhere. We will have to add this to our database." A system to track vaccination of employees can help you predict possible vacancy rates during flu season and determine availability of staff for certain infectious disease outbreaks such as avian flu or smallpox, says Hendershot.

In addition, knowing who is not vaccinated can help you to protect staff most at risk of being exposed during a flu outbreak, she adds. "We should have a process to place this person somewhere other than triage to decrease the likelihood of exposure."

About 50% of ED nurses receive the flu vaccine at Southern Ohio Medical Center in Portsmouth. "I don't expect the number to increase much," says **Betsy Marsh**, RN, assistant ED nurse manager. "Employees either want it or they don't, based on their past experience."

At Gwinnett Medical Center in Lawrenceville, GA, ED nurses have been offered the flu vaccine in the ED for the past four years, says **Sandy Vecellio**, RN, BSN, clinical manager for emergency services.

They have nurses schedule times in the ED so that staff can get the vaccine, she says. "Everyone is offered it, and we have about 60% that take it," says Vecellio. Someone is scheduled to give the vaccines on all shifts, she says. "It works well." ■

SOURCES

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Spinal cord injuries require special care

Early ED interventions are key

Patients with acute spinal cord injury are at risk for spinal shock and or neurogenic shock, and hypotension and bradycardia are major concerns, says **Jean M. Marso**, RN, BSN, trauma coordinator at University of Colorado Hospital in Denver.

"In addition, there may be respiratory impairment, depending on the level of the cord injury," she adds.

Spinal cord injury patients present many challenges to ED nurses, says Marso. "Patients with suspected or known spinal cord injury need 1:1 monitoring, so that ties up at least one nurse," she says. "Early interventions are key, because these patients cannot be kept in the ED for long periods of time. Rapid surgical intervention, if needed, is imperative."

To improve care of acute spinal cord patients, do the following:

• Make sure patients are adequately resuscitated.

A well-resuscitated patient is more likely to have a favorable outcome than one that is underresuscitated, says **Timothy J. Murphy**, nursing director of trauma and injury prevention at Robert Wood Johnson University Hospital in New Brunswick, NJ. "We used to advocate limiting fluids with patients suffering [central nervous system] injury to limit expansion of any lesion," he explains.

However, patients who maintain their blood pressure and mean arterial pressure are less likely to suffer ischemia and hypoxia, which tends to contribute to secondary injury, says Murphy. "So adequate fluid administration, blood component use and vasopressors should be considered for the spinal cord injured patient," he says.

However, usually hypotension in a spinal cord patient is due to vasodilatation and not volume loss, unless there is another reason such as hemorrhagic trauma or a burn, says Marso. Therefore, if it is not volume loss, hypotension in a spinal cord injury patient would be treated with pressor agents instead of volume replacement, she says. "It is imperative that these patients not be volume overloaded due to erroneously suspecting volume loss as the cause of hypotension when it is not," stresses Marso.

If patients are volume overloaded, acute respiratory distress syndrome is likely to occur, says Marso. "If this occurs, the patient would most likely require ventilatory support, which then puts the patient at increased risk for ventilatory dependence and infection," she adds.

• Know current research on steroids.

According to a new study, steroids continue to be given to patients with acute spinal cord injury mainly out of fear of litigation.

"Although steroids are given to spinal cord injury patients in many EDs, there is no proven benefit to this," says **John R. Hurlbert**, MD, PhD, FRCSC, FACS, the study's lead author and associate professor in the division of neurosurgery at the University of Calgary in Canada.[1] "Everyone involved in the administration of medications to patients should know the reason they are giving them, what they should expect from them, and what the possible side effects are."

At Robert Wood Johnson's ED, a methylprednisolone 24-hour protocol is used if the patient has a neurologic deficit from blunt trauma and presents within eight hours from the time of injury, says Murphy. "Just as the article points out, the major reason that most practitioners continue to use this regimen is because of medical-legal concerns of not initiating therapy," he notes.

• Do an early assessment of motor and sensory function.

Use the classification from the American Spinal Injury Association as a standardized way to assess progression of neurologic deficits, advises Murphy. "Serial examinations will help the clinician identify a worsening situation, which should be reported promptly to the attending physician," he says. **(See resource box to obtain these materials, p. 114.)**

Both motor and sensory function are measured independently on the right and left side of the body. A maximum motor score of 50 on each side for a total of 100 may be obtained, says Murphy.

Likewise, sensory dermatomes are monitored both right and left to pinprick and light touch, for a maximum score of 112 each, says Murphy. A decrease in any of the numeric scores should be reported to the spine surgeon, who may alter the treatment plan based on your findings, he adds.

"We have had patients whose score showed a sudden

EXECUTIVE SUMMARY

Patients with acute spinal cord injury need one-on-one monitoring and are at risk for spinal shock, neurogenic shock, and respiratory impairment.

- Make sure patients are adequately resuscitated.
- Assess progression of neurologic deficits to determine if the patient's condition is worsening.
- To prevent skin breakdown in young, elderly, or burn spine-injured patients, remove patients from backboards as quickly as possible.

decline," Murphy says. "The spine surgeon elected to take the patient to surgery emergently to stabilize the spine in hopes of preserving function."

• Maintain immobilization.

Immobilization is key if a neurologic deficit is identified or an injury is suspected, says Murphy. "This targets prevention of secondary injury," he says.

At the same time, be aware of the potential for development of complications such as respiratory compromise, pressure sores, deep vein thrombosis, and pulmonary embolism, adds Murphy.

Skin protection in spinal cord patients is of concern as these patients usually are on a backboard or other firm surface, says Marso. Spine-injured patients who are very young, elderly, or have concomitant burn injuries are at higher risk for skin breakdown, she says.

"The No. 1 preventative measure is early removal of the backboard if they are on one," says Marso. "This means getting X-rays and [computerized tomography scan] stat to determine if there is a spinal cord injury and whether early intervention, transfer, or admission are needed for stabilization of the injury."

Reference

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SOURCES/RESOURCE

For more information about treatment of acute spinal cord injury in the ED, contact:

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The American Spinal Injury Association (ASIA) offers a Standards Teaching Package, which includes a classification standards booklet, two video tapes illustrating the neurological assessments recommended in the booklet, and a manual that provides support and training materials referred to in the videotapes. The cost is $150, including shipping and handling. To order, contact ASIA, 2020 Peachtree Road N.W., Atlanta, GA 30309. Telephone: (404) 355-9772. Fax: (404) 355-1826.

Are children at risk for weight-based drug errors?

Pediatric dosing has small margin of error

Children are at high risk for medication dosage errors in the ED, partly because many medication doses are weight-based, says **Susan Paparella**, director of the Institute for Safe Medication Practices Strategies in Huntingdon Valley, PA.

"There is such a small margin of error when we're talking about pediatric dosing," Paparella says.

In addition, frequent distractions, multiple caregivers, frequency of verbal orders, and overcrowding also put children at higher risk in the ED, she adds. To avoid dangerous drug errors, do the following:

• Measure the weight in kilograms.

"There is always a potential for error when you

EXECUTIVE SUMMARY

Pediatric patients are at higher risk for medication dosage errors in the ED because drugs often are weight-based.

- Measure every child's weight in kilograms.
- Have pediatric orders written with "mg/kg" dose and the total dose.
- Do double-checks for narcotics, insulin, and other high-alert medications.
- Use "smart pumps" to support dose checking.

have to convert the weight from pounds to kilograms, so try to measure the weight in kilos as soon as the child arrives," advises Paparella.

To avoid errors, use only scales that display weights in kilograms, says **Michele Morin**, RN, clinical nurse educator for emergency services at Children's Hospital Boston. "We have disengaged our scales from being able to display pounds at any time," she says. "When it comes to pediatrics and dosing according to weight, it is vital that only kilograms get measured and recorded for each patient."

When you record a child's weight in the medical record, always use the same unit of measure that you use in your ED, says **Nancy Blake**, RN, MN, CCRN, CNAA, director of critical care services at Children's Hospital Los Angeles. For instance, when parents are asked their child's weight, they usually respond in pounds because that is how it is measured at the pediatrician's office, she explains.

"If your hospital records and sets their measurements in kilograms, the nurse needs to convert the weight into kilograms," says Blake. If the hospital uses kilograms as their measurement and it is accidentally written in the medical record as the weight in pounds, all of the medication dosages that are computed on that weight will be inaccurate, she warns.

ED nurses at Children's Hospital Boston always calculate medications using "mg/kg," says Morin. "If pounds are inadvertently recorded, the child could get twice the intended dose, which may or may not be lethal depending on the drug and dose," she says. Either way, it is not the intended dose, Morin emphasizes.

At Children's Hospital Los Angeles, weights are measured in kilograms and all documentation in the chart is listed in kilograms. Wherever possible, weigh the child so that medications are based on the actual weight on that day, says Blake.

At Children's Hospital Boston, "We weigh all patients upon arrival to our department," says Morin. "If the child is unable to stand, then a stretcher scale is used if medications are to be given."

They are awaiting the installation of a wheelchair scale to accommodate special needs patients confined to wheelchairs. The wall-mounted scales, which cost approximately $6,000, are manufactured by White Plains, NY-based Scale-Tronix and have a section that folds down if you need to measure a patient on a stretcher, she adds.

• Perform an independent double-check for high-risk medications.

Two nurses should check the medication order, dosage, medication vial and patient name, says Blake. "We will be moving to computerized physician order entry in our ED in the near future," she adds. "The alerts and standardizations can be forced at the time the order is placed, which minimizes risk for the patient."

Double-checks are particularly important for narcotics, insulin, and other high-alert medications, says Paparella. "You need to have an independent double check process in place, not only for the calculation, but at the time of administration," she adds. "The nurse verifies with another nurse whether this is the correct dose, syringe, and vial."

The newer "smart pumps" include dose range checking for an extra level of protection for pediatric medications, says Paparella. "They can be programmed to recognize doses and drug concentrations that are out of range," she says.

Do a second check process when doing calculations against the standard weight range for the child's age, recommends Morin. Recently, an ED nurse received an order for 15 mg/26 kg = 390 mg for a 3-year-old boy, who was in the range of 12.05 kg-17.77 kg according to national height and weight charts. When the nurse checked the chart, she realized the weight recorded didn't fit into the guidelines, reweighed the child, and noted that pounds was recorded instead of kilograms — thus the prescribed dose was twice as much as it would have been if kilograms was utilized, says Morin.

• Have orders written as "mg/kg."

Ideally all pediatric orders should be written with two pieces of information, the "mg/kg" dose and the total dose, so that an independent double-check can be done

SOURCES

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by the nurse, says Paparella. "If you have the dose written as '204 mg,' the nurse could never check if the dose was correct unless she knows the child's weight," she explains. "But if the order was written as '10 mg/kg, total dose 204 mg,' then the nurse could check that calculation and confirm that the physician used the correct weight and came to the correct conclusion." ■

Aspirin is underused for TIA patients, study says

When patients come to your ED with a transient ischemic attacks (TIA), do they receive antiplatelet medications even if they are asymptomatic?

A new study reveals that antiplatelets such as aspirin are underused for these ED patients, in conflict with current guidelines.[1] "Aspirin reduces the risk of stroke after TIA by 20%-25%, so by not giving it, you're not taking advantage of that reduction," says **Jonathan A. Edlow**, MD, FACEP, vice chair of the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston. "Think about our reaction to giving aspirin to patients with acute coronary syndromes. We do that so automatically."

Researchers looked at 769 TIA cases, using data from the 1992-2001 National Hospital Ambulatory Medical Care Survey. They found that 42% of TIA patients in the ED received no medications at all, including antiplatelet medications recommended by current guidelines.

"TIA and stroke should be thought of as the same disease," says Edlow. "Obviously a stroke patient at triage will trump a TIA patient. But in the past, there's been a tendency for both physicians and nurses to blow off the TIA patient because they're frequently asymptomatic when we see them."

However, 5% of these patients will have a stroke within the next 48 hours, says Edlow. Unless there is a contraindication, all TIA patients should receive aspirin or aspirin/extended-release dipyridamole, he says.

"Standard practice gives one the option of giving plain aspirin vs. aspirin/extended-release dipyridamole," Edlow says. "The data favor aspirin/extended-release dipyridamole, but this hasn't completely caught on yet. Aspirin/extended-release dipyridamole is much more expensive than aspirin and does have some side effects, which is part of the reason why most people still use aspirin as first line." A common side effect is headache, he adds.

When assessing a TIA patient, obtain a concise history and determine onset and duration of symptoms, says **Duane A. Young-Kershaw**, RN, BSN, clinical nurse educator for the ED at Beth Israel Deaconess Medical Center. Ask the patient, "What time did this start?" and check baseline status with family or caregivers, he recommends. In addition to the neurological assessment, a normal physical assessment should be performed with initial labs, electrocardiogram, and intravenous line, says Young-Kershaw. "Also continue to monitor the patient's neurological status and blood pressure, and place on cardiac telemetry monitoring to rule out dysrhythmia as a culprit," he says.

Your assessment should include performing an airway assessment, ensuring the gag reflex is present, and obtaining an immediate blood glucose level, says Young-Kershaw. Symptoms of hypoglycemia mimic stroke, he says. "Assess whether the patient is oriented to self, time, and place, facial symmetry, slurring of speech, sleepiness, and asymmetrical weakness of extremities."

EXECUTIVE SUMMARY

Antiplatelet medications often are not given to patients with transient ischemic attacks (TIAs), contrary to current guidelines, says a new study.

- Antiplatelets decrease the risk of stroke after TIA.
- Aspirin or aspirin/extended-release dipyridamole should be given to all TIA patients.
- Think of TIA and stroke as the same disease.

SOURCES

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Reference

1. Edlow JA, Kim S, Pelletier AJ, et al. National study on emergency department visits for transient ischemic attack, 1992-2001. *Acad Emerg Med* 2006; 13:666-672. ■

'Timeouts' can be useful for ED procedures

Use of a checklist helps

Do you assume that the "timeout" requirements from the *Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery* only apply to operating rooms? That's a wrong and dangerous assumption, according to **Richard J. Croteau**, MD, executive director for strategic initiatives at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which created the protocol.

In fact, the requirement applies wherever invasive procedures are done, says Croteau. "In the ED, people often say that they don't have time. In some cases that may be true, but it's generally not," he says. "It takes only a couple of seconds and protects the patient from a significant error."

The Joint Commission's universal protocol requires a timeout process before any invasive procedure and surgery, and compliance is a requirement for accreditation.

At Ogden, UT-based McKay-Dee Hospital, ED nurses created a timeout checklist to comply with the Joint Commission requirement. The checklist is used before any invasive procedure or surgery such as central lines, chest tubes, tracheotomies, needle thoracostomies, pinning a distal femur for traction, incision and drainage, intracranial bolts or cervical traction, and some vaginal bleeding procedures such as a curettage. **(See checklist on p. 118.)**

Staff caught on quickly, says **Teri Howick**, RN, nurse educator for the ED. The forms are readily available in the rooms that they do those procedures and surgeries in, Howick says. "Our ED physicians were great, but our trouble came with the consulting physicians," Howick says. "They are usually the most reluctant to change."

EXECUTIVE SUMMARY

Accreditation surveyors will want to see that the "timeout" requirements are done before every invasive procedure in the ED.

- Have a staff person call out "time out" before invasive procedures or surgery.
- Use a checklist to make sure that each step is followed.
- Verify that the correct site is marked with X-ray verification when possible.

SOURCES

For more information about the universal protocol, contact:

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- **Sylvie Simpson**, RN, BSN, Nurse Clinician, Emergency Department, Orlando Regional Healthcare, 1414 Kuhl Ave., Orlando, FL 32806. Telephone: (321) 843-4568. E-mail: sylvies@orhs.org.

The patient is identified using two identifiers, such as name and birth date, and nurses verify with the patient or legal guardian that this is the procedure they understand is being done. Next, staff visually confirm that the correct site is marked, with X-ray verification when appropriate or indicated, and check to make sure the proper equipment is available and ready.

Before the procedure begins, timeout is called out by the charge nurse or physician, and the checklist proceeds. "Since putting an identifying armband on, getting X-rays, and collecting equipment happen at different times and stages, we stop prior to the procedure beginning and do the timeout," Howick explains.

Staff then go down the list, saying, "Two identifiers?" "Verbal and armband?" "X-rays?" "Right site?" and staff respond "check" to each.

Verify correct patient

At Orlando (FL) Regional Healthcare's ED, when the decision is made to perform any surgery or procedure that involves distinction between right and left sides, multiple structures such as fingers and toes, or multiple levels as in spinal procedures, the following is done:

• **The correct person, procedure, and site are verified at the time the patient gives consent to surgery. Sylvie Simpson**, RN, BSN, nurse clinician for the ED, says, "All surgical procedure timeouts are completed during the consent signing, just prior to procedures such as a chest tube insertion, thoracentesis, or lumbar puncture. Joint Commission recommends patient involvement if the patient is alert, coherent, and not a minor."

• **The operative site is marked by the patient or ED nurses.**

Continued on page 119

Patient Identification, Procedure and Correct Site Verification Checklist

Date: _____ Procedure: _____

Patient identification, procedure and site verification will continue on all patients in the intraoperative / preprocedural phase per IHC "Correct Site, Correct Procedure, Correct Person Surgeries/Invasive Procedures" Policy.

The Following Steps Have Been Completed:	Not Applicable (NA)	Completed by Procedural Team
1. Verification of the correct patient using two patient identifiers.		☐ Yes
2. Verbal verification of the planned / scheduled procedure and site with the patient/parent/legal guardian/significant other.		☐ Yes
3. Verification of the accuracy and consistency of the above pertinent information with the planned procedure / surgical or procedural schedule, consent and history & physical.		☐ Yes
4. Direct visualization that the correct site is marked, where applicable, ensuring the patient's privacy.	☐ NA	☐ Yes
5. Verification of correct patient identification on all radiography images, where applicable (i.e., x-rays, scans, etc.).	☐ NA	☐ Yes
6. Verification of any required implants (may need to occur intra-procedure).	☐ NA	☐ Yes
7. Intraoperative x-rays are performed to verify and mark the "specific spinal level". The surgeon will interpret the x-ray to verify the site before proceeding.	☐ NA	☐ Yes
8. A **"Time Out" final team verification** using active communication occurred prior to the start of the procedure.		☐ Yes

Signature/Title (Designated Individual)	Initials

Comments:

INTERMOUNTAIN HEALTH CARE

IHC

PREPROCEDURE VERIFICATION CHECKLIST

Source: McKay-Dee Hospital, Ogden, UT.

• **The timeout period occurs right before the procedure, when all of the personnel involved are in attendance.** "The purpose is to conduct a final verification of the correct patient, procedure, and site," says Simpson. "JCAHO's motto rings loudly: Wrong-site, wrong-procedure, and wrong-person surgery can be prevented."

The process ensures that you have the right patient, says Howick. "Patients often change rooms, especially in the ED when a particular room might be used for a specific procedure," she says. "It also verifies the correct side. We've all heard the horror stories of the wrong foot being amputated or the wrong breast."

When available, an X-ray acts as a reminder of which side the pneumothorax, tumor, or fracture is on, adds Howick. "When you have three, four, or more people all checking the same thing, you are less likely to make mistakes," she says. ■

Which children are most likely to return to the ED?

Have you ever wondered why some children return to the ED many times? Researchers sought to answer this question, and of 932 cases, found that 25% had at least one visit during the previous three months and 4% had a return visit within 48 hours.[1]

Here are key findings:

• Children with nervous system diseases, sense organ diseases, digestive system diseases, infectious diseases, and parasitic diseases for children younger than 1 year old may be at greater risk for return visits.

• Patients younger than 1 year old were more than twice as likely to return to the ED within three months compared with other age groups.

• White patients were 39% less likely to have an ED return visit compared with the Hispanic population.

"Specific disease entities were identified that warrant focused attention in terms of discharge teaching, follow-up care arrangements, and primary care physician availability," says **Karen LeDuc**, MS, RN, CPN, CNS, clinical nursing specialist in the ED at Children's Hospital Denver. These diseases include nervous system diseases, sense organ diseases, digestive system diseases, infectious diseases, and parasitic diseases for children younger than 1 year.

The researchers recommend treatment protocols initiated by ED nurses and targeted interventions for children younger than 1 year of age. "Screening pediatric recidivists may reveal underrecognized target groups for specific cross-disciplinary preventive interventions," says LeDuc. "EDs must begin to define aspects of their delivery systems that may not be responsive to the unique needs of ED recidivists."

Reference

1. LeDuc, K, Rosebrook H, Rannie M, et al. Pediatric emergency department recidivism: Demographic characteristics and diagnostic predictors. *J Emerg Nurs* 2006; 32:131-138. ■

SOURCE

For more information on pediatric recidivism, contact:

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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. ■

COMING IN FUTURE MONTHS

■ How to tell whether patients are abusing prescription drugs

■ Foolproof ways to stop errors during patient handoffs

■ Strategies to comply with Joint Commission medication standards

■ Effective ways to educate nurses on new cardiac guidelines

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.

5. Which is required by the National Patient Safety Goals for 2007 from the Joint Commission on Accreditation of Healthcare Organizations?
A. Only psychiatric nurses should assess a patient's suicide risk.
B. Patients must be given a medication list only if they are admitted.
C. Don't allow patients to choose the form of pain relief.
D. Patients must be encouraged to report safety concerns.

6. Which is required by the Joint Commission's *Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery?*
A. The patient should not be involved in the process.
B. The correct patient, site, and procedure must be verified.
C. The requirements apply only to inpatients.
D. The ED is exempt from the requirements because of lack of time.

7. Which is recommended to prevent pediatric dosage errors, according to Michele Morin, RN?
A. Measure and record the child's weight in kilograms only.
B. Weigh patients only if high-risk medications will be given.
C. Avoid use of "smart pumps."
D. Perform double-checks only for narcotics.

8. Which of the following is recommended for patients with transient ischemic attacks, according to Jonathan A. Edlow, MD, FACEP?
A. Patients should be given no medications at all.
B. Patients should be given antiplatelet medications.
C. Aspirin/extended-release dipyridamole is contraindicated.
D. Aspirin should only be given if patients are symptomatic.

Answers: 5. D; 6. B; 7. A; 8. B.