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IN THIS ISSUE

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Abdominal pain is often misdiagnosed in the ED: Take steps to protect patients

Complaint may be much more serious than it seems

Gastrointestinal (GI) bleed. Cancer. Myocardial infarction (MI). Constipation. These are just some of the conditions that could present as abdominal pain in ED patients.

Acute abdominal pain often is overlooked or misdiagnosed in ED patients, says a new study.[1] Researchers compared two groups of patients with abdominal pain: 832 patients ages 65 to 80 years and 1,458 patients ages 20 to 64 years. They found that older patients were misdiagnosed 52% of the time, compared with 45% of the control group.

In addition, elderly patients more often had specific organic disease and arrived at the ED after a longer history of abdominal pain compared to younger patients. "ED nurses need to be aware that the presentation of the elderly patient with abdominal pain may be much more serious than it seems," says **Karen Hayes**, PhD, ARNP, assistant professor at the School of Nursing at Wichita (KS) State University.

Elderly patients also have a higher incidence of asymptomatic underlying pathology for aortic aneurysm, MI, and pneumonia, warns Hayes.[2] "All of these can present as vague abdominal pain, so maintain a high level of suspicion."

Pain among older adults is complicated by multiple, concomitant causes and locations of pain, which makes it difficult to distinguish acute pain caused by a new illness from that of an old condition, adds Hayes. For instance, a patient

EXECUTIVE SUMMARY

Patients with acute abdominal pain are at high risk for misdiagnosis in the ED, and elderly patients are at an especially high risk, says a recently published study. Patients may have vague symptoms and multiple causes and locations of pain.

- Give patients an electrocardiogram to rule out cardiac ischemia.
- Make sure that patients are not taking duplicate medications.
- Elderly patients with acute peritonitis are less likely to have fever and leukocytosis than younger patients.

with a history of diverticulosis presenting with a new onset of pain related to a bowel adhesion may believe the pain is from the old problem and delay presenting to the ED for the new, urgent problem, she explains.

The challenges for this patient population include multiple comorbidities, sensory losses, and dementia, says **Joyce A. Dixon**, RN, MSN, assistant nurse manager at the ED at University of California-San Diego Medical Center. "This complaint should be taken very seriously at triage," she says.

Patients with acute abdominal pain account for approximately 5%-10% of ED visits, and geriatric populations have a higher frequency of this complaint.[2] "They are typically more acutely ill than younger populations and therefore have a higher admission rate, as well as higher mortality and morbidity," says **Sam Shartar**, RN, CEN, nurse manager of the ED at Emory University Hospital in Atlanta.

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To improve care of patients with acute abdominal pain, consider the following:

• Rule out a cardiac event.

"Atypical cardiac presentations are common in the elderly," says Dixon. "An electrocardiogram should be done sooner rather than later, to rule out cardiac ischemia."

Elderly and female patients present with atypical patterns of pain when having an MI, says Shartar. "Presentation with epigastric pain may be their only symptom," he says. "Patients typically present with a complaint of abdominal pain without differentiating between abdominal and epigastric pain on initial presentation."

• Obtain a thorough medication history.

Elderly patients may unknowingly be taking duplicate medications, such as Tylenol and generic acetaminophen or Motrin and generic ibuprofen, says Dixon. "That can exacerbate or compound the search for a diagnosis," she says. "Obtaining a thorough medication history is essential, including over-the-counter medications. This is so important that the [Joint Commission on Accreditation of Healthcare Organizations] has declared it a National Patient Safety Goal." **(For more information on medication reconciliation, see "ED nurses are key to complying with new JCAHO medication goal," *ED Nursing*, April 2006, p. 61.)**

• Perform an accurate pain assessment.

Elderly people do feel pain as intensely as younger patients, but they are less likely than younger people to report it, says Hayes. Assessment of pain in elderly cognitively impaired patients may be difficult, she adds.

You'll need multiple assessment tools and approaches, including the verbal descriptor scale, visual analog scale, the Wong-Baker FACES pain rating scale, the pain thermometer, and observing the patient for increasing agitation, moaning, or pain on movement, says Hayes.

• Don't assume that constipation is the cause.

A common misconception is that constipation is the cause of most abdominal pain in elders, says Hayes. "This is a frequent problem, but the patient should also be asked about rectal bleeding or narrowed stool caliber," she says. "The elderly patient with abdominal pain and any of these symptoms should be evaluated for mass lesions or other organic problems."

• Be aware of the differences in how elderly patients present.

The study's researchers found that rebound tenderness, local rigidity, and rectal tenderness were less common in older patients with peritonitis. Elderly patients with acute peritonitis are much less likely to have the classic findings of an acute abdomen, says Hayes. "They are less likely to have fever or leukocytosis. In addition, their pain is likely to be much less

severe than expected for a particular disease," says Hayes.

Older patients often wait several days before they seek care, even in the presence of significant disease, says Shartar. "The nurse must practice diligence in identifying the often subtle signs that serious pathology exists," he says. You must do a thorough physical examination and history, look for changes in mental status, look for changes in functionality with regard to activities of daily living, and monitor trends with vital signs, he says.

• Remember that there still may be acute pathology, even if findings from the physical examination are negative.

This misconception is common, Shartar says. "For example, the presence of bowel sounds doesn't rule out peritonitis or small bowel obstruction," Shartar says. "Because of the increased frequency of significant problems such as neoplasm, ischemic bowel, and small bowel obstruction, this patient population is at extreme risk for increased complications and mortality."

Because of the difficulty in reliably diagnosing patients with abdominal pain, any patient with hypothermia, fever, hypotension, leukocytosis, or abnormal bowel sounds should be considered for admission, says Shartar. "In our ED, we use cross-sectional radiological studies to assist with the identification of serious disease," he says.

• Ask the right questions at triage.

When patients report abdominal pain, ask the following questions, says **Jeanette A. Trotman**, RN, BSN, CEN, co-director of emergency services at Albert Einstein Medical Center in Philadelphia:

— Where on the abdomen does it hurt? "This helps narrow down possible sources and etiology of the pain," says Trotman.

— What makes it better and/or worse?

— Is the pain associated with eating or moving?

— When did it start?

— Describe the quality and characteristics of the pain. Is the pain constant, intermittent, stabbing or dull and aching?

— Is there tenderness? Is the abdomen firm?

— When was the last bowel movement? Was it normal? "This helps determine if you might be dealing with possible obstruction," says Trotman. "Color may indicate a GI bleed."

— Is there any history of trauma, such as recent falls, blunt force or penetrating injuries? For example, a bicycle fall a few days ago may be forgotten or thought not to be relevant by the patient, but that could be the reason for the pain, says Trotman.

For females of childbearing age, also ask:

— When was your last menstrual period? Do you have any vaginal discharge or bleeding? "Pain in pregnancy puts two patients potentially at risk: mom and baby. Ectopic pregnancies are potentially surgical emergencies," says Trotman.

For men, also ask:

— Does the pain radiate into the scrotum? Is there any penile discharge? "For males, testicular torsion is a surgical emergency," says Trotman. "Flank pain could be related to kidney stones, disease, or infection."

SOURCES

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2. American College of Emergency Physicians. Clinical Policy: Critical issues for the initial evaluation and management of patients presenting with a chief complaint of nontraumatic acute abdominal pain. *Ann Emerg Med* 2000; 36:406-415. ■

Make your most common ED nursing tasks mobile

Patients and nurses are happier with mobile systems

It's a common source of frustration in many EDs: leaving patients in the waiting room until a "specialty" room is available, or placing the patient in a room that

EXECUTIVE SUMMARY

ED nurses are using mobile workstations on laptops or carts to improve patient flow and save time with registration and documentation.

- Carts bring supplies to patients for more flexibility.
- Patients can be moved out of waiting areas to be registered in their rooms.
- Nurses can chart in hallways.

doesn't have the right equipment, which delays care. That's why many EDs are investing in mobile workstations on laptops or wheeled carts.

At Seattle-based Swedish Medical Center's ED, wheeled equipment carts are used, which allows rooms to serve a variety of purposes, says **Judy Street**, RN, former ED nurse manager. The carts, manufactured by Armstrong Medical Industries, cost $600 to $1,200 per cart. **(For contact information, see resource box, this page.)** With the carts, you bring the supplies to the patient, thus creating flexible space, she says. "Flow is improved, as you do not have patients waiting for the 'special' room any longer," Street says. "Rooms now can be used for any patient type with the exception of the most critical patients, who would require maximum space and equipment."

Similarly, mobile registration carts (also manufactured by Armstrong, at a cost of $1,000 to $1,500 per cart) allow ED nurses at Swedish to move patients directly to a room instead of being held in a waiting room for registration. "Triage can be done by the 'back nurse or primary nurse' when beds are available, thus freeing up the triage nurse when there is a line of patients," says Street.

The ED's computer system allows for a quick registration so the patient is entered into the system, allowing the nurse or physician to initiate orders. "The idea is, if you can provide faster service to the patient, and shorter wait and treatment room times, you will improve patient satisfaction and volumes — and revenue as well," says Street.

Patients more satisfied

It wasn't easy for ED nurses to become accustomed to the "mobile" way of performing tasks, says Street. "It does require a new approach psychologically for nurses, physicians, and clerical staff. It is not always an easy transition," she says.

The most frequent complaint from ED nurses was that if a patient is placed in a room and a nurse is not immediately available, the nurse assigned to that room or section feels an urgency to get to the patient and worries that they will not be able to do so in a timely and safe manner, says Street.

Street reminded the ED nurses that a patient in a waiting room has no call light and the triage nurse is responsible for all the patients, which is much more of a safety issue than if the patient is in a treatment area. "If patients are not in rooms, 'out of sight, out of mind' can occur, especially during changes in shift," she says.

Gradually, ED nurses began to see that patients were more satisfied with the mobile processes. "It also improved their organizational skills, required tighter protocols for initiating treatment or tests, and smoothed out the flow vs. the usual 'the bus unloaded' experience," says Street.

Wheeled workstations save time

At Indiana University Hospital's ED, six computers on wheels, manufactured by Stinger Medical, were implemented at a total cost of about $5,000. **(See contact information for manufacturer in resource box on**

SOURCE/RESOURCES

For more information on mobile workstations, contact:

- **India Owens**, RN, BSN, Manager, Clinical Operations, Emergency Department, Indiana University Hospital, 550 N. University Blvd., Indianapolis, IN 46202. Phone: (317) 278-8306. E-mail: IOwens@clarian.org.

- "**Computers on wheels" are available using laptop computers wirelessly connected to various patient information databases**, at a cost of about $3,000, including cart and computer. For more information, contact: Stinger Medical, 1152 Park Ave., Murfreesboro, TN 37129. Phone: (888) 909-8930 or (615) 896-1652. Fax: (615) 896-8906. E-mail: sales@stingermedical.com. Web: www.stingermedical.com.
- **A variety of mobile equipment and registration carts are available** from Armstrong Medical Industries. For more information, contact Armstrong at 575 Knightsbridge Parkway, P.O. Box 700 Lincolnshire, IL 60069-0700. Phone: (800) 323-4220 or (847) 913-0101. Fax: (847) 913-0138. E-mail: quotes@armstrongmedical. com. Web: www.armstrongmedical.com.

p. 40.) The nurses call them WOWs (workstations on wheels). "The nurses seem to like them. They allow them to stand and do quick charting and also to look up stuff for physicians in the hallways, which is where they tend to use them," says **India Owens**, RN, BSN, the ED's manager of clinical operations.

The WOWs are set up so they can be lowered to accommodate nurses wearing bifocals as well as being able to be raised to eye level for nurses who are not, says Owens. "This was one of the pitfalls that nurses on the inpatient units complained about — that the workstations are too high and difficult to use if you are a bifocal wearer," she explains.

The WOWs must be plugged in most of the time, because the device shuts off if left unplugged; plugging it back in allows it to recharge. "Brief periods off power are OK, but very brief, so we needed to make sure there were ample outlets to plug them into before going live," Owens says. "During power outages with no computer access, we use paper forms that mimic the electronic ones."

When caring for critically ill patients, nurses use a wheeled station on one side of the bed along with a wall-mounted workstation on the other side of the bed, says Owens. "This allows the physician to view lab values and a nurse to enter orders live at the bedside while another nurse charts," she says. ■

Cut LOS for your patients who don't speak English

Immediate contact is 'tremendous anxiety reducer'

(Editor's note: This is the first story in a two-part series on caring for non-English-speaking patients in the ED. This month, we give strategies to reduce delays and improve care. Next month, we'll cover liability risks for emergency nurses.)

When a Spanish-speaking man approached ED nurses at Methodist LeBonheur Healthcare in Memphis, TN, pointing to his chest, nurses immediately called for translation services, but the interpreter was tied up with another patient elsewhere in the hospital.

"The patient needed a cardiac catheterization, but we couldn't have him sign the informed consent without translation," says **Marianne Fournie**, RN, BSN, MBA, corporate director for system ED services. There was a delay of more than 30 minutes before they could move him to the catheterization lab, she recalls. "We watched the clock the entire time while we waited."

ED nurses nationwide report caring for increasing numbers of non-English-speaking patients. "There is a great problem in our ED with health care providers being unable to communicate effectively with their patients," says Fournie. "This can affect access to care, delays in care, the efficiency of care, quality of care and, most importantly, the safety of care."

Pediatric LOS is longer

Length of stay (LOS) is longer for non-English-speaking children coming to EDs, says a recently published study.[1] Researchers looked at 48,497 visits in one year in a Toronto pediatric ED and compared length of stay for 6,051 English-, 628 Spanish-, 486 Cantonese-, 486 Mandarin-, and 417 Tamil-speaking families. The average length of stay was 3.86 hours for English-speaking patients, and 3.95 hours for non-English-speaking patients.

"I think the implications for emergency nurses are significant," says **Ran Goldman**, MD, the study's lead author. "ED nurses are the first to communicate with parents of sick children, and the language barrier can be challenging."

In the past, the ED used family members as interpreters since this method was the fastest to communicate with the patient, says Fournie. "We found that it is often inappropriate for the family member to be interpreting, due to patient confidentiality and especially in circumstances such as children interpreting for their parents," she says.

Using interpretive telephone services is not ideal because the translators sometimes do not understand medical terminology, and interpreters coming to the ED aren't always available to come immediately, says Fournie.

The Joint Commission requires EDs provide interpretive services for non-English-speaking patients

EXECUTIVE SUMMARY

Length of stay is longer for non-English-speaking patients in the ED, according to a recently published study. EDs are required by the Joint Commission on Accreditation of Healthcare Organizations to provide translation services for these patients as necessary.

- Use a phone service with trained medical interpreters.
- Develop a list of qualified interpreters.
- Encourage nurses to become certified as interpreters in your ED.

SOURCES/RESOURCES

For more information on reducing delays in caring for non-English-speaking patients, contact:

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- **Margaret Gaskins**, RN, BSN, Assistant Management Coordinator, Emergency Department, Inova Healthplex, 6355 Walker Lane, Alexandria, VA 22310. Phone: (703) 797-6819. E-mail: Margaret.Gaskins@inova.com.
- **Ran D. Goldman**, MD, Associate Professor, Department of Pediatrics, Division of Pediatric Emergency Medicine, University of Toronto, 555 University Ave., Toronto, ON M5G 1X8. Phone: (416) 813-7654, ext. 1486. Fax: (416) 813-5043.
- **A telephone service with trained medical interpreters is available** using dual-headset telephones that plug into any telephone line in the ED. For more information, contact: CyraCom International, 5780 N. Swan Road, Tucson, AZ 85718. Phone: (520) 745-9447. Fax: (520) 745-9022. E-mail: info@cyracom.com. Web: www.cyracom.com.
- **Telephone translation services are available from Language Line Services.** For more information, contact Language Line Services, One Lower Ragsdale Drive, Building Two, Monterey, CA 93940. Phone: (877) 886-3885. E-mail: info@languageline.com. Web: www.languageline.com.
- **"I Speak" cards can be downloaded free of charge** on the Northern Virginia Area Health Education Center (NVAHEC) web site in the following languages: Amharic, Arabic, Bantu, Bosnian, Croatian, Farsi, French, Russian, Serbian, Soomaali, Tigrigna, Urdu, and Vietnamese. Go to www.nvahec.org/ispeak.html and click on "I Speak Cards/Charts." Scroll to the bottom of the document to click on the language name. Laminated "I Speak" cards or charts in additional languages can be purchased, with cost depending on the languages and number of charts ordered, and shipping varying by location. For more information, contact the NVAHEC, 3131-A Mount Vernon Ave., Alexandria, VA 22305. Phone: (703) 549-7060. Fax: (703) 549-7002. E-mail: info@nvahec.org.

and patients with limited English proficiency as necessary, although the standards are not specific about who can translate or how quickly the translation must be provided. "We are required to provide language assistance to ensure equal access for programs and services," says Fournie. "These services cannot be of lower quality or delay delivery of care due to language barriers."

Methodist Le Bonheur Healthcare's ED is using a phone service with trained medical interpreters from Cyracom using "dual-headset" telephones that plug into any phone line in the ED. **(See contact information in resource box, left.)** The price of the service and what it includes depends on the provider's contract, but one may be able to negotiate a price that includes the phone or be able to negotiate a leasing fee for the phones. All contracts include a price per minute for use of the phone lines. Methodist LeBonheur pays about $1.95 per minute for use of the service at six hospitals in its system.

It's determined which language is needed by the patient pointing it out on a card supplied by the service or by asking a family member. **(See resource box, left, to obtain "I Speak" language cards.)**

Then the nurse picks up a headset, presses a button, and states which language is needed. Within minutes, an interpreter is available on the phone, and the patient picks up the other headset, which allows the ED nurse and patient to speak to each other through a trained medical interpreter.

"It can be used as soon as the patient enters the ED, so there are no delays in care," Fournie says. The translators are not only medically versed, they also are knowledgeable of cultural and ethnic nuances, she says. "We are able to provide clear communication without language barriers," Fournie says.

At Inova Healthplex in Alexandria, VA, the ED contacts qualified interpreters within the hospital when needed, and uses a phone service (Language Line Services; Monterey, CA) when these individuals are not available. **(See contact information in resource box, left.)** "Our biggest challenge is the wide variety of languages that we encounter: Spanish, Vietnamese, Farsi, Amharic, and different African dialects, to name a few," reports **Margaret Gaskins**, RN, BSN, assistant management coordinator for the ED. "However, our nursing staff does share this demographic."

To save time, bilingual ED nurses are encouraged to seek certification through the hospital's cultural diversity department, in conjunction with the Alexandria-based Northern Virginia Area Health Education Center, to become qualified medical interpreters. **(See contact information in resource box, this page.)** Currently, two ED nurses are certified interpreters, one in

Amharic and one in Tagalog. "We also have four staff members from radiology and registration certified in Spanish," says Gaskins. ED staff complete a verbal and written pretest to ensure fluency in the language before being accepted into the program, followed by five eight-hour classes over one month, ending with testing to receive final certification.

Using ED staff as interpreters saves time, because only two portable phones are available to use for interpretation; also, it takes a couple of minutes to be connected by phone to the appropriate representative, says Gaskins. "It also provides the patient with immediate face-to-face contact with someone who speaks their language," she says. "That is a tremendous anxiety reducer."

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Obese children at risk for wrong weight estimation

Tool accurately predicts endotracheal tube size

Many emergency nurses routinely use the color-coded Broselow Pediatric Emergency tape to obtain medication dosages for pediatric patients who can't be weighed. However, researchers in a new study compared the actual weight of 7,500 children with their predicted weight and found that the tape inaccurately predicted actual weight in one-third of children.[1]

ED nurses should not solely depend on the Broselow tape for accurate information when estimating weight during the resuscitation of a child, according to **Carolyn T. Nieman**, MSN, ACNP, the study's author and faculty at the School of Nursing at Case Western Reserve University in Cleveland.

"One should never rely on any system in place of clinical judgment," she says.

The tape seems to be more accurate if the children are the normal weight for their size, she says. Obese pediatric patients are at higher risk for discrepancies, Nieman says. "If the patient looks large for their size, you may need to make some adjustments," she says. "Weigh the child whenever possible."

However, weight will need to be estimated if it is not safe to weigh a critically ill or injured child, or if the child is frightened and uncooperative, says **Susan M. Hohenhaus**, MA, RN, FAEN, clinical human factors nurse researcher at Duke University Health System's Office of Patient Safety and Quality in Durham, NC. Hohenhaus has reported extensively on the use and misuse of the Broselow tape over the past several years.[2,3]

ED nurses should have formal education on how to use any resuscitation tool, including the Broselow tape, she emphasizes. "There is a need for this type of training to be incorporated into all standardized pediatric advanced life support education," Hohenhaus says. **[For more information, see "Use color-coded tapes correctly or risk errors," *ED Nursing*, September 2003, p. 130. To download a free educational packet on the tape, go to the Duke University Medical Center's "Duke Enhancing Patient Safety" web site at www.dukehealth.org/deps. Click on "Clinical Education" and then "Study Packet (Version 2) on the Correct Use of the Broselow Pediatric Emergency Tape."]**

In 2005, a new edition of the tape was created, eliminating the infusion section, to comply with the Joint Commission's National Patient Safety Goal requiring that all hospitals move to standardized concentrations of drugs by 2008.

Hohenhaus notes that the hallmark study that reported on the validity of the Broselow tape was looking at its accuracy in predicting equipment size, not weight. "So its original purpose still is valid. As illustrated in this study, the Broselow tape length accurately predicted endotracheal tube size," she says.

Medications used for resuscitation should be based on lean body mass, says Hohenhaus. Therefore, going by the child's length instead of actual weight, which is

EXECUTIVE SUMMARY

The color-coded Broselow tape inaccurately predicted actual weight for one-third of children in a recent study.

- Weigh pediatric patients when possible to ensure the correct weight is obtained.
- Obese pediatric patients may be at higher risk for discrepancies.
- Give nurses formal education in use of the tape.

SOURCES

For more information about obtaining accurate medication dosages for pediatric patients, contact:

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unlikely to be available during a pediatric resuscitation anyway, actually may be best to ensure correct dosages of resuscitation drugs, she says.

Other studies have shown that the correlation between actual weight and weight estimated using the tape seems to be better in children who weigh less than 15 or 20 kg, says Hohenhaus.[4,5] "This is a particularly vulnerable group of pediatric patients — the smallest ones," she says.

Hohenhaus cautions nurses against interpreting the study's findings as an indication that the Broselow tape is not safe. Studies have shown that parents and clinicians are inaccurate when guessing a child's weight, she notes. "There is no method that is currently available that has been proven to be more accurate for clinicians to use in a pediatric resuscitation to estimate a weight, other than the Broselow tape," says Hohenhaus.

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ED nurses check off tasks when JCAHO comes

Surveyors scrutinized medication practices

The minute you learn that accreditation surveyors are on site, you probably have a "wish list" of tasks that should be done immediately. At Providence St. Vincent Medical Center in Portland, OR, ED nurses created checklists for technicians, nurses, physicians, and health unit coordinators to use.

When the "Dr. J" page is heard overhead, indicating that a mock or actual survey is taking place, ED staff refer to the checklist as a reminder to perform tasks such as pulling curtains closed or disposing of food containers. **(See the checklist used by ED nurses on p. 45.)**

During drills, leadership walks through the ED, talking with staff, reviewing the National Patient Safety Goals from the Joint Commission, and reviewing patient charts. During these mock surveys, staff use "prompt cards" with questions and answers on various topics that surveyors are likely to ask about, says **Eileen Wheaton**, RN, the ED charge nurse who helped to develop the cards. "I pretend to be a surveyor and ask questions about medication administration, patient safety, environment of care, infection control, or patient rights."

The cards have the answers on the back, if staff need prompting. "However, after using them for many months, there is less prompting needed for the answers," says Wheaton. "The question-and-answer drills helped desensitize staff to the fear around talking to a surveyor." Nurses may know the answers, but under pressure may have a difficult time articulating them, so the repetitive drills help staff feel comfortable and "think quick on their feet," says Wheaton.

During the actual survey, the prompt cards and

EXECUTIVE SUMMARY

During an accreditation survey at a Portland, OR, hospital, ED nurses used checklists as reminders to perform certain tasks before surveyors came to the ED.

- Surveyors wanted pharmacy review of medication orders.
- Nurses were expected to obtain a list of medications taken by patients.
- "Prompt cards" with questions and answers were used to prepare staff.

checklists paid off, says **Julie Briggs**, RN, BSN, manager of the ED. "We helped each other out in answering their questions and bragging about our accomplishments," she says.

Last-Minute Joint Commission Checklist

Check When Done	Task
_____	Check your rooms for overall cleanliness
_____	Carts locked/Personal protective equipment available
_____	Patient is safe with call bell and rails
_____	Patient knows your name
_____	Check your charts for current documentation
_____	Check your monitor alarms (if the patient does not need a monitor or alarm, do not have it on)
_____	Patient privacy: Curtain pulled, door closed
_____	Get rid of coffee cups/food

Source: Providence St. Vincent Medical Center, Portland, OR.

Medications under scrutiny

At one point during the survey, three surveyors appeared at once in the ED, all asking different questions. The physician surveyor asked for a tour of the ED. "He was very complimentary of the ED and our processes," says Briggs. "We shared with him all the great things we have been doing — our shared governance, our [quality assurance] projects, our door-to-balloon times."

The surveyor asked to see a closed chart and reviewed it with an ED nurse. "While the documentation was very good, he found an unapproved abbreviation — 'U' rather than units — when a nurse documented she had administered insulin," says Briggs.

Meanwhile, the nurse surveyor asked about ED processes, and an administrative surveyor focused on medications. "That is where we took our biggest hit," she says.

The surveyor didn't like that nurses mixed their own antibiotic bags. He also asked to see the ED's conscious sedation forms, the form used to document correct-site verification, and reviewed a closed chart from a conscious sedation patient seen earlier that day.

Upon reviewing a medication reconciliation form, the surveyor didn't like that the nurse had written "unknown" under medications. "They seemed to feel if he was alert and oriented, then we should have been able to obtain the name of medications he was taking," says Briggs. The hospital is moving to a computerized charting system, which will have all the patient's meds listed. "The system will be integrated into pharmacy, so they will have all the records we have," Briggs says. ■

SOURCES

For more information on the ED's survey, contact:

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JOURNAL REVIEW

Marco CA, Marco AP, Plewa MC, et al. **The verbal numeric pain scale: Effects of patient education on self-reports of pain.** *Acad Emerg Med* 2006; 13:853-859.

When ED patients watched an educational video or read a brochure about pain assessment, the patient's self-report of pain often was lower compared to previous self-reports, says this study from St. Vincent Mercy Medical Center in Toledo, OH.

At triage, patients were asked to rate their pain using a numeric rating scale. Patients then were given an educational intervention about pain scales and their use, with 155 patients watching a three-minute videotape and 155 reading a printed brochure, both with identical text. Both were developed by a panel of emergency physicians and anesthesiologists, with the videotaping and editing done by the hospital's audiovisual department. **(See the ED's patient education tool on p. 46.)** Immediately afterward, the patients were asked to rate their pain again. Researchers found that a significant percentage of both groups of patients had decreased self-reported pain scores by 2 or more points (28% of the patients who watched the videotape and 23% of the patients who were given the brochure, compared with 5% of patients in a control group). Since pain interventions such as narcotics often are based on pain scores, educational interventions may prevent overmedication and reduce complications and

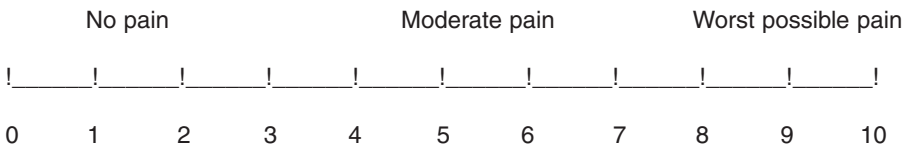
length of stay in the ED, the researchers suggest. They add that the interventions cost very little since the panel of experts volunteered their time and production was done in-house by the hospital's audiovisual department. Videotape reproductions and printing costs were donated by the ED.

"The savings gained in improved communication with patients, increased patient satisfaction, and nursing time could offset these minimal increases in cost," the researchers wrote. ■

The Verbal Numeric Pain Scale: How to Rate Your Pain

Many people who come to the Emergency Department are having pain. Some people are injured, and other people have painful conditions, such as headache, chest pain, or other medical conditions. Regardless of the cause, it is important for the doctors and nurses taking care of you to understand the pain that you are experiencing.

There are several ways that we can measure pain. They all depend on you telling us more information about your pain. Very often, we use "The Verbal Numeric Pain Scale." This is where we may ask, "How would you rate your pain, on a scale of 0 to 10, where 0 is no pain, and 10 is the worst pain imaginable?"



It is important for the doctors and nurses to understand your pain, so that they can treat your pain appropriately. Let's first think about the number "0." This means "no pain at all." Many of us would say that our pain is zero when nothing is going on, we feel fine, and we are experiencing no pain.

Now let's think about the top number, "10." This means "the worst pain imaginable." Most of us have never really experienced pain that is a "10." Even those of us who have gone through childbirth or had a severe injury can probably think of a worse pain. So a "10" would be very unusual and should be used when you are experiencing the worst pain you can think of.

Now let's think about some of the middle numbers. It may be very difficult to choose a number that represents the pain you are having. We would like to give you some examples of how some people have rated pain for Emergency Department conditions and procedures. Perhaps you have experienced some of these things. We hope that it might be helpful to you, to know what other patients have said about levels of pain for various conditions and procedures. It's important to remember that everyone experiences pain a little differently, so these examples might not be exactly what your experiences have been. But hopefully these examples will give you some ideas:

- Eye drops. Most people say that when they get drops in the eye, that pain is about a "1."
- The Blood Pressure Cuff. Most people say that when the blood pressure cuff is inflated and squeezing their arm, that pain is about a "1" or a "2."
- Blood drawing. Most people say that when they have their blood drawn through a needle for blood work, the pain is about a "2."
- IV. Most people say that when they get an "IV," or intravenous catheter with a needle, that pain is about a "3" or "4."
- Shot at the dentist. Most people say that getting a numbing shot at the dentist is about a "3."
- Pelvic Examination. Women who have had pelvic examinations say that the pain from the examination is about a "3."
- Spinal Tap. Some people need to have a spinal tap, or lumbar puncture. This is when the doctor places a needle into the lower back to get a sample of spinal fluid. People who have had a spinal tap rated the pain about a "3" or "4."
- Nasogastric tube. Sometimes patients need to have a tube placed through the nose into the stomach. People who have had this tube placed rated the pain about a "5" or a "6."
- Broken Bone. Most people with a broken bone say that their pain is about a "7."
- Kidney Stone. Most people who have had kidney stones about an "8" or "9."

In conclusion, we'd like to remind you that everyone experiences pain differently. No one can tell you what your pain score should be based on your illness or injury, and no one but you really knows what kind of pain intensity you are experiencing. It is important to the doctors and nurses to know the level of pain you are experiencing.

Source: St. Vincent Mercy Medical Center, Toledo, OH.

Give patients an extra thank you after a long wait

Long waits are the most common cause of patient complaints in many EDs, so why not give patients a special "thank you" when wait times are long?

ED nurses at Vanderbilt University Hospital in Nashville, TN, make sure that patients know their patience is appreciated. "We announce that every patient is important to us and ask that they bear with us while we are trying to give each person care," says **Donna L. Mason**, RN, MS, CEN, nurse manager of the ED. Nurses say this at triage to every patient who has to wait so they know what to expect, and when the ED is crowded, a charge nurse announces it to the entire waiting room.

While patients and their family members are waiting to see a physician, nurses offer "extras" including warm blankets for their comfort; cappuccino, coffee, or hot cocoa; and meal vouchers for the hospital cafeteria. "It is the small things patients and their families appreciate after a long wait," says Mason. *[Editor's note: For more information, contact Mason at Vanderbilt University Hospital, 1211 Medical Center Drive, Nashville, TN 37232-7240. Phone: (615) 343-7223. Fax: (615) 322-1494. E-mail: donna.mason@vanderbilt.edu.]* ■

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CE instructions

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

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

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

COMING IN FUTURE MONTHS

- Update on women and atypical heart attack symptoms
- How to tell if your patient is abusing caffeine
- Stop dangerous medication storage practices
- Which diagnostic tests are needed for pediatric febrile seizures

CNE *objectives/questions*

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

5. Which is true regarding elderly patients with abdominal pain, according to Karen Hayes, PhD, ARNP?
A. Older patients tend to come to the ED more quickly than younger patients.
B. Electrocardiograms aren't necessary unless the patient also has chest pain.
C. Older patients with acute peritonitis are less likely to have fever or leukocytosis.
D. The presence of bowel sounds always rules out peritonitis and small bowel obstruction.

6. Which is in compliance with accreditation requirements for non-English-speaking patients?
A. Providing interpreters only upon request of the patient.
B. Having interpreters available only for patients with life-threatening conditions.
C. Having interpreters available only for patient populations that comprise a significant percentage of an ED's volume.
D. Providing medical trained interpretive services for all non-English-speaking patients.

7. Which is true regarding use of the Broselow Pediatric Emergency tape, according to a recently published study?
A. The tape accurately predicted only weights for obese children.
B. Obese pediatric patients are at higher risk for discrepancies.
C. The tape did not accurately predict endotracheal tube size.
D. Medications used for resuscitation should not be based on lean body mass.

8. What resulted when ED patients watched an educational video or read a brochure about pain assessment, according to a recently published study?
A. The patients all reported more severe pain.
B. The patient's self-report of pain often was lower compared to previous self-reports.
C. Patients had increased difficulty rating pain levels.
D. Patients were overmedicated more often.

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