ED NURSING™

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ED nursing care of chest pain patient ruled homicide by jury

Case is an ED nurse's 'worst nightmare'

The 49-year-old woman reported classic heart attack symptoms — chest pain, shortness of breath, and nausea — to nurses at an Illinois ED. But according to public records, the patient was seen only briefly by the triage nurse and then waited two hours. When nurses came back to check on the woman, she was dead. A coroner's jury declared it a homicide, which means that the ED nurse involved could be criminally prosecuted.

"This case has definitely created lots of discussion among emergency nurses," reports **Evelyn Lyons**, RN, MPH, manager of the Illinois Emergency Medical Services for Children program, based at Loyola University Medical Center in Maywood, IL, and president of the Illinois chapter of the Emergency Nurses Association. "There is a really strong reaction from ED nurses throughout our state. We'll be following this case very closely."

The case hit home with ED nurses who are struggling with long wait times and sicker patients, she says. "Our EDs are overcrowded, and we have a nursing shortage," she says. "Nurses are overextended, and EDs are stretched to the seams."

At press time, no criminal charges or lawsuits had been filed, but emergency nurses nationwide are waiting for further news. **Kathryn Eberhart**, BSN, RN, CEN, a Santa Rosa, CA-based legal nurse consultant and ED nurse at Santa Rosa Memorial Hospital, says she has never heard of this situation happening

EXECUTIVE SUMMARY

When a patient died of a heart attack in an Illinois ED waiting room, a coroner's jury declared it a homicide, opening the door for criminal prosecution of the triage nurse. Long wait times and overcrowded EDs increase liability risks for nurses.

- Instruct patients or caregivers to tell the triage nurse if symptoms worsen.
- Tell individuals accompanying the patient to act as an advocate.
- Use cordless phones or electronic systems to keep triage and charge nurses updated about patients who are waiting.

before. "However, two hours with chest pain? That's too long," says Eberhart. The patient should have been classified as emergent and taken into the ED immediately for an electrocardiogram and work-up, she says.

Since the patient never saw a physician, the triage nurse would be the one on the hook if any charges are brought, says Eberhart. "It's hard for me to understand how a triage nurse could not identify this patient as one of those that you don't put in the waiting room," she says. "You find a bed, notify the charge nurse, and document, document." **(See story on p. 15 about EDs using other medical personnel in triage and waiting rooms.)**

Regardless of the details, this case should be a wake-up call for ED nurses, says Eberhart. ED nurses need to be careful and diligent in the triage process, she says. "Triage is a big responsibility and should never be taken lightly," Eberhart says. "Triage is one of the toughest jobs in the ED and should only be performed by experienced nurses."

What happened is "a nurse's worst nightmare," but the circumstances are not unusual for ED nurses dealing with the burden of overcrowding, says **Patricia Iyer**, MSN, RN, LNCC, president of Flemington, NJ-based Med League Support Services, a legal nurse consulting firm specializing in malpractice and personal injury cases. "No emergency nurse ever wants any patient to wait, but every triage nurse has had to place patients in the waiting room they were uncomfortable with," she says.

Surge in lawsuits?

This is a dramatic case with a dramatic outcome, and thus it is unusual, says Iyer. "However, if the damages are significant, more lawsuits could arise," she says.

Lawsuits claiming "ED nurses made me wait too long" are a real possibility, says Eberhart. "I think we may see an increase in malpractice cases alleging that the patient waited too long," she says. "With overcrowding of EDs, closing of hospitals across the country, and long wait times, really sick people may be waiting for an empty gurney. "

However, the plaintiff has to prove that a long wait resulted in a worsening of their condition, with tangible damages associated with the wait, cautions Iyer. "The dissatisfaction alone of having to wait will not provide the basis of a lawsuit," she says. "Plaintiff attorneys can't afford to take cases involving dissatisfaction without real injuries."

Regardless of liability risks, there is no question that patients are dissatisfied over long waits, says Iyer. "Fast track systems that siphon off the less urgent patients to a separate area of the ED are one way to keep the focus on the sicker patients," she says. People in our culture are generally accustomed to rapid service, Iyer says. "Long waits breed discontent and sow the seeds for a disaster such as the one reported in this story."

To reduce risks in your ED's waiting room, implement the following practices:

• Inform every patient to tell the triage nurse if they feel worse.

Triage nurses should advise patients that if they feel worse or if any other symptoms begin to occur while they are in the waiting area, they need to notify the triage nurse promptly so that they can be reassessed, says Lyons.

"When the patient is elderly or a child, the triage nurse needs to provide these instructions to the parent or caregiver so they can be attentive to any changes in

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the patient's condition," Lyons says.

• Reassess patients often.

You must continually observe all patients in the waiting room, advises Iyer. Periodic vital signs and reassessments are needed, particularly when waits are long, she says. "Verify that symptoms have not gotten worse while the patient is in the waiting area," Iyer advises. "Observe the patient, noting the focus of the primary complaints." **(For more information on this topic, see "Are patients with life-threatening conditions in your waiting room?" *ED Nursing*, August 2005, p. 109.)**

Ask questions specific to the patient's complaints; reassess vital signs, pulse oximetry, pain, and skin signs; and look for any new complaints or changing symptoms, says Eberhart.

• Give patients an advocate.

"If there is someone that I feel is at higher risk for injury and yet there is no place to put them, no empty gurneys, and my hands are tied, I make sure they have a family member or friend that will stay with them in the ED waiting room and be an advocate," says Eberhart.

If patients come in alone, they are placed in a wheelchair within view of the triage are, or as a last resort, in front of a secretary or tech in the hallway until a room is available, says Eberhart. "They are placed in a visible place so that the triage nurse can continue with triage of the rest of the patients and yet be able to eyeball the patient that is at high risk or has a complaint that places them in a higher risk category for injury," she says.

• Improve communication.

Always keep the charge nurse updated as to the status of the waiting room and the patients waiting for triage or waiting for a bed, says Eberhart. "Communication is a key factor in any emergency department," she emphasizes.

At Santa Rosa's ED, triage nurses carry a cordless phone and pager at all times to alert other staff when triage becomes overloaded. During these times, a secondary triage area is set up, and an ED technician assists with vital signs and moving patients.

The triage nurse can dial the charge nurse's phone that is carried at all times to keep the charge nurse updated as to the status of triage, adds Eberhart. "Our ED's tracking system [MEDHOST, based in Addison, TX] has an icon that informs the charge nurse of exactly how many patients are waiting," she adds. "With a click, you can see what the chief complaint is and the acuity at triage."

The media coverage of the Illinois case has caused added tension between patients and ED nurses, making good communication even more important, says **Elda Ramirez**, MSN, RN, PhD, FNP-C, CEN, an ED nurse practitioner at the University of Texas Health Science Center (UTHSC) in Houston and assistant professor of nursing in the emergency care division of UTHSC's School of Nursing. "Patients already have a preconceived notion that we won't help them," she says. "They come in with the attitude, 'If I'm not aggressive and rude, they won't pay attention to me.' The level of hostility has really increased. This disrupts the flow of care." ■

EDs using non-nurses in triage, waiting rooms

Practices 'take a lot of the risk out of triage'

A recent Illinois case of a patient dying in an ED waiting room after being seen briefly at triage underscores the increased pressures emergency nurses are facing, due to long wait times and overcrowded EDs.

"Most disturbing is the fact that this kind of scenario could happen in almost any ED," says **Donna L. Mason**, RN, MS, CEN, nurse manager of the ED at Vanderbilt University Medical Center in Nashville, TN.

Failure to address ED crowding and wait times is "a disaster waiting to occur" in many EDs, she says. "It affects patient safety. The frustration leads to nurse dissatisfaction and retention issues, leading to an even worsening of nursing shortages," Mason adds.

To ensure that no patients are overlooked during long waits, some EDs are using non-nurses at triage

EXECUTIVE SUMMARY

To reduce risks when the ED is overcrowded, some EDs are using physicians or midlevel practitioners at triage, and others are using paramedics or volunteers in waiting rooms.

- Physicians at triage cut the number of patients who left without being seen from 11% to 2% at a Tennessee ED.
- Nurse practitioners or physician assistants at triage help to identify patients at risk for worsening during their wait.
- Paramedics in the waiting room report changes in a patient's condition to triage nurses.

and in waiting rooms. Here are two of the ways this is being done:

• Physicians or midlevel providers work with triage nurses.

At Vanderbilt's ED, a physician is at triage 16 hours a day to initiate orders, evaluate patients, or determine who can be treated in the waiting room safely. The program has been very successful, reports Mason. "Some patients never go to an exam room," she says. "Our left-without-being-seen rate has dropped from 11% to 2%."

To see how this program works, consider the example of a young person with abdominal pain who is hemodynamically stable with good vital signs. This patient would be assessed by the triage nurse, with necessary tests ordered by the physician. An LPN or paramedic would ensure contrast is given and any necessary medications are started. "Then tests are obtained and done, and the patient never goes to a bed," she explains. "When a bed becomes available, they are placed."

The ED has two triage stations and three "team triage" small examination rooms divided by walls with curtains in the front for privacy. "Blood draws are done in these rooms if needed but may also be done at triage," says Mason. "There are stretchers in the rooms, so electrocardiograms can be done there also."

Don't miss patients at risk

At University of Texas Health Science Center in Houston, nurse practitioners or physician assistants work with ED triage nurses 24 hours a day. "I sit up front with the triage nurses so I can actually start treating the patient, which takes a lot of the risk out of triage," says **Elda Ramirez**, MSN, RN, PhD, FNP-C, CEN, an ED nurse practitioner at the University of Texas Health Science Center (UTHSC) in Houston.

The goal is to be sure that patients at risk of getting progressively worse aren't missed, she says. "The patient may be awake and alert and breathing right now, but based on their history, this can change quickly," says Ramirez. "I may see a baby playing at triage, but if the history is vomiting and diarrhea for 24 hours, that kid can turn on me on a dime."

• Patients in waiting rooms are closely observed.

At Vanderbilt's ED, paramedics alert nurses when a patient's condition changes or their pain become more severe. The paramedics are seated at a desk at the ED entrance, with clear visibility of the waiting room. Triage nurses tell patients that the paramedics are there in case they have any concerns. "Having those medical 'eyes' in crowded waiting rooms lets patients and families know there is a medical person to liaison with," says Mason.

For example, patients may present with kidney stones without pain but may develop significant pain during their wait. "The medical 'eyes' can spot an increase in pain, changes in a patient's color, or altered behavior, and address it immediately with the triage nurse, physician, or charge nurse," she explains. "They are also the 'go-to' person for questions that our patients may have."

At University of Texas' ED, volunteers and security guards are stationed in waiting rooms, wearing identification so patients are alerted to their presence. Volunteers attend orientation training, and they communicate with triage nurses using handheld radios. "They go directly to the nurse if a patient doesn't look right or for any kind of situation," says Ramirez.

SOURCES

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Recently, a greeter ran to Ramirez and told her that a patient looked very ill. The man had come in earlier with family members saying that his arm had been shaking earlier in the day, but he reported no other symptoms. "I immediately went out front and saw that his eye was flickering, and it turned out he was having a petit mal seizure," she recalls. The man was taken right to a room, had an intravenous line put in, and medications administered. "If this patient had been kept waiting, he could have lost oxygen to his brain or his airway could have been compromised," says Ramirez.

The Illinois case underscores the liability risks emergency nurses face every day, she notes. "Right now, every nurse is feeling, 'This could have happened to me,'" Ramirez says. "As emergency nurses, we never know what's going to come in the door." ■

Reassess pain to comply with JCAHO standards

Avoid having dissatisfied ED patients

If you don't reassess a patient's pain levels periodically and document this reassessment, you're not in compliance with requirements from the Joint Commission on Accreditation of Healthcare Organizations.

"Management of patients' pain translates into higher patient satisfaction, efficiency, and quality care delivery," says **Karen Rollo**, RN, BSN, CEN, SANE-A, ED nurse at Christiana Care Health System in Newark, DE.

To improve reassessment of pain, do the following:

• Ensure consistent reassessment.

ED nurses at Christiana Care have been inserviced on the Joint Commission standards. "The timing of pain re-assessments should be based on when the intervention is expected to work," says Rollo. "For most medications, this would be approximately 15-30 minutes after administration."

Nurses are encouraged to strive to improve consistency of pain reassessment, with constructive feedback, e-mail reminders, and periodic inservices, she reports. For example, ED leadership recently sent an e-mail to nurses stating, "Congratulations to all staff on achieving 100% compliance with regard to assessing patient's pain in the ED for this month."

Rollo says, "If the staff feels that they are responsible for high scores and positive patient feedback and are made aware of this, they are much more motivated to be proactive in pain assessment and management."

• Ask patients for input.

When reassessing pain levels, nurses at Christiana Care's ED use a numerical pain scale and also ask the patient, "Have we managed your pain to your satisfaction?" "This elicits both objective and subjective responses," says Rollo.

• Use electronic systems.

At University of Tennessee Medical Center in Knoxville, an icon on the ED's tracking system [First Net, manufactured by Kansas City, MO-based Cerner Corp.] reminds nurses that the patient is due for another pain score assessment. A pain score is documented before and after administrating any pain medications, says **Sheila Duncan**, RN, EMT, ED nurse manager.

Once the nurse gives pain medication, she or he clicks on the pain reassessment icon so that the nurse or the technician working in that zone will have a reminder to recheck the effects of the medication on an hourly basis, she explains.

When nurses perform pain reassessment, they also check vital signs. "Any changes in the patient's condition can be identified, and pain assessment is part of that process," says Duncan. The process also has helped with the ED's patient satisfaction scores because patients feel they are being checked by the nurse at frequent intervals, adds Duncan. Satisfaction scores have increased from 69% into the low 80s, she reports.

• Audit charts for reassessments.

At Baylor Regional Medical Center at Plano (TX), charge nurses perform "pain audits" for 100% of patient charts one day every week, says **Mark Sargent**, RN, clinical manager of the ED. "We monitor or spot-check charts to ensure that if a pain medication was given, a reassessment was accomplished within one hour of administration," he says.

Nurses look specifically for initial pain assessment upon arrival to triage, intervention at triage or in treatment rooms, and reassessment within one hour. "The spot checks are performed by me on the off days

EXECUTIVE SUMMARY

Reassess a patient's pain at regular intervals, based on when the medication is expected to work, to comply with accreditation requirements.

- Send e-mails to nurses congratulating them on improvements in pain reassessment.
- Ask patients if their pain has been managed to their satisfaction.
- Use electronic systems to remind nurse that patients are due for another pain score assessment.

SOURCES

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between pain audits," Sargent says. He checks 10% of the charts per day, he says. "If the documentation is not in the chart, it becomes a coaching opportunity for me and the individual nurse," says Sargent.

Coaching for nurses

The ED's weekly compliance rate is posted on the communication board, along with a graph showing the percentages rates of individual nurses whose charts were audited. "If pain is not assessed in triage and reassessed after pain intervention within one hour, that nurse is coached by me," he says. Currently, the ED is averaging 97% compliance, he reports.

At Christiana Care, ED nurses on the hospital's performance improvement committee monitor charts to assess consistency of pain medication administration and reassessment, then update staff with the results and any opportunities for improvement, says Rollo. One previous problem was that pain was reassessed inconsistently when the ED was overcrowded. "Reassessing pain after the administration of medication may be delayed if the nurses are initiating a lot of care from the triage area," says Rollo.

During high-volume times, patient care technicians now help with retaking vital signs and obtaining pain scores, adds Rollo. "The technicians are not making an assessment, but if someone needs more pain medication or a reassessment, they bring it to the nurses' attention," she says. ■

Pneumonia with atypical symptoms: Risk of delays

Nursing documentation is key

Only 43%-64% of adult ED pneumonia patients in two Pennsylvania EDs got antibiotics within four hours as recommended by current guidelines, says a new study. In addition, researchers found that patients with atypical symptoms had the biggest risk for delays.[1]

"Atypical symptoms include the absence of respiratory complaints or focal lung findings, such as a nursing home patient with abdominal pain who ends up having an lower lobe infiltrate on abdominal CT, or an immunocompromised patient with fever without a cough who ends up having a pneumonia," says **Jesse M. Pines**, MD, MBA, the study's author and an ED attending physician at the Hospital of the University of Pennsylvania in Philadelphia.

Four-hour antibiotic administration in patients admitted with pneumonia is being measured by the Centers for Medicare & Medicaid Services (CMS) and soon will be tied to hospital reimbursement in a pay-for-performance program. "ED nurses should be aware of this," he says. "Delays in antibiotic administration can exist across all processes involved in the ED diagnosis and treatment of pneumonia." An example of a nursing delay is a delay in antibiotic administration after antibiotic order, he says.

To determine compliance in the pay-for-performance program, hospitals go by when antibiotics are marked as given by an ED nurse, says Pines. This determination is done by a retrospective chart review of patients who are discharged from the hospital with a

Continued on page 20

EXECUTIVE SUMMARY

Adult pneumonia patients often are not receiving antibiotics within four hours, and patients with atypical symptoms are at higher risk of delays, says a new study.

- Document that antibiotics are given immediately after administration.
- Consider ordering chest X-rays from triage, and use standing orders for labs.
- Save time by asking radiologists to inform ED physicians when X-rays are completed.

Name

MR Number

Patient Identification

Patient Label

VCU Health System
MCV Hospitals and Physicians
Richmond, VA 23298

Date

Community Acquired Pneumonia Guidelines

Inclusion Criteria

- — Infiltrate on Chest Radiograph
- — One or more of the following symptoms
  - — Cough
  - — Malaise
  - — Fever (T greater than 101.5)
  - — Heart Rate less than 120/min

Exclusion Criteria

- — No infiltrate on Chest Radiograph
- — Age less than 18 years old
  - — Clinical suspicion of
  - — Aspiration pneumonia
  - — Tuberculosis
  - — Pulmonary Emboli

Stratify Patient by Fine criteria

Patient Characteristics		**Points**
Age in years		
Male		_____
Female (age minus 10)		_____
Nursing home pt	+10	_____
Neoplastic Disease	+30	_____
Liver Disease	+30	_____
CHF	+10	_____
Cerebrovasc disease	+10	_____
Renal disease	+10	_____
Resp rate greater than 30	+20	_____
Systolic BP less than 90 mmHG	+20	_____

		Points
Altered Medtal Status	+20	_____
Temp (less than 95 or greater than 104	+15	_____
Pulse greater than 125/min	+10	_____
pH less than 7.35	+30	_____
BUN greater than 30 mg/dl	+20	_____
Sodium less than 130 mEql	+20	_____
Glucose greater than 250 mg/dl	+10	_____
Hematocrit less than 30%	+10	_____
Pleural effusion	+10	_____
PO2 less than 60 or Sao2 less than 90%	+10	_____

TOTAL POINTS _____

Risk Class I - II: less than 70 pts, Class III: 71-90 pts, Class IV: 91-130 pts, Class V: greater than 130 pts - Outpatient management for class I & II unless clinically contraindicated. Class III - Decision for admit based on clinical picture.
Admission is recommended for class IV & V.

Physician Orders		**General Orders**	Nursing Documentation	
Initials	Time		Initials	Time
		Heme 18		
		Basic Metabolic Profile		
		CXR		
		Blood Culture prior to antibiotic administration *(admitted pts)*		
		Sputum culture if obtainable (admitted patients only)		
		Pulse Ox: _____RA Nasal oxygen at: _____L/min		
		IVF:_____		
		Negative pressure isolation		
THE GOAL IS FOR ANTIBIOTICS TO BE GIVEN WITHIN 4 HRS OF PRESENTATION				
Inpatient Antibiotic Therapy				
		Levofloxacin 500 mg PO or 500 mg IV (located in Pyxis)		
		Ceftriaxone 1 gram IV (located in Pyxis)		
		Azithromycin 500 mg PO or IV (both located in Pyxis)		
ICU & Imunocompromised Inpatient Antibiotic Therapy				
		Ceftriaxone 1 gram IV (located in Pyxis) ***AND either***		
		Azithromycin 500 mg IV (located in Pyxis)		
		Levofloxacin 500 mg IV (located in Pyxis)		
		Zosyn 3.375 gm IV (located in Pyxis)		
Standing Nursing Preventive Medicine Orders				
		Pt is: __smoker ___quit within 12 mos___household w/ smoker		
		If any apply, please give smoking cessation flyer to patient	**____Non smoker**	
Additional Orders				

Print/Signature: MD _____/_____ **Print/Signature: RN** _____/ _____

Print/Signature: MD _____/_____ **Print/Signature: RN** _____/ _____

Form H-MR-714 5/06
Emergency Department

Source: Virginia Commonwealth University Health System, Richmond.

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primary diagnosis of pneumonia or a primary diagnosis of respiratory failure and a secondary diagnosis of pneumonia, and who meet other criteria as determined by Joint Commission and CMS, he explains. "Nursing documentation is important to these reviews," he says.

Some computerized information systems require that medications be signed off as given, but in order to meet federal performance standards, ED nurses should not wait to do this in the case of pneumonia, says Pines. Instead, document that the medications were given immediately after administration, he advises.

Make physicians aware that pneumonia is suspected, and consider ordering chest X-rays from triage, suggests Pines. "Because early antibiotic administration has been associated with improved outcomes, it is possible that early recognition and early treatment of pneumonia with antibiotics may improve care," he says.

Use criteria to speed treatment

At Virginia Commonwealth University Medical Center in Richmond, ED nurses use a tool to identify community-acquired pneumonia patients with inclusion or exclusion criteria. Standing orders are used for labs, with a goal to give antibiotics within four hours of presentation, says **Steve R. Rasmussen**, RN, CEN, clinical coordinator. **(See pneumonia identification tool used by ED nurses on p. 19.)**

"Once identified, we stratify patients by assigning point values to patient characteristics criteria, calculate a 'risk class,' and determine a plan of care," he reports. "This form helps streamline the medical orders and fast track the patient into the treatment plan."

To expedite treatment, antibiotics now are stored in the ED for immediate use, reports Rasmussen. "The time it took to obtain an antibiotic order, send it to the pharmacy, prepare the medication, and administer it was prohibitive to our four-hour window," he says.

At Gwinnett Medical Center in Lawrenceville, GA, "We have put a lot of work into identifying patients who present with symptoms suggestive of pneumonia, getting blood cultures, and giving the first dose of antibiotic within four hours," says **Denise Proto**, RN, MS, CEN, nurse educator for emergency services.

Triage nurses use the following criteria: Altered mental status that is not drug- or alcohol-related, fever of over 100.5° without obvious source, difficulty breathing, and oxygen saturation less than 95%. If a patient presents with any of these symptoms, a "community-acquired pneumonia (CAP) alert" chest X-ray is ordered by the triage nurse. "We have trained the radiology technologists to alert the designated ED physician when a 'CAP Alert' X-ray has been completed," says Proto. "We identified that the radiology staff were the best ones to tell the physician that the X-ray was done, vs. an ED charge nurse trying to keep on top of that."

Compliance with antibiotic administration has been steadily improving since the new system was implemented in May 2006, she reports. "This has given us a chance to work through the kinks before the really busy cold and flu season hits," she says.

Reference

1. Pines JM, Morton MJ, Datner EM, et al. Systematic delays in antibiotic administration in the emergency department for adult patients admitted with pneumonia. *Acad Emerg Med* 2006; 13:939-945. ■

Identify children at high risk for poor ED aftercare

Failure to comply is 'pervasive problem'

Only 60.4% of pediatric patient guardians followed up with ED discharge instructions to see a physician, says a new study.[1] Researchers found that patients with lower socioeconomic status were at greatest risk of poor aftercare compliance.

"Those without private insurance are much less likely to follow up than those with private insurance," says **N. Ewen Wang**, MD, the study's lead author and associate director of pediatric emergency medicine at Stanford (CA) University School of Medicine.

This problem is pervasive, says **Marianne Hatfield**,

EXECUTIVE SUMMARY

Discharge instructions given to pediatric patients in the ED often are not followed, and patients without private insurance and lower socioeconomic status are at higher risk.

- Tell caregivers what could happen if instructions aren't followed.
- Put instructions in writing.
- Ask parents to demonstrate tasks such as dressing changes.

RN, system director of emergency services at Children's Healthcare of Atlanta, who adds that she thinks the study results are accurate. "Part of our discharge routine is to ask if the family has a primary care physician," Hatfield says. "If they do not, we have a referral line, and we ask that they utilize the number to try to get them enrolled with one."

In addition, the ED has financial counselors who follow up with all self-pay patients to see if they are eligible to be enrolled in Medicaid or indigent care funding and who help them to find a primary care physician. This is not a violation of the Emergency Medical Treatment and Labor Act, because payer status is not shared with clinical staff, and the financial counselors meet with patients only after they are discharged from the ED, adds Hatfield.

To improve compliance with discharge instructions for pediatric patients in your ED, do the following:

• Find alternatives when possible.

If you are discharging a child and think it's likely that parents may not comply with follow-up care, try to do all possible interventions in the ED, suggests Wang. For example, for a very young child with a urinary tract infection or abscess, encourage the physician to give the first dose of antibiotics in the ED, she says.

• Be specific about what may happen if instructions aren't followed.

Explain verbally what patients need to do, why they need to do it, and what may happen if they do not, says **Jennifer Hinrichs**, MSN, RN, CCRN, advanced practice specialist at the Emergency Medicine and Trauma Center at Children's National Medical Center in Washington, DC. "Most parents do not want to do harm to their child," she says. "If they hear they can cause harm by stopping antibiotics before the course is over or by not doing a dressing change, you can get them to do it," says Hinrichs. **(See sample script of discharge instructions, below.)**

• Write instructions down for caregivers to refer back to.

"While they are in our ED, they may be stressed or have multiple things on their mind. It is so easy to forget the details of the instruction," says Hinrichs.

Say this when child is discharged with asthma

Say the following to caregivers of a preschool age child with asthma being discharged from the ED, suggests **Jennifer Hinrichs**, MSN, RN, CCRN, advanced practice specialist at the Emergency Medicine and Trauma Center at Children's National Medical Center in Washington, DC:

"Your child will be on a five-day course of prelone. This is day one, so you will have four more doses starting tomorrow. When giving prelone, remember it tastes really bad and your child may not want to take it, or he/she may vomit after taking it. To make it taste better, you can mix it with chocolate syrup or powdered drink mix. This helps the taste without increasing the volume. One of the biggest mistakes that can be made is mixing this drug with liquid and increasing the volume. It is just more yucky stuff to get down. If your child vomits immediately after the dose, repeat the dose. If vomiting occurs 15 minutes or later after the dose, do not repeat unless the vomit looks just like the medication.

When your child is on prelone, expect him/her to be moody and have increase in appetite. This is very normal. In addition to prelone, you need to make sure you are doing nebulizer treatments every four hours. He/She had his/her last treatment at 1:30 p.m. It is now 3 p.m., and your next treatment needs to be at 5:30 p.m. Will you have the means to deliver this next treatment? Do you already have albuterol at home?

Lastly, you are to follow up with your primary care physician in five days. Your doctor will want to reassess your child to assure that the lungs sound better and that the asthma exacerbation is truly resolving. It is very important to get to this visit so your primary care physician will be updated on this illness and can ensure that further treatment, like a day or two more of steroids, is not necessary. Now, if your child worsens and has difficulty breathing, increased wheezing, or shortness of breath, you need to contact your primary care physician prior to your appointment and either get in to that physician's office or return to the ED.

Do you have any questions? When will you give the next dose of prelone? When will your give the next breathing treatment, and what about the next one? ■

SOURCES

For more information about improving compliance with discharge instructions, contact:

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- **Jennifer Hinrichs**, MSN, RN, CCRN, Advanced Practice Specialist, Emergency Medicine and Trauma Center, Children's National Medical Center, Washington, DC. Phone: (202) 884-3683. E-mail: jhinrich@cnmc.org.
- **N. Ewen Wang**, MD, Department of Emergency Medicine, Stanford (CA) University School of Medicine. Phone: (650) 723-0757. E-mail: ewen@stanford.edu.

• Have the caregiver demonstrate tasks to you.

"If you are giving instructions to do a dressing change, it is helpful to have the caregiver demonstrate back the task," says Hinrichs. "It shows they understand the instructions, and it gives them a one-time practice."

Reference

1. Wang NE, Kiernan M, Golzari M, et al. Characteristics of pediatric patients at risk of poor emergency department aftercare. *Acad Emerg Med* 2006; 13:853-859. ■

ED is only source of care for many asthma patients

Better home management prevents ED visits

A patient comes to your ED with a severe asthma attack holding an empty inhaler, and he says he ran out of medication weeks ago. Other patients say they've been asthmatic their entire lives, but they have taken only albuterol through inhalers.

"It could all have been avoided if they had just been on daily medication. It's very, very frustrating," says **Christine Benson**, RN, MSN, educator of emergency services at Akron (OH) City Hospital. "Somehow, these patients slipped through the cracks and have not hooked up with the system."

Many asthma patients use the ED as their sole source of care, which results in inadequate and poor care, says a new study.[1] Patients at most risk are young, lack access to a clinic with evening hours, forget to keep appointments, and have conflicting priorities in their daily lives. For this reason, the patients rely on easy access to the ED on an as-needed basis for medications and prescriptions. Since many of the patients fail to use inhaled corticosteroids, which can prevent exacerbations, the researchers recommend ED asthma education programs. To improve asthma education in your ED, do the following:

• Do what is realistic.

Ideally, patients should be put on a daily regimen, but this isn't always possible to achieve in the ED, says Benson. "We see plenty of asthma patients that don't have insurance or any means of buying their medications and having follow-up care," she says. In these cases, the ED staff members talk to the patients and find out what is feasible for them. "We don't want to send them home with prescriptions they can't fill or a referral to a pulmonologist that we know they can't see," Benson says.

In some cases, ED physicians give asthma patients an intramuscular injection of 40 mg of triamcinolone, instead of sending them home with a prescription for five days of prednisone. "Getting them to commit to buying and taking the medication for five days is often impossible," she explains. "This way, we know they are covered for the next five days until they can get to somebody."

• Give patients a before-and-after comparison.

Whenever possible, ED nurses obtain a peak flow reading before the first treatment is given, says Benson. "Since we don't know what their normal peak flow is, we have to rely on what they tell us. They may or may not know it," says Benson. "We can try to show them the improvement they are making here by comparing the two numbers from before receiving the nebulizer and after."

By doing this step, ED nurses can tell patients that when they do a peak flow reading and get a number similar to what they had when they came in, that's a clear sign that they should come to the ED immediately, Benson says.

"In the ED, we can't get very specific with giving them an exact target range," says Benson. "But if we've

EXECUTIVE SUMMARY

A significant number of asthma patients rely on the ED for treatment and medications, which results in poor and inadequate care.

- Find out what is realistic for patients.
- Take a peak flow reading before treatment is given, so a before-and-after comparison can be done.
- Ask patients to demonstrate use of their inhalers.

SOURCES

For more information about asthma education in the ED, contact:

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- **Marianne Catanzaro**, RN, Charge Nurse, Emergency Department, Albert Einstein Medical Center, 5501 Old York Road, Philadelphia, PA 19141. Telephone: (215) 456-6666. E-mail: nursemar1@comcast.net.

improved their peak flow reading by 140 points and they see how much better they feel than when they came in, we can tell them [that the number they came in with is] their danger zone, and now they know what it feels like."

• Observe patients using inhalers.

If patients are not administering their inhaler correctly, they aren't getting the correct dosage of medication, says Benson. "Sometimes I see patients using it in crazy ways, such as squirting it and taking it right out," she says. "This is a very good time to teach correct usage."

• Enroll patients in educational program.

At Albert Einstein Medical Center in Philadelphia, ED nurses were seeing 300-500 asthma patients per month, many who came to the ED frequently with severe exacerbations, reports **Marianne Catanzaro**, RN, charge nurse in the ED.

Now, if patients have had over five visits to the ED in the previous six months, they are enrolled in the Asthma Intervention and Retraining (AIR) program. Patients are given an action plan to get their asthma under control, identify triggers, take the correct medications, and learn how to use inhalers. "The reason asthma patients use the ED as opposed to their primary care provider is because of lack of insurance and education," says Catanzaro.

Reference

1. Alavy B, Chung V, Maggiore D, et al. Emergency department as the main source of asthma care. *J Asthma* 2006; 43(7):527-532. ■

Have clinical staff wear locator badges

At Swedish Medical Center's ED in Seattle, WA, all clinical staff wear locator badges [manufactured by Versus, based in Traverse City, MI] that identify where specific individuals are located, both via a light above the patient rooms and on a tracking view of a computer. **(See resource box, below, for ordering information.)**

"The badges do not indicate if staff members are in bathrooms or out of the department, so if they are not on the locator board, you can assume one or the other," says **Judy Street**, RN, manager of emergency services.

If a patient is calling for his or her nurse, or if a doctor is looking for another physician, they are easily located. A call can be placed to the patient's room, for example, to determine if someone else needs to respond or that a nurse already has taken responsibility, says Street. "This helps us avoid the 'hunt' process we all experience that is both time-consuming and frustrating," she says.

SOURCE/RESOURCE

For more information, contact:

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Staff locator badges manufactured by Versus integrate with SimplexGrinnell's 500 Nurse Call System. The cost of the badges is approximately $60 per badge, but they require hardwired cable infrastructure along with computer hardware and software for a complete system. For more information, contact: Barry Reimer, Electronic System Sales, SimplexGrinnell, 9520 10th Ave. S., Suite 100, Seattle, WA. 98108. Phone: (206) 291-1400, ext. 1441. Fax: (206) 291-1500. E-mail: breimer@tycoint.com.

COMING IN FUTURE MONTHS

- ■ Dramatically cut delays with order sets for psychiatric patients
- ■ Steps to take when abdominal pain is life-threatening
- ■ Which drugs are most dangerous for geriatric patients
- ■ What Joint Commission surveyors ask about medication orders

Four tracking boards are located throughout the ED, but even if nurses are in a hallway away from the tracking board, it's easy for them to tell where a nurse, physician, or technician is located by looking above the patient rooms. "In addition, if a patient's light is flashing and the staff indicator light is on above the room or in the room, then there is no duplication of staff responding," says Street. ■

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.

21. Which is recommended for reassessment of pain, according to Karen Rollo, RN, BSN, CEN, SANE-A?
A. Avoid patient input because it's too subjective.
B. Reassess pain only if medications have been given.
C. Reassess a patient's pain at regular intervals, based on when the medication is expected to work.
D. Don't require reassessment unless the patient's chief complaint is severe pain.

22. Which is recommended to improve care of adult pneumonia patients in the ED, according to Jesse M. Pines, MD, MBA?
A. Document medication administration immediately after antibiotics are given.
B. Avoid ordering chest X-rays at triage.
C. Use standing orders only for patients with typical symptoms.
D. Wait to administer antibiotics until the patient is admitted.

23. Which is recommended to improve compliance with discharge instructions given to pediatric patients, according to Jennifer Hinrichs, MSN, RN, CCRN?
A. Don't ask patients if they have a primary care physician, to avoid EMTALA violations.
B. Inform all clinical staff of the patient's insurance status.
C. Avoid giving written instructions because it increases liability risks.
D. Ask the caregiver to demonstrate tasks back to you.

24. Which is recommended to improve care of asthma patients in the ED, according to Christine Benson, RN?
A. Advise patients to wait until medication has run out before returning to the ED.
B. Always give oral medications instead of injections.
C. Don't obtain peak flow readings until after treatment is given.
D. Ask patients to demonstrate use of their inhalers.

Answers: 21. C; 22. A; 23. D; 24. D.

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.

The semester ends with this 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. ■

ED NURSING™

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