ED Management®
The monthly update on Emergency Department Management

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Author Steve Lewis, Senior Managing Editor Joy Dickinson, and Editorial Group Head Glen Harris, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses he is a consultant for The Abaris Group and conducts research for Ferno Washington. Diana S. Contino, Nurse Planner, discloses that she performs consulting for hospitals.

NOVEMBER 2006
VOL. 18, NO. 11 • (pages 121-132)

Coronor calls ED death a homicide — Some predict chilling effect

Legal experts question whether any prosecution would be successful

It seems that the legal ED horror stories never end. Just a few months after a Florida family sued over the death of a stroke victim who they say waited too long for a neurosurgeon, a Lake County, IL, coroner's office has ruled an ED death a homicide that was the "result of gross deviations from the standard of care that a reasonable person would have exercised in this situation." **(For more details on the earlier case, see "Lawsuit over lack of call coverage raises new concerns about liability," *ED Management,* September 2006, p. 97.)**

According to the deputy coroner's testimony, a 49-year-old woman waited almost two hours after complaining of nausea, shortness of breath, and chest pains for a doctor to see her in the ED at Vista Medical Center, Waukegan, IL. She was seen by a triage nurse about 15 minutes after she arrived, and the nurse classified her condition as "semi-emergent," according to a media report.[1] There has been no action taken by the county district attorney's office, and Vista spokeswoman **Cheryl Maynen** says the hospital has received no communication from that office. She also tells *ED Management* that the coroner and deputy coroner are former employees of the hospital, while refusing to attach any significance to that fact. She also indicates that one of them (she would not say which) had worked in the Vista Medical ED.

While the future of the case is unclear, it has understandably sent shock waves through the ED community. "This will have a chilling effect," predicts **Frederick C. Blum**, MD, FACEP, FAAP, president of the Dallas-based American College of Emergency Physicians (ACEP). "Whether what they say happened actually happened, or who did — or did not — do what, I think the fact that they've criminalized

Executive Summary

A coroner's claim opens the possibility of criminal charges against ED staff for the death of a patient. While you can't prevent legal action from being taken, you *can* limit the potential liability of you and your staff.

- Ensure that your staff follow reasonable triage procedures at all times.
- Make sure your triage staff are well trained and portray good intentions.
- Keep your patients and their families informed about timeliness of service and any delays.

the emergency care of folks is a very, very troubling event," he says.

This could be terrible news, because the "jury" is the public at large — and the public does not understand emergency medicine, says **Gregory L. Henry**, MD, FACEP, risk management consultant for Emergency Physicians Medical Group in Ann Arbor MI. "Medicine is a statistical probability science, and without the concept of a reasonable 'miss rate,' you can't practice science," he says.

No legal case?

Despite the troubling aspects of this case, it is highly doubtful it could be successfully prosecuted, argues **Michael Frank**, MD, JD, general counsel for Emergency Medicine Physicians, an emergency physician partnership group based in Canton, OH.

"Some zealous prosecutor might get the bright idea a nurse's negligence should be transformed into something criminal, but intent is very difficult to actually prove, even in the context of things like manslaughter or negligent homicide," he says. Juries usually are not sympathetic to that approach, Frank adds.

"You cannot bring it to the doorstep of the ED manager if the wait is too long," he says. If the nurse involved in triage showed total disregard and recklessness, then that might be a different case, Frank notes, "but from all I read, either the nurse didn't know or appreciate what was going on, so it's a malpractice case at best."

While concerned about the ramifications of the case, Henry agrees that the legal "reasonable man" doctrine cited by the coroner would not stand up in court.

Reality not reflected

The key issues in the case do not reflect the reality that exists in EDs today, Henry says.

There's a dramatic difference between what we'd like to exist in this country and what *does* exist, he says. "The 'standard of care' is not what happens at the Mayo Clinic at 2 o'clock in the afternoon," he says. *(Editor's note: This case occurred after midnight.)* "ED waits have gone up, types of diseases have gone up, total volume has gone up, and the number of EDs has been reduced by 20%."

Blum agrees. "I don't know what was going on in that ED, but I will tell you there are frequently times in emergency medicine when you need to be in two places at the same time," he says. "If you're on the night shift and a patient comes in with a cardiac arrest or is near one and someone else comes in with a similar level of acuity, there's just *one* of you; you have to pick and choose where you will spend your time."

Imagine that you are the only provider in an elevator, and two people have dropped over with cardiac arrest, Blum says. "One of them is not going to get the care you otherwise might be able to give," he points out. "Sometimes, it's a 'numbers' thing."

The idea of facing criminal prosecution can be terrifying for anyone, but as this case shows, it now is a possibility for the ED staff. Is there anything that can be done

ED Management® (ISSN 1044-9167) is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 12.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 12.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 15 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 24 months from the date of the publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291 (customerservice@ahcmedia.com). **Hours of operation:** 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST. Subscription rates: U.S.A., one year (12 issues), $489. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $82 each. (GST registration number R128870672.)

Sources

For more information on the legal ramifications of deaths in the ED, contact:

- **Frederick C. Blum**, MD, FACEP, FAAP, President, American College of Emergency Physicians, Dallas. E-mail: fblum@acep.org.
- **Michael Frank**, MD, JD, General Counsel, Emergency Medicine Physicians, 4535 Dressler Road, Canton, OH 44718. Phone: (330) 493-4443.
- **Gregory L. Henry**, MD, FACEP, Risk Management Consultant, Emergency Physicians Medical Group, 1850 Washtenaw Ave., Ann Arbor MI 48104. Phone: (734) 995-3764. Fax: (734) 995-2913. E-mail: gamhenry@aol.com.

to minimize that risk?

"The only thing you can do is follow reasonable triage procedures," says Frank. "If you have people of good will who are well trained or well intentioned, even if they fail in doing what we think of as reasonable, that will not transform it into a criminal case."

Keep your patients and their families informed about why the work-up is taking a significant amount of time, advises Henry. State legislation such as the omnibus civil justice reform package signed by Georgia Governor Sonny Perdue in February will help ED managers breathe a bit easier, he says. "It's fantastic," Henry says. "Unless there is gross negligence in the ED, you can't sue."

You have your limits

There are, however, limits to what an ED manager can do. "We really can't limit our variety of cases, or the type and variety of cases we see; we only have limited control over our practice environment," says Blum. "You can be the fastest and most efficient ED around, but if 10 people walk through your door at the same time you are nine behind — and if more than one are critical, someone will not get the care in as timely a fashion."

Will such situations result in more legal cases in the future? Frank doesn't think so. "I doubt there will be a lot based on EDs," says Frank, noting that occasionally a rash of cases arises — such as the recent cases related to medical treatment given during Hurricane Katrina — and then fade away. "They pop up, they get a lot of publicity, and it certainly sends a chill through physicians — but these cases rarely go anywhere," he contends.

From Blum's point of view, one case is one too many. "It's chilling to think about criminalizing our treatment process," he says. "In fact, with the shortage of nurses and, in the future, a probable shortage of doctors, people who have options may pick something other than emergency medicine — and those shortages will become even worse."

It's one thing for an emergency clinician to face the specter of uncontrolled liability, and another to face jail for what may be a system issue more than performance issue, Blum says. "I'm also board-certified in internal medicine and pediatrics," he says. "If [continuing to practice emergency medicine] means I risk going to jail, what's my decision go to be?"

Reference

1. ABC News. Illinois woman's ER wait death ruled homicide. *Good Morning America.* Sept. 17, 2006. Accessed at: abcnews.go.com/GMA/Health/story?id=2454685&page=1. ■

Diversion's not a problem for *this* ED

On divert for just 1 hour in 2 years

The ED at Tahlequah (OK) City Hospital has been on diversion for just one hour in the past two years, says **Brian Hail**, RN, director of the department. According to Hail, his department has combined the good fortune of close proximity to another hospital with an array of targeted strategies to achieve such an impressive statistic.

Tahlequah City Hospital is located mere yards away from Hastings Indian Medical Center. The two hospitals have never been on divert at the same time, according to **Kyle Kuhns**, Tahlequah's emergency medical services director. On the rare occasion when there is a divert, the ambulance simply has to go up or down a hill.

"They have a higher volume because they have a fast-track unit," says Hail of the neighboring facility.

Continued on page 125

Executive Summary

One ED has limited its diversions to just one hour in two years. Here are some strategies they employ that you can implement in your ED:

- Create a graduated response protocol, so you do not have to wait until the divert stage to take action.
- Set up a dedicated phone line between your ED and those in nearby facilities, so you can be available to assist each other as diversion nears.
- Utilizing ancillary beds and treating some patients in the waiting room can help relieve the pressure.

REQUEST FOR DIVERSION STATUS

1. **General Reason:**

2. Total # of patients logged into the ED?_____

   # of emergent (red) _____

   # of urgent (yellow) _____

   # of non-urgent (green) _____

3. What would best alleviate the situation?

ED Director called at: _____ by _____ Responded at: _____

Other calls made to: _____ at _____ by _____

Other calls made to: _____ at _____ by _____

Other calls made to: _____ at _____ by _____

ED Diversion Level _____ Began: _____ Ended: _____

Source: Tahlequah (OK) City Hospital.

Sources

For more information on keeping diversions to a minimum, contact:

- **Brian Hail**, RN, Director, Emergency Department; **Kyle Kuhns**, Emergency Medical Services Director, Tahlequah City Hospital, 1400 E. Downing, P.O. Box 1008, Tahlequah, OK 74465. Phone: (918) 456-0641.

"If they do approach divert status, then we will feel the pressure as well, since patients will be hoping for a shorter wait." His department has been to maximum capacity (the department has 11 beds) more than that single time in the past two years, Hail says, "but we have a few ancillary beds, and we will also treat some patients in the waiting room."

A dedicated telephone hotline between the two EDs helps keep things from getting out of hand, says Kuhns. "It's there for physicians or nurses to discuss patient load or specific patients," he says. "If they want to transfer someone here for nuclear medicine or imaging studies, if they need our hospitalist, or if we have patients that present here who want to be admitted there, then we will call and transfer them up." If either ED is approaching saturation, that information generally will be communicated to the other facility. Hail's ED has a policy called "maximum capacity," which employs color-coded levels to indicate how crowded the department is.

A graduated response

Depending on the level in the ED or in the waiting room (red is the most serious), there is a graduated response. "On the first level above normal, we contact the house supervisor and say we face first-phase maximum capacity, and they will try to help us with throughput by giving us priority for beds and usually bringing in an extra RN," says Hail. "On the next level, we will get a physician extender or another physician." **[Editor's note: A copy of the form used at Tahlequah can be found on p. 124. A copy of the entire policy is available with the on-line version of *ED Management.* If you're accessing your on-line account for the first time, go to www.ahcmedia.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, go to www.ahcmedia.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "ED Management," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the November 2006 issue. For assistance, call Customer Service at (800) 688-2421.]**

The key to this protocol, he says, is that it strives to be proactive early on, rather than waiting until the divert stage to take action. "We also utilize EMA [emergency medical evacuation] and air ambulances for transfers if patients are going to have to wait too long," Hail adds.

Tahlequah City Hospital has made a commitment to avoiding diversion, he says. "If we have transfers pending, EMS will put on extra trucks to move the patients out," Hail says.

Technology offers backup

If these procedures ever prove inadequate, says Kuhns, there is a statewide database accessible online that has current information on the bed and ED status of every ED in the state. "It lets us know what facilities have — what specialties are on call that day and are available," says Kuhns, noting they use this information to transfer patients, as needed. In addition, he can tell at a glance which hospitals are on divert.

The database has helped streamline the processes tremendously in the past six months, Kuhns adds. This statewide call panel even extends into Oklahoma and Texas hospitals, and they've been told Arkansas will be on-line in the near future, he says.

Of the interstate transfers, Hail says, "We've never really had to do that, but I regularly enter our information. It's a function I perform daily."

'A longstanding relationship'

The benefits of Tahlequah City Hospital's close proximity to Hastings Indian Medical Center extend beyond the virtual elimination of diversions, reports Kuhn. "Since they are literally next door, we've had a longstanding relationship where we share supplies," he says. "There was even one patient who stole a wheelchair in the ED at Hastings and wheeled themselves down the hill to us."

Kuhn says it's easy for the department heads to walk back and forth between their facilities and talk to their counterparts. That is the real key to keeping those diversions at a minimum, he says. "It's just a case of constant communication. We know what they're working on, and they know what we're working on."

Hail says this cooperation is facilitated by the fact that many staff members work at both facilities, and both he and his counterpart at Hastings have worked in the other's ED in the past, so the level of familiarity with both operations is quite high. ■

How much does poor quality cost *your* ED?

Techniques can quantify costs, savings opportunities

Every ED manager is concerned about maintaining high-quality standards in their department and recognizes the impact poor quality can have on outcomes and patient satisfaction. However, say the experts, only a small minority recognizes and calculates the impact poor quality can have on their bottom line.

Assessing the cost of poor quality (COPQ) is one of the concepts in Six Sigma and Lean methodologies that you can look at when quantifying your work, or assessing improvements you should make, explains **Diana S. Contino**, RN, MBA, CEN, FAEN, manager of public services-health care for Costa Mesa, CA-based BearingPoint, which provides consulting, application services, technology solutions, and managed services for health care clients and others. Six Sigma methodologies are focused on reducing errors and decreasing variability in processes, and Lean methodologies are focused on eliminating waste (extra or unnecessary steps) in processes.

"The actual terminology of the COPQ is something you may not hear real frequently, but the concept that there is an expense or a cost to having a poorly run business is widely held," she notes. **(For more on Six Sigma and Lean methodologies, see "System issues are at the heart of flow woes," *ED Management,* July 2006, p. 77.)**

How does this play out in the ED environment? One example, says Contino, would be the entering of a wrong order. "Let's say you have four orders to be entered, and one is incorrect," she offers. "You have the cost of someone drawing the tests, then having to come and redraw it." The total cost would involve not only the time it takes, but, for example, the extra waiting time for the patient and extra staff time, Contino says.

Another example is impact on revenue cycle, she notes. "If somebody documents a wrong medication, you could kill somebody and end up in litigation, and the cost could be the entire income of the doctor who loses his malpractice insurance," Contino says.

Poor quality has such a widespread impact that it is virtually impossible to calculate its *total* cost, asserts **Prentice Tom**, MD, chief medical officer of California Emergency Physicians, an Emeryville, CA-based physician partnership that staffs about 60 hospitals. "When an incorrect lab is ordered or a wrong order is entered — which happens with frequency — you not only have the absolute cost of correcting the order and the wasted time of nurses, physicians, and patients, but you also have the cost, for example, of bed space that has to be utilized for that period of time," he notes.

Executive Summary

Applying Six Sigma and related methodologies to your operations can uncover hidden opportunities to reduce expenses and improve your bottom line.

- Calculate the cost of poor quality for all of the major segments of your ED visits.
- Analyze the data to determine which segments have the highest poor-quality costs and which offer the opportunity for quick "wins."
- Address the areas of weakness using process improvement techniques such as treatment algorithms and pre-formatted order sheets.

Sources

For more information on the cost of poor quality in the ED, contact:

- **Diana S. Contino**, RN, MBA, CEN, FAEN, Manager, Public Services-Healthcare, BearingPoint, 600 Anton Blvd., No. 700, Costa Mesa, CA 22626. Phone: (949) 683-0117. Fax: (949) 861-6426. E-mail: diana.contino@bearingpoint.com.
- **Peggie Parniawski**, MSN, RN, Director of Emergency Medicine and Oncology Services, Bridgeport Hospital/Yale New Haven Health System, 267 Grant St., Bridgeport, CT 06610. Phone: (203) 384-3431. E-mail: nmparn@bpthosp.org.
- **Michael J. Pineau**, MS, RN, Performance Management Coordinator, Bridgeport Hospital/Yale New Haven Health System, 267 Grant St., Bridgeport, CT 06610. Phone: (203) 384-3189, Fax: (203) 384-3750. E-mail: nmpine@bpthosp.org.
- **Prentice Tom**, MD, Chief Medical Officer, California Emergency Physicians, 2100 Powell St., Suite 920, Emeryville, CA 94608. Phone: (510) 350-2777. Fax: (510) 879-9100. E-mail: tomp@medamerica.com.

You can quantify costs

Be that as it may, says Contino, Six Sigma methodologies offer a means of quantifying COPQ. **(See the story, p. 127, for an example of how COPQ is calculated.)**

But this is more than just a mathematical exercise. "When you look at ED operations from a Six Sigma perspective, one of the good things about quantifying the problem is that you can look at the costs and statistically analyze where the biggest costs are," she explains.

At Bridgeport (CT) Hospital, for example, the ED determined about a year ago that their walkout rate was costing them $400 for each patient who left without

How to calculate the cost of poor quality

The following is a hypothetical example to illustrate how to calculate the cost of poor quality (COPQ) and the financial impact of improved quality in the ED. The example was provided by **Diana S. Contino**, RN, MBA, CEN, FAEN, manager of public services-health care for Costa Mesa, CA-based BearingPoint, which provides consulting, application services, technology solutions, and managed services for health care clients and others. She also is a certified Six Sigma Green Belt and is obtaining Lean certification. Six Sigma Sigma methodologies are focused on reducing errors and decreasing variability in processes, and Lean methodologies are focused on eliminating waste (extra or unnecessary steps) in processes.

Assume the following: A 40,000 visit ED with a 20% admission rate. The goal is to reduce time to patient exit for discharged patients.

The ED staff collaborate on a process improvement project to reduce their time to patient exit. Through incremental data collection, they discover the median time from MD disposition to the patient leaving the ED is 20 minutes. They brainstorm on solutions and implement three significant changes, focused on eliminating steps (waste in their discharge process):

1. The team created a process in which the physicians directly discharged patients who didn't require any additional nursing or hospital services.
2. For those patients who needed additional services, the physician communicated the disposition order directly to nurse and entered it into their patient tracking system. Also, the physician instructed all stable patients to dress and wait in the internal waiting room where the nurse would take prescriptions and discharge instructions.

The ED reduced their median disposition time to 10 minutes, and data analysis revealed that the outliers were those patients who needed closer observation after medication administration or while they waited for their ride home. The gaining of 10 minutes for each of the 32,000 discharged patients (admitted patients were tracked separately with a goal of 60 minutes) led to an increase in room availability of 14 hours per day. If the median turn around time for discharged patients is two hours, their project essentially gave them additional space for seven more discharged patients.

If the average facility reimbursement for an ED visit is $100, then that would equate to $700 per day, or $255,500 per year, in revenue gained by eliminating poor quality.

This revenue is the reason that so many facilities strive to change their culture to one focused on reduction of error, reducing process variability, and data-based decision making, Contino says. She adds that the "1, 10, 100 rule" provides additional insight into COPQ. That rule states that if the operator finds the error, it is one time the error cost; if a quality double-check finds the error further down into the process, then more value is added to the cost through a multiplier of 10. If the patient/customer finds the error, it is estimated to be 100 times the cost of the operator finding the error at the point of occurrence.

Additional information on Six Sigma can be found at: www.isixsigma.com. ■

being seen. "When you look at our raw charges, they are between $800 and $1,000," explains **Peggie Parniawski**, MSN, RN, director of emergency medicine and oncology services. "We usually recover about half of that."

As part of their Lean project, the entrance and triage areas were completely revamped to add more capacity and smoother flow, now providing two triage bays instead of one, and ensuring that equipment nurses commonly need (i.e., meds, blood pressure cuffs, ice machines) are always readily available, says **Michael J. Pineau**, MS, RN, performance management coordinator and a Six Sigma Master Black Belt. In addition, he says, color-coded visual cues now tell doctors and nurses when flow is falling behind so they can react in "real time"; redundancies in triage nurse and charge nurse documentation were eliminated, and all documentation now is entered electronically and tied to a bed-tracking system.

Parniawski reports that in one year, the walkout rate has been reduced from nearly 5% to about 2.5%. "We've saved $297,600 by reducing and preventing those walkouts," she asserts.

Before you decide to take these types of actions, Contino warns, the data must be analyzed carefully — by someone who truly understands ED operations. "For example, if someone did not know that ED volumes crescendo in the middle of the day, they might look at the data and make assumptions that are incorrect," she notes. "The data alone can't speak for itself; you have to put it in context with ED operations."

Still, she notes, the savings can be substantial. "Within Six Sigma circles, they estimate that COPQ runs anywhere from 25%-40% of the cost of the product — which in our case is the ED visit." ■

Satisfaction Rx: Run hospital like an ED

Unified care stops some problems before they start

Numerous emergency medicine experts have noted that a number of ED overcrowding and flow problems really are hospitalwide problems; few, however, have recommended running a hospital "like" an ED to solve those problems.

However, that's precisely what **Charles Flinn**, MBA, CHE, vice president at Saint Clare's Hospital/Denville (NJ), and **Jan Bednar**, RN, BSN, ED manager, have done. Their efforts have earned them a national patient satisfaction award from The Jackson Organization, a Laurel, MD-based market research firm specializing in health care. The organization uses a percentile ranking system similar to that used by Press Ganey.

The ED's scores usually are in the mid-90s. "We've been doing that for several years now," Bednar says.

At the root of those rankings are improvements in several areas that relate to patient satisfaction. For example, it formerly took about three hours from the time a patient presented until all labs were completed; that time has been cut to one hour. And there have been no diversions since February 2005. The key to this success, says Flinn, is "a unified approach to patient care involving physicians, nursing, and ancillary services. A synergistic team has been created down in the ED."

Bednar says, "We've been building this team for the last five years. Customer service *has* to be No. 1."

Driven like an ED

Flinn, who came to the facility two years ago, has a background in emergency medicine and "decided to drive the whole thing like an ED" to address patient flow and diversion issues.

Emergency medicine, he explains, is episodic, and providers sometimes do not get to see the effects of their work over the entire continuum of care. Accordingly, Flinn says, "They like to come up with quick wins — develop an idea and execute it."

Discussing patient flow

Those quick wins are enabled by what originally were called "bed huddles." Now known as patient flow meetings, they began in January 2005. "We chose a small office for all department managers to come together every day at noon to discuss the ED's needs," Flinn recalls. "This unraveled the whole picture of what flow looks like."

The meetings, which last 12 minutes, involve all clinical departments, social work, case management, and the house department; even EMS staff participate by phone.

"What happens is we come to the meeting with our [bed] needs, and don't leave until we have them filled," Bednar explains. Bargaining goes on between the departments. A kidney stone patient may be admitted to the pediatric unit, or a unit that has been shut down may open up as "flex" unit to accommodate ED needs. "The beds may need to be cleaned, but basically we walk away from the meeting with [more] beds in the ED," says Bednar. "It's now rare that we hold anyone more than a couple of hours, and there's improved satisfaction because of that."

Testing speeded up

Flinn often turns to the ED staff for suggestions on how to improve. "For example, we had some opportunities for improvement in outpatient and pre-admission testing," he says. "What they suggested did wonders."

The suggestion was to open the fast-track sooner than normal. It still officially opens at 10:30 a.m., but now at 6 a.m. it is open for pre-admission testing of patients, with the ED tech functioning as the "concierge" who facilitates the process.

"Patients are not being triaged," Bednar explains. "We are simply utilizing the space in the ED for pre-admission testing." In other words, she adds, it is an outpatient service using ED space and staff. Flinn says, "Patients used to go to a different floor for X-rays, EKGs, and labs, and often they would get lost. Now it's all done in one area." Blood is drawn by the tech, and a nurse does the assessment, he says.

This change hasn't added anything to the budget, Bednar says. "We've just rotated duties and been more creative with staff hours." The tech and nurse, she

Executive Summary

Since many "ED" problems are truly hospitalwide problems, running your hospital like it is one big department can open up the possibility of cooperative strategies to improve service and boost patient satisfaction.

- Interdepartmental "bed huddles" can help address small patient flow problems before they become large ones. Seeking such "quick wins" is an approach that your staff will easily relate to.
- Look to your staff for innovative ideas, such as opening up the fast track for preadmission testing, which can help improve flow across the hospital.

Sources

For more information on ED-driven patient satisfaction strategies, contact:

- **Jan Bednar**, RN, BSN, Manager, Emergency Department, or **Charles Flinn**, MBA, CHE, Vice President, Saint Clare's Hospital/Denville, 25 Pocono Road, Denville, NJ 07834. Phone: (973) 625-6000.

explains, are already working during those hours, so all that has changed are their responsibilities and scope of practice.

Watch the 'little things'

Flinn also has brought an entirely new type of management to the ED, says Bednar. "It made me realize that the little things we may not notice, our patients do," she says.

Flinn says he has adopted the "broken windows, broken business" approach first used by former New York City mayor Rudolph Giuliani. "If the lighting is not right, if the signage is crooked, they have to be fixed," he says. The staff pay attention to all the little details, Flinn says. "Pick your head up when you see someone walk through the hall," he says. "Have a smile on your face."

The ED physicians and nurses have bought into the approach, says Bednar. "They live by example, so I try to set the right example and tone, and that helps," she observes. "But they are an awesome team."

Having Flinn provide greater administrative presence in the ED also helps, Bednar says. "So many services depend on what happens in the ED, and now the ED is driving the way the hospital operates," she says.

400-plus callbacks every month

Bednar says her attention to patient satisfaction also has caused her to be very proactive about doing callbacks. For example, a patient may complain that the length of stay was longer than he or she thinks it should have been, "If their nurse flags me, I'll call the patient within 24 hours to ask if there's anything we could have done better," she explains. Bednar says she originally had a goal of calling back 15% of all patients (400-600 a month), but recently increased it to 25%.

Not all patients who have a positive experience will share it, "but if they have a negative one, they'll tell 20 people," she admits. ■

New CDC survey results echo report from IOM

A new report from the Centers for Disease Control and Prevention's (CDC) reinforces the assertions of a report on the state of emergency medicine by the Institute of Medicine (IOM) that crowding in the nation's EDs has reached nearly epidemic proportions.[1] **(For more on the IOM report, see the July 2006 issue of *ED Management.)***

The CDC report, based on data from the 2003-04 National Hospital Ambulatory Medical Care Survey (NHAMCS), notes that almost half of U.S. hospitals experience crowded conditions in the ED, with almost two-thirds of metropolitan EDs experiencing crowding at times. About one-third of U.S. hospitals reported having to divert an ambulance to another ED due to overcrowding or staffing shortages at their ED. Crowding in metropolitan EDs was associated with a higher percentage of nursing vacancies, higher patient volume, and longer patient waiting and treatment durations, the report says. Half of EDs in metropolitan areas had more than 5% of their nursing positions vacant. According to NHAMCS figures, the United States had an average of 4,500 EDs in 2003 and 2004, more than half of which saw fewer than 20,000 patients annually. However, one in 10 EDs had an annual visit volume of more than 50,000 patients.

"I think our findings jibe with the IOM's virtually everywhere," says **Catharine W. Burt**, EdD, chief of the Ambulatory Care Statistics Branch at the National Center for Health Statistics at the CDC and lead author of the report.

Not an aberration

If anything, Burt says, the CDC's report has even greater statistical underpinnings. "A lot of the IOM report was based on some studies about crowding and

Executive Summary

A report from the Centers for Disease Control and Prevention can be used to benchmark your department against national averages and offer explanations for what management might call "poor performance." For example:

- One-third of EDs cite staffing shortages or overcrowding as caused of diversion. Does your ED suffer from one — or both?
- What are your nursing vacancies? Half of EDs in metropolitan areas had more than 5% of their nursing positions vacant.
- Since 8% of the hospitals nationwide are not allowed to go on diversion, ED crowding is not just a diversion issue.

ambulance diversion done in different states, while this report is national — saying it's true everywhere, and not just in the places that 'talk' the loudest," she explains.

The validity of national statistics emphasizes that this trend "is not the result of an aberration in Los Angeles, or Massachusetts," Burt says. "The higher your daily occupancy rate, the more likely you are you will have to go on ambulance diversion."

There was one area in which her statistics differed from the IOM's, says Burt, although she is quick to add it doesn't detract from the significance of the problem. In the IOM report, the authors quote a study that found that 91% of hospitals were crowded in the opinion of the ED director, she says.

"But this report is objective: We actually count how many diversion there were, how many left without being seen, and how many urgent cases that should have be seen had to wait longer than an hour on average," Burt says. "Our statistics show that 50% of EDs were crowded — not 91% — but it's still a common thing."

James Augustine, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group based in Canton, OH, says, "I thought they may actually be underestimating what's going on in the market. It depends on how they surveyed the participants." What Augustine means is that at present there are no nationally accepted definitions for diversion, rerouting, and so forth. "At this point those are all community definitions," he says.

However the figures are calculated, Burt also notes that because 8% of the hospitals nationwide are not allowed to go on diversion, ED crowding is not just a diversion issue. Besides, she asserts, "diversion is not a best practice." **(For more on this issue, see "ED diversions banned by Seattle-area hospitals," *ED Management,* June 2006, p. 66.)**

More solutions-oriented

Burt says that in the future her surveys are going to expand to address potential solutions to the problems it identifies. For example, in the 2007 survey they have added questions for hospital and ED directors about some of the things that were in the IOM report, such as electronic whiteboards; zone nursing, in which a nurse sees patients in a very specific set of locations, all next to each other; and some technology issues such as radio frequency identification (RFID), she shares. **(For more on RFID technology, see "Increasing ICU bed capacity cuts diversions," *ED Management,* September 2006, p. 103.)**

The formulation of questions is critical in such surveys, Burt says. In 2002, it appeared that about 32% of EDs had electronic medical records (EMRs), she says. "But in 2005, we asked about specific system features, and when we started looking at those answers, and at what experts say EMRs really have to have, that number comes down to 5%," Burt says.

EMRs are another area in which the emergency field doesn't have good definitions, Augustine says. "We may have some EMR pieces in place, yet the entire EMR has not been perfected yet and certainly not implemented yet in the ED." The most developed system is the one at the Veterans Affairs (VA) medical centers, he says. "They are very far ahead on this," Augustine notes. "Their EMR is as functional and friendly as system makers can design them now."

The EMR at the VA is an internal product, developed with the Massachusetts Institute of Technology in Boston. The name given the basic database that all VA medical centers throughout the nation access is VISTA (Veterans Health Information and Technology Architecture). **(See resource box, below.)**

Sources/Resources

For more information on the survey, contact:

- **James J. Augustine**, MD, FACEP, Director of Clinical Operations, Emergency Medicine Physicians, 4535 Dressler Road, Canton, OH 44718. Phone: (330) 493-4443. E-mail: jaugust@emory.edu.
- **Catharine W. Burt**, EdD, Chief, Ambulatory Care Statistics Branch, National Center for Health Statistics, 3311 Toledo Road, Hyattsville, MD 20782. Phone: (301) 458-4000.

A copy of the report from the Centers for Disease Control and Prevention can be downloaded free of charge at www.cdc.gov/nchs/data/ad/ad376.pdf.

For more information about the Veterans Health Information and Technology Architecture, contact Himanshu Singh in Augusta, GA, at (706) 733-0188, ext. 1955.

COMING IN FUTURE MONTHS

- How do you handle a celebrity being treated in your ED?
- New video 'game' simulates disasters to help train ED responders
- How to property schedule resources in your ED
- Warning: 'Mystery shoppers' soon may pay a visit to your ED

Reference

1. Burt CW, McCaig LF. Staffing, capacity, and ambulance diversion in emergency departments: United States, 2004-04. *Adv Data* 2006; 376:1-23. ■

ACEP elects new officers

The American College of Emergency Physicians (ACEP) has installed a new president and elected a new president-elect during the organization's annual meeting in New Orleans. Brian Keaton, MD, FACEP, of Akron, OH, assumed the presidency, and Linda L. Lawrence, MD, FACEP, of Fairfield, CA, has been elected president-elect.

Keaton is an attending physician, director of emergency medical informatics, and core faculty for the emergency medicine residency program at Summa Health System in Akron. He has worked at the national and state levels to improve quality of patient care through technology and the development of a nationwide health information network. Keaton was appointed by Mike Leavitt, Secretary of the Department of Health and Human Services, to serve as a member of the bio-surveillance workgroup of the American Health Information Community. That community is a task force focused on developing a national strategy for using health care data to detect, manage, and minimize the impact of events such as pandemic flu and bioterrorism events.

Lawrence has served as vice president of ACEP and is chief of medical staff for David Grant Medical Center at Travis Air Force Base, CA, and an attending physician in the Emergency Department at the medical center. In addition, she serves as a consultant to the U.S. Air Force surgeon general. ■

CE/CME instructions

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

CE/CME *questions*

7. According to Michael Frank, MD, JD, a homicide case involving the death of a patient can be blamed on the ED staff only if:
A. The wait is too long.
B. The patient was misdiagnosed.
C. The nurse involved in triage showed total disregard and recklessness.
D. Malpractice is involved.

8. According to Kyle Kuhns and Brian Hail, RN, the following strategy can significantly reduce diversions:
A. A graduated response protocol.
B. Phone and computer connections to other EDs.
C. Ancillary beds to ease ED overcrowding.
D. All of the above

9. According to Prentice Tom, MD, which of the following factors can contribute to greater costs when an incorrect lab is ordered?
A. Correction of the order.
B. Wasted staff time.
C. Poor utilization of bed space.
D. All of the above

10. According to Diana S. Contino, RN, MBA, CEN, FAEN, how much can poor quality cost an ED?
A. As much as 30% of the cost of the visit.
B. As much as 40% of the cost of the visit.
C. As much as 50% of the cost of the visit.
D. As much as 60% of the cost of the visit.

11. According to Charles Flinn, MBA, CHE, which of the following is *not* part of his strategy to run the hospital like an ED?
A. Seeking quick wins.
B. Having the ED test new strategies and then share them with the rest of the hospital.
C. Holding bed huddles.
D. Encouraging ED staff to come up with innovative solutions.

12. According to Daniel Stern, an ED manager today must have or acquire the following skills:
A. Diplomatic skills.
B. Recruiting skills.
C. Quality skills.
D. All if the above

CE/CME objectives

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

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
ED Management	1 0 4 4 - 9 1 6 7	10/01/06
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$489.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Steve Lewis , same as above

Managing Editor *(Name and Complete Mailing Address)*
Joy Daughtery Dickinson, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	1725 K Street NW, Suite 700
	Washington, D.C. 20006

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: ED Management
14. Issue Date for Circulation Data Below: September 2006

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			1150	1357
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	801	845
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	7	5
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	8	10
	(4)	Other Classes Mailed Through the USPS	20	31
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			836	891
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	26	25
	(2)	In-County as Stated on Form 3541	1	1
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			29	25
f. Total Free Distribution *(Sum of 15d and 15e)*			56	51
g. Total Distribution *(Sum of 15c and 15f)*			892	942
h. Copies Not Distributed			258	415
i. Total *(Sum of 15g. and h.*			1150	1357
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			94	95

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2006 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda L. Mooney Publisher — Date: 9/27/06

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

CE/CME answers

7. C; 8. D; 9. D; 10. A; 11. B; 12. D.

ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

To comply with new patient safety goal, here's how to assess patients for suicide risk

Do you have a process in place in your ED to identify patients at risk for suicide? If you don't have one in place by Jan. 1, 2007, you won't be in compliance with a new National Patient Safety Goal that requires hospitals to assess patients at risk for suicide.

In statistics released this year, the Joint Commission on Accreditation of Healthcare Organizations said the No. 1 sentinel event was patient suicide that accounted for 13.2% of sentinel events between January 1995 and March 31, 2006.

The most important thing for ED managers to remember is that there is are relatively significant rates of psychiatric illness and associated suicide risk among individuals who present to an ED, says **Laura J. Fochtmann**, MD, professor in the departments of psychiatry and behavioral sciences and former director of the Comprehensive Psychiatric Emergency Program at Stony Brook (NY) University School of Medicine. Fochtmann has written a section on emergency services for "Textbook of Suicide Assessment and Management." **(See ordering information, p. 3.)**

Executive Summary

As of Jan. 1, 2007, EDs and other hospital departments are required to identify patients at risk for suicide.

- If patients appear potentially suicidal, ask them directly if they are considering suicidal thoughts and/or have had previous attempts.
- Ask these patients about alcohol and substance abuse, and ask about illnesses and/or pain that could be contributing to suicidal thoughts.
- Determine if such patients have a support system in place.
- Identify patient populations who may be at particular risk for suicide, including adolescents, older adults, younger men, and women who are postpartum.

It's important for ED staff to treat patients in a fashion so they're most likely to be open about those feelings, she says. Coming to an ED is stressful, especially if people have emotional and psychiatric issues, Fochtmann points out. "With the rush of trying to deliver care in an ED setting, oftentimes the urgencies there make it difficult for people to reach out to people with emotional difficulties," Fochtmann says. "That makes it hard to identify individuals who may be at risk for suicide or may have already had an attempt and may not be forthcoming about that."

The new patient safety goal is particularly challenging for EDs, acknowledges **Gigi Acevedo**, RN, MSN, associate director of standards interpretation at the Joint Commission. "It's not their primary focus," she says. "Also, the personnel there aren't primarily behavior health specialty personnel."

The process can be time-consuming to sit and talk to someone in psychiatric crisis, Fochtmann acknowledges. "It involves getting input from the family or other persons who have come with the patient to the ED," Fochtmann says. "That more detailed history-taking needed to identify someone at risk for suicide is difficult to fit into typical ED workflow."

To address this challenge, offer education and competency testing, Acevedo says. "There needs to be some internal training so the ED can do a good screenings," she says.

There's no rating scale that makes it easy to identify individuals who are potentially suicidal, Fochtmann warns. "You're left with evaluating individuals on a variety of risk factors and then coming to a clinical judgment

Financial Disclosure:
Senior Managing Editor Joy Dickinson and Editorial Group Head Glen Harris report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses he is a consultant for The Abaris Group and conducts research for Ferno Washington.

2007 National Patient Safety Goal

Goal 15	The organization identifies safety risks inherent in its patient population.
15A	The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]

Source: Joint Commission on Accreditation of Healthcare Organizations. Accessed at www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/07_hap_cah_npsgs.htm.

on the overall level of risk, in terms of making a decision about hospitalization," she says.

Consider adding these areas to your ED assessment:

• Ask patients directly about suicidal thoughts.

Ask patients, "Are you feeling like you're going to hurt yourself or someone else?" suggests **Shirley Goodman**, MS, RN, director of psychiatric services, care management, and specialty school at Overlake Hospital Medical Center in Bellevue, WA. At Overlake, ED triage nurses bring any patients who seem suicidal to a back room, where they are assessed by a social worker who reports to Goodman.

Staff members ask patients who appear potentially suicidal whether they have made a previous suicide attempt, she says. They also ask the patients what suicide method they would use, in order to determine if the plan is imminent, firm, and/or lethal, she says. "The lethality of those previous attempts is also important," Goodman says. For example, has the patient tried to hang himself/herself or taken a very serious overdose? Such serious past attempts should raise the possibility that the patient is currently suicidal, she says. Also ask about a family history of depression and suicide attempts, Goodman advises. "Someone who has had a parent, brother, sister, or someone else fairly close attempt suicide, that would raise red flags," she says.

• Determine their current physical status.

At Overlake, patients who appear potentially suicidal are asked whether they are depressed, are abusing substances, are eating and drinking, "all the varied symptoms you'd see with someone who is depressed, psychotic, etc.," Goodman says.

Patients who are abusing alcohol or drugs do have an increased suicide risk, particularly with other psychiatric symptoms such as a psychotic disorder, says Fochtmann. "But even by themselves, they can increase suicide risk," she says.

Determine whether the patients are relatively healthy physically or have been under the care of a physician, Goodman says. Patients with chronic, painful, or terminal physical illness may be particularly at risk for suicide, Fochtmann says. Patients may have been diagnosed with a disease that runs in their family and has had poor outcomes, Goodman says.

• Examine their support system.

When assessing patients who seem potentially suicidal, ask questions that will reveal the strength of their support system, Goodman suggests. For example, ask what's going on with the patient that brought them to this situation. Is it interpersonal or job-related? The support network is critical, she notes. "Have they just moved to a new place or lost their job? Or can they not cope with their job?" Goodman says. "Do they have no family or friends to support them? Those are all things to take into consideration."

Also, determine whether patients are looking forward to events in their lives, she says. "If they're talking about their son's birthday party coming up or a vacation next month, those are positive things," Goodman says. "At least they're thinking there will be a tomorrow, vs. people who have nothing going for them."

JCAHO clarifies confusion over goal

There has been a significant amount of confusion among ED managers and others regarding a new national patient safety goal on patient suicides, according to the Joint Commission on Accreditation of Healthcare Organizations.

In terms of the ED, the revised goal applies only to patients whose primary reason for coming into the ED is to obtain treatment for emotional or behavioral disorders, according to **Gigi Acevedo**, RN, MSN, associate director of standards interpretation at the Joint Commission. "For patients with other conditions who also happen to have psychiatric diagnosis, or when the staff has concern about self-harm, we encourage hospitals to do a suicide assessment, but we will not survey or score for that in their accreditation survey," she says. For example, when a psychiatric patient comes in with a sprained ankle, the organization does not need to assess for suicide risk "unless the organization is concerned about the patient doing some type of self-harm," Acevedo explains.

The goal *does* apply to hospitals that don't have designated psychiatric services, she emphasizes. ■

• Identify safety risks inherent in the patient population.

The new patient safety goal requires EDs and other departments to identify safety risks inherent in the patient population.

Acevedo says, "The organization should do a proactive risk assessment and identify those areas that have high risk potential, based on a previous sentinel event or other data they already have."

Also keep in mind that certain patient populations are at a higher risk for suicide, including adolescents, older adults, and younger men, Goodman says. Look at who is presenting, she advises. "Is it a male, in his 30s or 40s, who has lost his job and his wife?" she asks. "It is a drinker who has a problem with depression? Those are all causes for you to stop and say, 'Whoa, what's going on here?'"

Also, closely examine postpartum women who have endured hormone changes and are sleep-deprived, Goodman warns. "They can get very, very depressed to the point of having psychotic symptoms and not being able to sleep," she says. **(For more information on the new patient safety goal, see "New patient safety goal: Involve your patients — Another new goal targets patient suicides," *ED Management,* July 2006, p. 82. In its implementation expectations, the Joint Commission says the organization provides information, such as a crisis hotline to individuals and their family members for crisis situations. For information on how to access such a hotline, see resource box, left.)** ■

Resources

A Quick Reference Guide to assessing suicidal behaviors from the American Psychiatric Association is available at www.psych.org/psych_pract/treatg/quick_ref_guide/Suibehavs_QRG.pdf. The full guideline is available at www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf. The full guideline contains tables of suicide risk and protective factors as well as a list of example questions to ask suicidal patients in assessing their risk.

The New South Wales Australia suicide guidelines include a version targeted to the emergency setting at www.health.nsw.gov.au/pubs/2005/pdf/emergency_dept.pdf.

The National Suicide Prevention Lifeline web site offers resources and a national crisis phone number [(800) 273-TALK (8255)]. Web: www.suicidepreventionlifeline.org.

The *Textbook of Suicide Assessment and Management* is available from The American Psychiatric Publishing in Washington, DC. The book includes a chapter on emergency services. The cost of the book (item 62213) is $85 plus $9.95 for shipping and handling. To order, call (800) 368-5777 or go to appi.org. Under "Books," click on "Featured Titles" and then "The American Psychiatric Publishing Textbook of Suicide Assessment and Management."

The publication *Meeting the Joint Commission's 2007 National Patient Safety Goals,* is available from Joint Commission Resources. The book includes a compilation of articles, book excerpts, and tips, including topics such as identifying safety risks inherent in patient populations, and encouraging the involvement of patients and families in patient care. Features include a matrix that identifies which 2007 goals are applicable to an organization, compliance solutions for each goal, tips and strategies for implementing the goals, answers to frequently asked questions, case studies from organizations that have successfully complied with the goals, and a summary of changes to the 2007 goals. The cost is $60 plus $12.95 for shipping and handling To order, call (877) 223-6866, 8 a.m. to 8 p.m. Central Time weekdays, or order on-line at www.jcrinc.com. Click on "Online Ordering," then "Publications and Multimedia" to search for the title.

Tips on meeting standard for organ donation policy

Hospitals are scrambling to develop a policy regarding organ donation after cardiac death (DCD) in order to be in compliance with a revised standard from the Joint Commission on Accreditation of Healthcare Organizations that goes into effect Jan. 1, 2007.

One of the most critical aspects of such a policy is clinical triggers for organ donation, according to **Denise Mogg**, RN, MSN, director of emergency services at St. Luke's Hospital in Kansas City, MO. While the overall policy is important, it's critical to give nurses a list of situations that might meet criteria for organ donation, "getting those triggers so imbedded in practice that it triggers the contact of our organ bank so they can come in and say 'yes' or 'no,'" she says. At St. Luke's, the criteria for DCD include:

• The patient has suffered a nonrecoverable neurological illness or injury requiring dependence on mechanical ventilation.

• The family, with the medical staff, has decided to withdraw life support.

• Based on the evaluation of the transplant network

staff, with the hospital health care team, the determination is made that cardiopulmonary death likely will occur within 60 minutes following withdrawal of life support.

• The transplant network staff will determine if the patient is a suitable candidate for DCD. That staff will utilize the most current criteria in determining the patient's suitability for organ transplantation.

Give nurses a card to carry

Because nurses are so busy, it's important to give them that information in an abbreviated format for everyday practice, Mogg says.

St. Luke's has compiled a condensed list of clinical triggers for all potential organ, tissue, and eye donors. That list includes the triggers above, plus the absence of two or more of the following brain stem reflexes: cough, gag, pupillary response, respiratory effort, or response to pain. According to the policy, determination must be made with the exclusion of: drug intoxication, hypothermia, severe hypotension, neuromuscular blockade, central nervous system depressants, and metabolic disturbances. **[The complete organ donation policy is available with the on-line version of *ED Management.* Section XIII covers DCD. If you're accessing your on-line account for the first time, go to www.ahcmedia.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, go to www.ahcmedia.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "ED Management," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the November 2006 issue. For assistance, call Customer Service at (800) 688-2421.]**

These clinical triggers have been put on a reference card that nurses carry behind their name badge and have been put in a book at the nurse's station, Mogg says. "That jogs their memory," she says. "Those clinical triggers are what they work with every day."

Nurses normally are assessing those triggers anyway, Mogg says. "We're just asking them to take it a step further and say, 'Hey, this is a good time to call the organ bank or the organ procedure agency, and this patient may be a potential donor," she says. "They're not making any donor decisions; they're just saying this is a potential one."

You should define cardiac death

In addition to clinical triggers, policies for DCD should include a definition of cardiac death, based on circulatory and respiratory criteria, says **Susie McBeth**, associate director of standards interpretation at the Joint Commission.

"Once they determine that there's no life, no possibility of life, then they determine how they will contact the OPO [organ procurement organization]," she says. ■

Joint Commission revises look-alike/sound-alike list

For the first time in several years, the Joint Commission on Accreditation of Health Care Organizations has revised the look-alike/sound-alike drug list.

New medication pairs added to the list for hospitals are hydroxyzine and hydralazine; metformin and metronidazole; and OxyContin and oxycodone. Deleted pairs include cisplatin and carboplatin, fentanyl and sufentanil, lantus and lente (insulin products), and taxol and taxotere.

In addition to identifying pairs or groups of medications that easily can be confused, the list identifies potential complications and strategies to avoid confusion.

ED managers can view the tips and the entire list with detailed information at www.jointcommission.org. Go to "Patient safety" on top navigation bar and select "National Patient Safety Goals." Under "2007 Resources," select "Look-alike/sound-alike drug list." The most recent additions appear in bold italics. ■

Joint Commission, Quality Forum announce winners

The Joint Commission on Accreditation of Healthcare Organizations and the National Quality Forum have announced the winners of the Joint M. Eisenberg Patient Safety and Quality Awards.

The winners for innovation in patient safety and quality at a regional level include:

• **Minnesota Alliance for Patient Safety (MAPS)**. MAPS is a partnership between the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health, and more than 50 other health care organizations. MAPS is a forum for sharing best practices and patient safety improvement efforts.

• **Pennsylvania Patient Safety Authority**. The Pennsylvania Patient Safety Authority is an independent state agency charged with reducing and eliminating medical errors by identifying problems and recommending solutions that promote patient safety in health care facilities. ■

ED Management®
The monthly update on Emergency Department Management

Times are good for emergency staffers, but for managers, the frustration continues

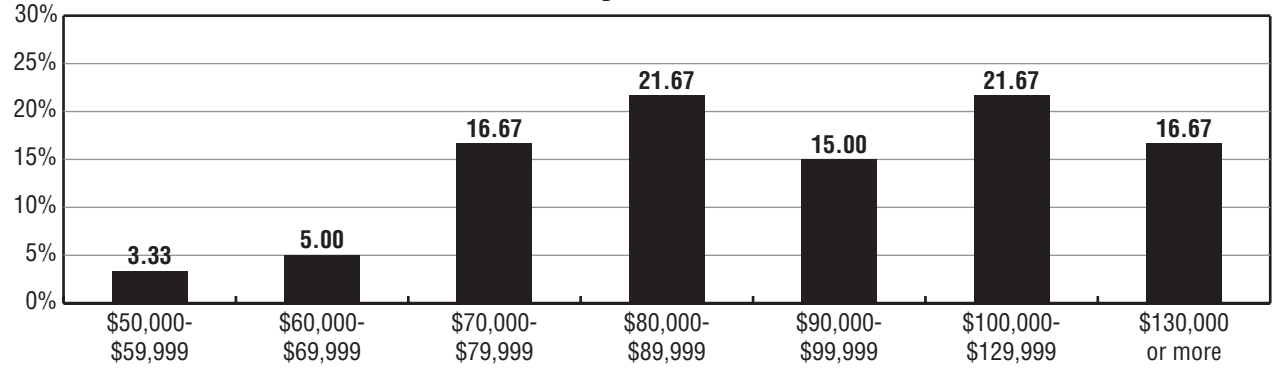
The continuing shortage of nurses and a growing shortage of physicians has created a twofold challenge for ED managers, say the experts. The first challenge: How to attract and retain talented staff. The second: Dealing with the sad fact that while staff salaries are surging, ED director and manager compensation lags behind.

"Unfortunately, compensation has not held up as much for managers as it has for staff nurses," says **Nancy Bonalumi**, president of the Emergency Nurses Association and director of emergency and trauma nursing at Children's Hospital of Philadelphia. "There's been an increase across the board [for staff nurses] because it has become so competitive."

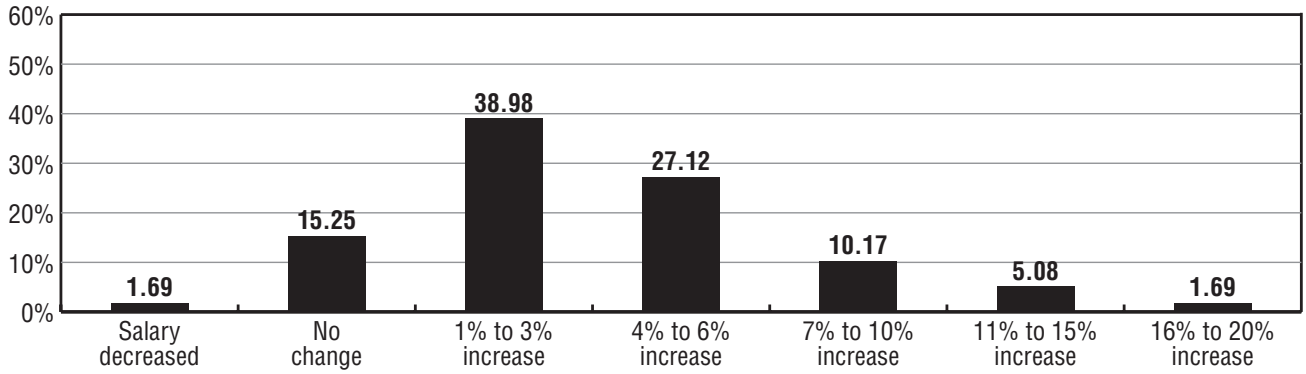
For the *ED Management* 2006 Salary Survey, 892 surveys were disseminated. There were 17 responses, for a response rate of 2%. The greatest percentage of ED physician and nurse managers (38.98%) received a modest increase of between 1% and 3% over the previous year. Another 27.12% received increases of between 4% and 6%. While 23.08% of survey respondents in 2004 reported annual gross income of between $80,000 and $89,999; this year, 21.67% said their income fell within that range. The figures for those making $90,000-$99,999 rose slightly, from 13.85% of respondents to 15%; for those making $100,000-$129,999, the increase was from 13.85% of respondents to 21.67%. **(See charts, below, and p. 2.)**

According to Bonalumi, however, individuals in ED management often end up in what she calls a "compression" situation, where staff nurses actually make more than they do. "The additional incentives offered staff nurses can be frustrating for managers," she explains. "We also need to be sure we are compensating our

What is Your Annual Gross Income from Your Primary Health Care Position?



In the Last Year, How Has Your Salary Changed?



leaders as well."

Nor are ED physician managers faring as well as the physicians they supervise, according to a survey of emergency physicians conducted by Daniel Stern & Associates, a Pittsburgh-based physician recruitment firm specializing in the field of emergency medicine, in partnership with PhysicianWork.com. According to their 2006 National Emergency Physician Salary and Compensation Survey, while total compensation for emergency physicians increased 6%, ED directors' total compensation remained basically flat.

"In cases where the staff people got more of an increase, it is because recruiting has become a major headache," says **Daniel Stern**, president of the firm that bears his name. "There is a shortage of ED docs — especially those who are credentialed — and it's a real competitive situation."

The disparity between staff and management increases is not always resented by ED managers, he says. "Some of the ED directors are older and looking to do less clinical time," he says. "You can work 30%-40% less clinically and not get paid as much, but your quality of life is better."

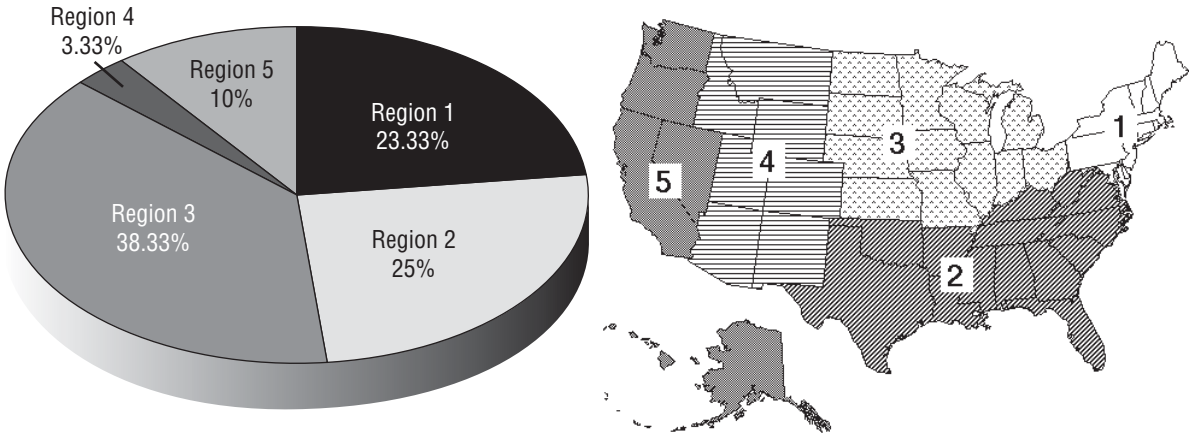
Becoming recruiters

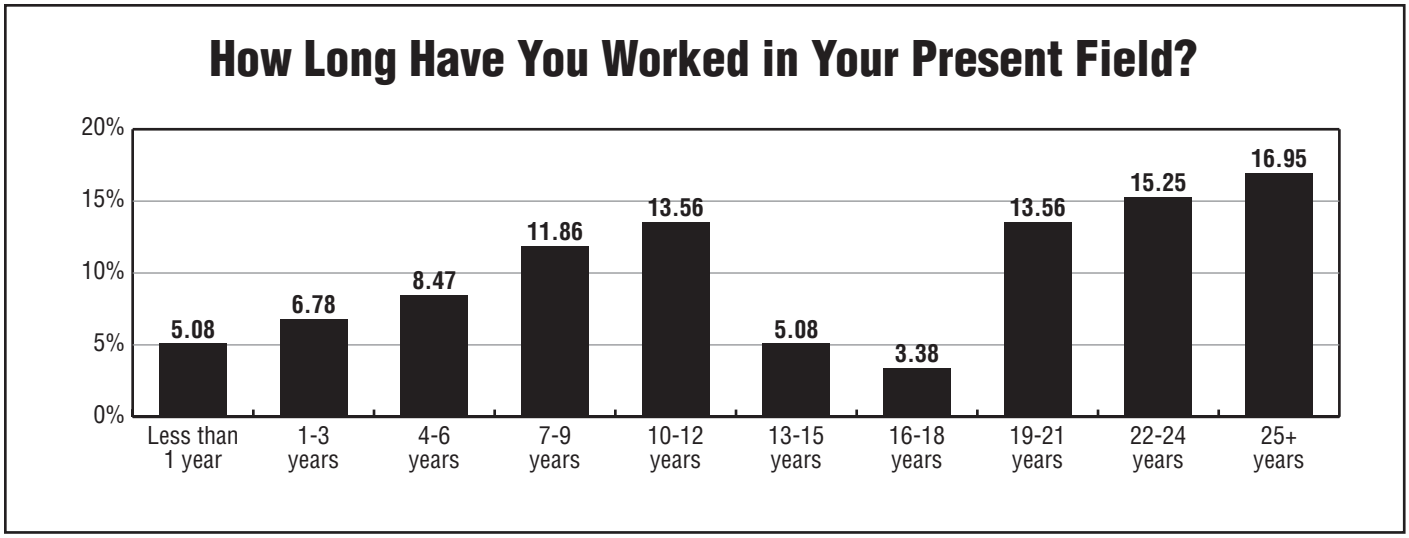
The harsh realities of staffing shortages have made it increasingly difficult for ED managers to recruit.

There have been some adjustments made in the last couple of years for recruitment and retention purposes, says **Peggie Parniawski**, MSN, RN, director of emergency medicine and oncology services at Bridgeport (CT) Hospital. "Usually, what we will do is the human resources department will scan the environment to see what salaries are and go through and make adjustments."

Bridgeport Hospital tries to simply raise the hourly base salary to be competitive, she continues. "This

Please Indicate Where Your Employer is Located





year, we went up $2 an hour," she reports of nurses' and managers' salaries.

For physician directors, it's the same story in terms of recruitment. There are several different approaches, says Stern. "One is to try to entice staff with more money and benefits," he says. If they're not successful, often the hospital will turn to management companies such as Emergency Medical Associates (EMA) in Livingston, NJ, or EmCare in Dallas, "and turn the whole recruiting headache over to that group," Stern says.

Turning over that responsibility is not necessarily a good thing for the director, he says. "Sometimes the director loses his job and the group takes over. Then the now ex-director may or may not stay [to practice as a physician] with the new group," Stern notes.

How can this situation be avoided? "You need to improve your negotiating skills," he advises. "A good ED director today needs diplomatic skills, quality skills, and a head for management."

These are definitely skills that were not part of the ED manager's skill set 10 years ago, Stern notes. "However, if directors are not successful in recruiting, it could cost them their job."

What attracts staff?

To be a more effective recruiter, say the experts, it's critical that an ED manager understand what attracts staff to a facility — and it's not always money. That knowledge can be especially important if your hospital's budget doesn't allow you to be competitive when it comes to salary.

"One of the biggest reasons a nurse will choose a facility is the work/life experience," says Bonalumi. "They are looking for work that is meaningful and rewarding, and they want to do it in a way that doesn't wear them out." Accordingly, she says, organizations are looking at creative scheduling, such as weekend only, so their staff can maintain a sense of balance.

"ED nurse managers have the ability to advocate within their organizations [for such arrangements]," says Bonalumi. "I encourage them to make a coalition with other nurse managers in their hospital; in fact, the ED nurse managers should be the leaders."

Bridgeport Hospital just put in a 403B with an employer match — which is important to employees, Parniawski says. The contribution, she says, varies from 3% to 8%, depending on years of service.

She, too, stresses the value of noneconomic incentives. "The key is creating a work environment that will attract providers," Parniawski says. "That includes collaborative relationships, good communication, having the equipment that is necessary to do your job in good working condition, a clean workplace, and management that allows employees to have a voice in decision making."

Attracting ED physicians in areas where salaries are lower is very difficult, admits **David McKenzie**, CAE, director of the reimbursement department for the Dallas-based American College of Emergency Physicians (ACEP). "If your physicians are on salary, perhaps they might work shorter shifts for the same pay — or someone else might pay their malpractice insurance premiums," he suggests.

What you can't control

Knowing what attracts staff becomes even more important when you factor in issues over which you have no control — such as geography. In the Southeast and North Central areas, for example, ED physicians are paid up to 20% more than those in the Northeast

and South Central areas, according to Stern's survey. At present, the largest number of ED managers who responded to the 2006 Salary Survey (38.33%) are located in Region 3 — the Midwest — and 25% are located in Region 2 — the South, and these statistics closely reflect the greater desirability of working in those areas where physician pay is highest and recruiting may be easiest. **(See map and corresponding chart of regional salaries on p. 2.)**

Geographic preferences also are related to malpractice costs, says Stern, noting that states which cap malpractice awards are seen as more attractive. "When I talked to the doctors, they said they would not move to a state that had no caps because it was too stressful," he shares. ED directors, he adds, tend to be generally less mobile than their staffs, but they are moving from state to state because of their own rising malpractice insurance rates and general demographic trends, such as cost of living.

. . . Recognition can be as important as additional compensation, Parniawski says. "You want to work for an organization that is committed to recognizing and rewarding employees thoroughly and competitively — especially when you have achieved recognized outcomes."

More money to recruit?

Malpractice costs also affect the ability of the ED director to recruit physicians, says McKenzie. They may be high in seniority in their group, "But in terms of the director having to come up with more money to retain or recruit clinical physicians, that's a factor of the group structure," he says

Group structure is one of the key factors in compensation for ED physicians and managers, notes Stern. "The most lucrative is the private group," he reports. "Fee for service can also be lucrative if you are well-organized and have a good patient mix." At the low end of the spectrum are academic groups, Stern says.

For nurse managers, geographic disparities in salary can be an added frustration. 'While there is an awful lot of regional variance [in compensation], what's not being reflected is how challenging the work is becoming for the nursing leader, regardless of region," says Bonalumi. "The cost of living may be different in some areas, but they are still not compensating you for the hours you put in."

The road to greater pay

The good news is that the future may bring greater increases for ED managers, Stern says. "As the baby boomers slowly but surely retire and a younger cadre of doctors moves into their slots it will aggravate the staffing problem, but that means an overall shortage of doctors on all levels," he notes. "It'll bode well for compensation of ED directors."

The proposed movement of Medicare to a pay-for-performance model of reimbursement also could create additional earning opportunities for ED directors, says McKenzie. 'This involves the management of the entire ED staff, and documenting the clinical behaviors tied to [Medicare's] performance measures," he notes. "There could well be incentives tied to that." It follows, then, that if you have a group that does well in terms of those performance measures, there will be more money — and if you do poorly, you will receive less, McKenzie says. "Physician payment will be directly tied to that very soon," he says. "It would benefit your department as well as the docs if they earn more." If your hospital pays staff salaries, "it is very important for them to maximize the revenue they are generating so they can cover salaries and hopefully keep something for themselves," McKenzie says.

How to benefit

How can ED directors put themselves in a position to benefit from this new reality? "They will have to understand exactly what the measures are and what documentation will be required to allow whoever is extracting the data to recognize whether the performance measures are met, are not met, or are not met unintentionally due to extenuating clinical circumstances," McKenzie says.

ACEP will be in a position to provide such instruction, or the directors can learn from the payers, McKenzie says. "Medicare is currently designing a pay-for-performance program, but private payers have pay-for-performance programs, too, so the physicians would have to work with their payers to identify what performance measures are in place and how they should be documented," he says.

Parniawski agrees that meeting quality performance measures is taking on greater importance for ED managers. However, recognition can be as important as additional compensation, she says. "You want to work for an organization that is committed to recognizing and rewarding employees thoroughly and competitively — especially when you have achieved recognized outcomes," Parniawski says. Recognition does not always have to be financial, she says. "It can simply be a thank you from the CEO, or recognition programs where your name is mentioned at forums or in organizational publications." ■

Title/Description			Filing No.
EMERGENCY DEPARTMENT MAXIMUM CAPACITY/DIVERSION - DRAFT			
Effective Date	Replaces No. New	Applied to: Emergency Room	Approved by: Connie Davis RN, DON

POLICY:

Events resulting in multiple emergencies or massive casualties may exceed the safe capabilities of available staff and technology of TCH. This policy will serve as a guide to define these situations.

POLICY:

Tahlequah City Hospital Emergency Department has a responsibility to provide appropriate and timely care to those persons who present with an emergency medical condition. Therefore when all resources are utilized to the maximum, it may become necessary for TCH to divert patients to facilities whose resources are both more appropriate and available. Diversion status will operate on a graduated level basis, meant to address pressing needs quickly. The ED charge RN will be responsible for the initiation of each level, in consultation with the ED Physician, by submitting diversion request information to the House Supervisor. The House Supervisor will relay the information to the ED Director. Depending on the level of diversion, the ED Director will consult with other area hospitals and the EMS Director. At no time will a cardiac arrest or any patient who presents by POV be diverted from the emergency room.

PERSONNEL:

All ER staff, Physicians, Hospitalist, ED and EMS Directors, and Administration.

PROCEDURE:

ED Code Triage: Is to be used when resources are being taxed by high volume (high volume will be defined at 18 patients minimum checked into the ED) of patients logged into the ED or high volume, coupled with the presentation of several urgent (Priority II) patients. The ED charge RN may initiate **ED Code Triage** if:

There is a minimum of 18 patients logged into the ED or,
There is a combination of 6 Priority II and/or Priority I patients, or
There are 3 Priority I patients
Wait times are beginning to exceed 2 hours

ED Code Triage is meant to "divert" internal resources to the ED to assist in processing patients to prevent total obstruction of movement through the ED. The key resource at this stage will be the ED charge nurse and House Supervisor, who can pull people from other areas, allowing the ED charge nurse to assign specific tasks to individuals to ease the load and expedite patient processing.

ED Code Triage would expect to be resolved within 30 minutes to a maximum of 2 hours. If not,

Title/Description			Filing No.
EMERGENCY DEPARTMENT MAXIMUM CAPACITY/DIVERSION - DRAFT			
Effective Date	Replaces No. New	Applied to: Emergency Room	Approved by: Connie Davis RN, DON

move to **ED Triage – Level 1**.

ED Triage – Level I – Should **ED Code Triage** last longer than two hours and the ED continues to have a large volume of patients (18+) or coupled with urgent (Priority II) and emergent (Priority I) patients, the **ED Triage – Level I** should be initiated.

A second physician or secondary provider shall be called in from the ER physician group along with a RN to process patients. EMS should be actively pursued at this point for any assistance they can give, including ongoing triage and assessment. Lab, Cardiopulmonary and Radiology should be alerted to assist with high priority ED needs. At this point, utilization of air assets should be considered if ground ambulances are not available and the lack of transportation will result in delays of transfers out of the ER.

ED Triage Level I shall be evaluated every 30 minutes by the ED charge RN for progress. If after 2 hours the situation is not resolving or in fact is deteriorating, the charge RN should request to move to **ED Triage – Level II**.

ED Triage – Level II – Shall be initiated in the event that:

The ED has been at a Triage – Level I for more than 2 hours, and
There is a minimum of 24 patients checked into the ED, or
4 or more urgent (Priority II) and/or the presentation of 3 or more emergent (Priority I) patients.

The House Supervisor shall call in all Nursing Directors to evaluate their units for additional resources; be it manpower, space or the ability to redirect patients within the hospital.

The ED Director will call local resources for possible redirection of current ED patients, or ambulance diversion. Ambulance diversion will occur only after consultation with the EMS Director and will require updating every 30 minutes.

At this point TCH will make every effort to call in a third Physician or Physician Extender and RN to facilitate patient processing in other areas of the hospital.

The goal at this level will be to see and discharge non-urgent (green) patients as quickly as possible. (Medical screen and F/U appointments for those who can wait with PCP is an option) Admit or transfer by EMS urgent (Priority II) patients, and stabilize and transfer emergent (Priority I) patients.

ED Triage – Level II will be reevaluated every 30 minutes by the ED charge RN, Director of the ED and Director of EMS. Any further stress on hospital resources, for example other hospital resources are experiencing the same load and cannot accommodate any additional volume, will require initiation of hospital-wide **CODE ORANGE.**

Title/Description			Filing No.
EMERGENCY DEPARTMENT MAXIMUM CAPACITY/DIVERSION - DRAFT			
Effective Date	Replaces No. New	Applied to: Emergency Room	Approved by: Connie Davis RN, DON

REQUEST FOR DIVERSION STATUS

1. General Reason:

2. Total # of patients logged into the ED?_____

# of emergent (red) _____

# of urgent (yellow) _____

# of non-urgent (green) _____

3. What would best alleviate the situation?

ED Director called at: _____ by _____ Responded at: _____

Other calls made to: _____ at _____ by _____

Other calls made to: _____ at _____ by _____

Other calls made to: _____ at _____ by _____

ED Diversion Level _____ Began: _____ Ended: _____