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IN THIS ISSUE

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Tension in the waiting room — 86% of ED nurses report recent violence

Crowded waiting rooms 'bring out the worst' in patients

What makes tension erupt into violence in an ED? Sometimes it can be as simple as long waits and frightened people: Patients or family members may not understand why others keep getting seen while they sit waiting.

"We do see increased tension when there is overcrowding," says **Linda Fisher**, RN, director of emergency nursing at Boston Medical Center. It usually manifests itself in the waiting room, she says. "Patients may not accept the explanation of the triage nurse. They may escalate and start yelling out."

A recent survey of 1,000 ED nurses conducted by the Emergency Nurses Association (ENA) reported that 86% had been the victim of workplace violence in the past three years, and 20% said that they experience workplace violence frequently. More than 40% of nurses indicated their workplace was somewhat safe or not safe at all.

Overcrowded EDs are one factor causing nurses to feel unsafe, reports **Donna L. Mason**, RN, MS, CEN, current ENA president and ED nurse manager at Vanderbilt University Hospital in Nashville, TN. "Crowding and boarding always tend to bring out the worst in people," she says. When people have waited for hours to be seen or to get an inpatient bed, they grow impatient, Mason says. "Their anger is often directed to the nurse who spends the most time with the patients and their families."

Nurses interviewed by *ED Nursing* recommended educating staff on de-escalation techniques and appropriate use of chemical or physical restraints.

"Failure to act at the appropriate time can be unsafe," says Fisher. "We certainly

EXECUTIVE SUMMARY

Of 1,000 ED nurses surveyed, 86% had experienced violence during the past three years, and more than 40% said their ED is only somewhat safe or not safe at all. Overcrowded waiting rooms are causing increased tension.

- Inform the entire waiting room why wait times are long.
- Document aggressive behavior by patients.
- Comply with simple requests of patients.

do not overuse restraints but appreciate that there is a time when this is an appropriate intervention."

At St. Thomas Hospital in Akron, OH, ED nurses use a "proactive violence" protocol for any patient presenting to the ED with a complaint of suicidal/homicidal thoughts or a history of violent behavior, says **Nance Donel**, RN, BSN, ED manager. Using one of the ED's observation rooms, staff request that the patients remove all clothing, put on hospital gowns, and place all of their belongings in a bag. Next, security searches their belongings and removes any dangerous objects found.

Past searches have unearthed knives and guns, says Donel. For psychiatric patients being admitted from the ED for medical reasons, a screening process is used to assess the potential for violence. The screening consists of a few questions that tell nurses if a further evaluation is needed by psychiatry to ensure the patient will not become violent, says Donel.

"We began this protocol after we had several patients admitted from the ED to our psychiatric unit, and they found knives on them," Donel says. Nurses were alone with those patients, she says. "Although no one was harmed, we decided to do something before it happened," Donel says.

Security personnel are located at the ED entrance 24 hours a day, which is a powerful deterrent, she says. "The noticeable presence of security helps reduces tension and creates an environment not conducive to violent behavior," Donel says.

Give periodic updates

To reduce tension in your ED's waiting room, do the following:

• Give a reason for the wait.

When wait times are long, ED nurses at Boston Medical Center give periodic updates to the entire waiting room, says Fisher. For example, nurses may say, "We have had several patients arrive that are severely hurt, and they are requiring a great deal of help. This has resulted in a delay for all of you. We anticipate that we can again start taking patients to rooms within 20 minutes."

• Document previous problems with patients.

If a patient is abusive to ED staff at Boston Medical Center, this fact is documented by nurses and the patient is flagged in the ED's electronic documentation system, says Fisher. If a flagged patient comes to the ED at any time, the administrator is called. "This way, someone not involved in their direct care is dealing with their behavioral issues." They talk with the individual and remind them of what the consequences are if the behavior is not appropriate, says Fisher. "This is appreciated by the staff and does help to prevent acting out," she says.

For example, a patient was flagged after he verbally abused a nurse and spat in her face. "When this patient now arrives in the ED, he is reminded of what his behavior was and told that if there is any repeat of this behavior or any other unacceptable behavior, that we will have to ask him to leave," says Fisher, adding that a patient would only be asked to leave if it were medically safe.

• Have a designated person communicate with patients in waiting rooms.

At Stony Brook, a patient representative was hired to act as a liaison between ED nurses and patients, to find solutions to problems, and handle special requests. "This helps us a great deal with communication, because we are so busy running around doing tasks," says **Anna Rosenthal**, RN, ED nurse manager. "Patients are much happier being told up front that they are going to be waiting four hours, than

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Say this to defuse tension while patients are waiting

Below are examples of scripts and interventions used by emergency nurses at Stony Brook (NY) University Medical Center to reduce tension while patients are waiting:

• Triage.

"Our goal is to see you as quickly as possible."

"The business of the emergency department makes it very difficult to give you an exact time when you will be seen."

• Entry.

"May I come in?" (This should be said prior to pulling back curtain and walking in.)

Identify the patient by last name (Mr./Ms _____). My name is _____. I am a nurse." Explain your role and what your interaction is for. "I see from your chart you are here because _____."

Tell the patient what is next and when they can expect it to happen.

• Communication.

"We understand you would like your family here with you."

"Would you like me to tell your family about what is happening?"

"We have kept your family informed of what is happening."

"Is there someone here that you would like included while we explain to you your plan of care/results?"

"Is there anyone you would like us to call?"

"We have contacted _____, and they are on their way."

• Privacy.

Always offer a second gown or an additional sheet when needed to cover the patient.

"I am speaking quietly to preserve your privacy."

"I am pulling the curtain/closing the door for your privacy."

"I am arranging a room to examine you in, for your privacy."

"I apologize for the lack of privacy."

• Delays.

Communicate with the patient every 30 minutes.

"This is what you can expect. "(Explain). "You can expect this to happen in the next _____ [state time frame]."

"I am sorry you are waiting. Let me find out what the delay is, and I will come back and tell you."

"I am sorry you are still in the emergency department. I can assure you that someone is trying to find you a bed. What can I do to make you more comfortable while you are waiting?"

"I am sorry there is a delay in getting a room assignment for you. We are going to put you in a hospital bed to make you more comfortable."

"Right now there are _____ patients waiting to be seen. If anything changes, I will let you know."

• Exit.

Wait until the patient is finished speaking before turning toward the door.

"Is there anything I can get you before I leave?"

"Do you have any questions?"

"I want to know you understand everything. Again, my name is _____. Please ask me if you have a question."

sitting there having no idea what is going on."

The patient representative conducts "comfort rounds" that involve visiting patients and families routinely; updating them on their care, wait times, and results; assisting patients with making telephone calls; and offering reading materials, warm blankets, and meals.

• Give patients choices.

At Stony Brook's ED, nurses were given training in ways to give patients choices so they feel in control of their care. For example, nurses might allow patients to choose where they will receive an injection, which type of pain medication works best for them, or whether they want to switch to a less noisy room. "It's important to incorporate the patient in their care," says Rosenthal. "They know themselves best."

• Use scripts.

Nurses at Stony Brook attended a class on scripting as a guideline for what to say to patients at key points during their ED visit, given by the ED educator. "Nurses don't memorize the wording or necessarily say it verbatim; it's more to keep that flow of communication going," says Rosenthal. **(See the ED's scripts, above.)**

• Comply with simple requests of patients.

Whenever possible, address whatever is upsetting the patient or family member, advises **Inge Morton**,

SOURCES

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RN, CPN, education manager of the ED at Childrens Hospital in Los Angeles. "If a mom is worried that her child has a fever, rechecking that temperature is going to be more effective in reassuring her than platitudes," she says. Or if a parent is stressed because he has to pick up another child from school, offer to troubleshoot on how to get the child picked up, instead of just restating the expected wait time, says Morton.

At St. Thomas's ED, a 52-year-old psychiatric patient with traumatic brain damage began yelling and banging on a bedside table. "There was talk of leather restraints. He kept saying, 'I never get cheeseburgers and fries' over and over," recalls Donel. When an ED nurse ordered the patient these items from the hospital cafeteria, the man immediately calmed down.

They kept the patient in the ED for several hours afterward to watch his behavior, Donel says. "He never became violent again," she says. "This is a good example of how small things can make a huge difference." ■

Women with heart disease may be overlooked in EDs

Study: They're at risk even if no blockage is visible

If women present to ED nurses with chest pain but no evidence of clogged arteries, they may be told it's heartburn and sent home — but many are at high risk for serious cardiac complications or death, according to new research.[1]

Researchers studied 564 women with chest pain who underwent coronary angiography and were found to have no visible obstructive coronary artery disease. They compared them with 1,000 women free of documented heart disease. The women with chest pain were four times as likely to develop serious cardiac complications or die within a five-year period. "The message here is, you do not want to tell a woman who comes to you and says, 'I have chest pain,' not to worry," says **Rhonda Cooper-DeHoff**, PharmD, the study's author and research assistant professor at the University of Florida in Gainesville.

Patients with chest pain but no visible blockage may have coronary microvascular syndrome, in which smaller arteries become glazed with plague. Symptoms may be triggered, but the condition is not detectable using standard coronary angiography. "Typically, when men present with chest pain and signs and symptoms of cardiovascular disease and we take them to the cardiac catheterization lab, they end up having some sort of obstruction in a major cardiac vessel," Cooper-DeHoff says. However, in women with similar signs and symptoms of ischemic disease, most do not have obstruction, she explains.

"Women who don't present with typical symptoms may get triaged the wrong way," says Cooper-DeHoff.

EXECUTIVE SUMMARY

Women with chest pain but no visible obstructive coronary artery disease are at high risk for serious cardiac complications or death.

- Patients may have coronary microvascular syndrome, which isn't detectable with coronary angiography.
- Give patients a thorough cardiac evaluation even if they present with atypical symptoms.
- Refer patients to a cardiologist to manage risk factors aggressively.

"You need to be sure these women get a thorough cardiac work-up, which should include being evaluated by a cardiologist."

Even if only minor plaque is detected by cardiac catheterization, women should be referred to a cardiologist for aggressive management of their cardiac risk factors. The disease process they have does not go away even though the symptoms may resolve, Cooper-DeHoff says. "Days, months, or a year down the road, these symptoms will present again," she says.

Refer these patients to a cardiologist, because aggressive management of risk factors can prevent or delay future significant cardiovascular events, says Cooper-DeHoff. "These women should not be sent home and told the pain is in their head," she says. "We should not be discounting symptoms that women present with and tell them, 'Go home take an antacid and you'll be fine.'"

Speed care with protocol

At Shands at the University of Florida in Gainesville, anyone who presents to the ED with chest pain is brought right back to a room from the triage area, placed on a monitor, and started on the chest pain protocol, says **Coleen G. Booker**, RN, an ED nurse at the hospital. The protocol includes an electrocardiogram (ECG), intravenous placement with blood draw for cardiac enzymes that are sent to the lab and tested at the bedside, medications including nitroglycerin and aspirin if not contraindicated, and a physician called to the bedside to evaluate the patient.

ED nurses ask the following questions: What is the location of the pain? What is the nature of the pain (dull, sharp, heaviness)? How long has it been present? How long does it last? Is it constant or intermittent? What makes it start or stop, if anything? Is it associated with dizziness, shortness of breath, diaphoresis, nausea, vomiting, or any other concerning symptoms?

The patient does not always have to have chest pain in order to be placed on the chest pain protocol, says Booker. "Anyone who is the least bit concerning for a cardiac event may be placed on the protocol once the physician sees the patient," she says. "These patients are also brought right to a room from the triage area." This includes patients with unexplained syncope or shortness of breath or symptoms of congestive heart failure.

The protocol has caught several patients with vague symptoms who might have otherwise been overlooked, says Booker. When a man came to the ED complaining of scapular pain, with no other symptoms and no cardiac history, he was sent home for treatment for muscle strain. He returned a few days later. "The pain was no better and upon further history, the patient admitted that he also had left arm pain," says Booker. "The physician got an ECG, and the diagnosis of myocardial infarction was made."

Similarly, when a registration clerk felt weak and dizzy with slight chest tightness while working in the ED, she was sent for a dobutamine stress test, which came back positive. "She went for a cardiac cath, which found blockages, and she underwent an emergent bypass," says Booker.

SOURCES

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Reference

1. Cooper-DeHoff RM, McClure CK, Johnson B, et al. Adverse cardiovascular outcomes in women with no obstructive coronary artery disease: A report from the WTH project. *Circulation* 2006; 114:1991. ■

When patients don't speak English, what is the risk?

Understand your obligations under the law

(Editor's note: This is the second story in a two-part series on caring for non-English-speaking patients in the ED. This month, we give strategies to reduce liability risks. Last month, we reported on what ED nurses can do to decrease communication delays.)

Like many ED nurses, you're probably caring for an increasing number of non-English-speaking patients. But did you know these patients present

EXECUTIVE SUMMARY

Caring for non-English-speaking patients presents liability risks for ED nurses if you fail to provide translation services when needed.

- Obtain informed consent if invasive procedures are performed.
- Verify that patients understand their discharge instructions.
- Document the time you contacted an interpreter.

significant liability risks for ED nurses?

Federal regulations require all hospitals that receive federal financial assistance to provide meaningful access to patients with limited English proficiency. If you fail to provide this access, it could result in lawsuits, fines, and violations of federal regulations, says **Sue Dill**, RN, MSN, JD, director of hospital risk management for Columbus, OH-based OHIC Insurance Co.

"Many ED nurses are not aware that a violation of the interpreting standards is not only a violation of CMS [Centers for Medicare & Medicaid], Office of Civil Rights, and Joint Commission standards — but the Department of Justice may also be visiting the hospital as well," she warns.

Be aware of your obligations under federal law, advises **Patricia Iyer**, RN, MSN, LNCC, president of Flemington, NJ-based Med League Support Services, a legal nurse consulting firm specializing in malpractice and personal injury cases. "ED nurses need to understand their responsibilities to secure a translator as quickly as possible," she says.

Your ED could be sued

To reduce liability risks when caring for non-English-speaking patients, do the following:

• Make sure you obtain consent.

Your ED could be sued for lack of informed consent if invasive procedures are performed on a person who does not understand explanations being offered and there is an untoward outcome, such as a punctured lung from insertion of a central line, says Iyer. "Keep a list of invasive procedures that require consent, such as insertion of chest tubes, central lines, and so on," she recommends.

You also must inform patients of their rights in advance of receiving care, to comply with federal patient privacy laws and the CMS Hospital Conditions of Participation, given in a language or method of communication that the patient understands, says Dill. For example, if the triage nurse uses a telephone translation service, have the interpreter tell the patient that he or she will be given a copy of the hospital's notice of privacy practices, she says. "The nurse should then document this process in the medical record," Dill says.

• Verify that patients understand discharge instructions.

If discharge instructions are given but are not understood by the patient, and the patient is unable to perform appropriate self-care as a result, the ED nurse could be held liable, says Iyer.

"ED nurses who ask a patient to sign discharge instructions should be verifying that the patient understands them," she says. "Using the interpreter, have the patient verbalize the instructions."

• Be sure that patients know interpreting services are available.

Post a sign in your ED stating, "Interpreting services available at no cost to the patient," recommends Dill. "Do this in several different languages, such as those most likely to present to your ED for treatment," she says.

• Don't use family members unless the patients make this request.

You may be tempted to automatically use family members as interpreters, but this is legally risky except in case of emergencies, says Dill. It's true that some patients may feel more comfortable when a trusted family member or friend acts as an interpreter, but you should verify this request by an impartial interpreter, and not just take the word of the family member who is interpreting, says Dill. "Then have the patient formally waive their right to a professional interpreter," she says. ■

SOURCES

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Changes in requirement for ED medication order review

Retrospective review by pharmacy now is allowed

During 2006 surveys, The Joint Commission found many EDs were not complying with Standard MM 4.10, which requires a pharmacist to review prescriptions or medication orders before these are given in the ED.

"The Joint Commission's position is that pharmacy review for all medication orders is important for quality and safety," says **Robert Wise**, MD, vice president of The Joint Commission's Division of Standards and Survey Methods. "What we've been hearing from EDs, though, is that prospective pharmacy review slows workflow, which can cause quality and safety issues."

The original standard said that an immediate pharmacy review was not required if the need for a medication is urgent and/or when a licensed independent practitioner controls the ordering, preparation, and administration of the medication. "What we found was that many EDs were calling any medication used in the ED as an urgent medication, which is clearly not true," he says.

As a result of these concerns, an interim action was approved specifically for EDs, allowing for the retrospective review of medication orders by a pharmacist in the ED, to be completed no more than 48 hours after the medication order was written or electronically recorded. The new requirement has the goal of preventing treatment delays and was effective as of Jan. 1, 2007.

The interim action permits medication orders to be reviewed retrospectively, but if a prospective system is in place and is working, the ED does not need to switch to a retrospective system, says **Kelly Podgorny**, RN, MS, CPHQ, project director in The Joint Commission's Division of Standards and Survey Methods. "The 48-hour requirement may be helpful to reduce patient backup in the ED, but each organization has to make that assessment for themselves," says Podgorny. "If a retrospective system is used, it should be done within 48 hours to make sure that any safety issues are dealt with."

Additional changes to the standard may be made in late 2007. "We are currently engaged in a field review for Standard MM 4.10 regarding other types of options that may be helpful to EDs," says Podgorny.

Many ED nurses report that they were unable to comply with the previous Joint Commission requirement. "It is a problem from a nursing perspective," says **Debra Steveson**, RN, clinical educator of the ED at Exempla Good Samaritan Medical Center in Lafayette, CO. There is a potential for delay of patient care, especially with patients reporting a high pain level, Steveson says. "The expectation of the public today is fast service," she says. "People are not willing to wait even if it means a safer delivery method."

Easier to comply

An ED information system could make it easier to meet the standard for many EDs, says **Ellen DiStefano**, RN, emergency services performance improvement manager at Providence Portland (OR) Medical Center.

During a Joint Commission survey last fall, surveyors looked closely at this area, reports DiStefano. "We did not have a system in place to review orders consistently," she says. However, when Providence Newberg (OR) Medical Center was surveyed the previous month, surveyors approved of the medication order review process, which used a newly implemented ED computerized information system (ED PulseCheck, manufactured by Wakefield, MA-based Picis) Pricing for the system, including standard interfaces, starts at $100,000.

The electronic system ensures that medication orders are consistently reviewed by the pharmacy. When a medication is ordered, a red "M" appears on the tracking board to notify the nurse that a order has been placed, says **Julia S. Florea**, RN, BSN, CCRN, CEN, emergency services manager.

"The pharmacy has access to our tracking board, and they watch for the red 'M,'" she says. "When they see it, they can go into the order and cosign the order if they agree with it."

The pharmacist also has the ability to see the patient's present medication list, allergies, and lab work if they think it is necessary, says Florea. "Because they have real-time viewing of the order, this allows them to cosign orders real time as well," she says.

Currently, 95% of orders are cosigned by pharmacy prior to the medication being given. "Even if we need

EXECUTIVE SUMMARY

The Joint Commission has changed its requirements for pharmacy review of ED medication orders, and it now is allowing these to be reviewed retrospectively.

- The pharmacist review needs to be completed within 48 hours.
- If your ED has a prospective system in place, you don't need to switch to a retrospective system.
- Electronic systems can display medication orders to the pharmacist automatically for review.

SOURCES/RESOURCE

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- **ED PulseCheck is a web browser-based ED information system** that combines triage, patient tracking, physician and nursing documentation, risk management, charge management, integrated voice recognition, and prescription writing. The cost varies depending upon the size of the installation and additional features. For more information, contact Picis, 100 Quannapowitt Parkway, Suite 405, Wakefield, MA 01880. Telephone: (781) 557-3000. E-mail: info@picis.com. Web: www.picis.com.

to give a medication emergently, the pharmacist usually has cosigned prior to us getting into the room," says Florea. If not, one of the staff will call to let them know they need immediate review of an order. "Joint Commission loved our process and raved about how we were one of the few hospitals they had seen with this figured out," Florea says.

When the medication order is entered by the ED physician, it is displayed to the pharmacist electronically. The order is reviewed and acknowledged, and the nurse administers it. "We are considering using a similar process at our smaller EDs that do not have 24-hour pharmacists," says DiStefano. "The order could be entered and reviewed by a pharmacist at one of our larger facilities that staffs 24-hour pharmacists."

In contrast, faxing medication orders for review by the pharmacist is very inefficient, says DiStefano. "With the electronic system, we save five minutes per order," she estimates. ■

EDs not complying with pediatric seizure guidelines

Invasive work-ups are discouraged

A decade after the American Academy of Pediatrics (AAP) published its guidelines for the acute management of febrile seizure, ED staff still are giving children head CT scans, which aren't recommended for these patients, says a new study.[1]

The AAP guidelines for febrile seizure discourage aggressive neurodiagnostic testing.[2] The researchers reviewed records of 1,029 children between 6 months and 6 years of age diagnosed with febrile seizure at 42 community EDs. They found that although lumbar punctures were done in only 5.2% of cases, head CT scans were done in 11% of cases.

The relatively frequent use of head CT scans is inconsistent with current recommendations, says **Louis Hampers**, MD, the study's lead author and ED physician at the Children's Hospital in Denver. "The AAP guidelines emphasize the very benign nature of febrile seizures and discourage invasive work-ups," he says. Children who have had a febrile seizure are at no greater risk for serious bacterial illness than febrile children of the same age group who have *not* had a seizure, he adds.

"It is often difficult to recognize this parallel, as most kids who've had a febrile seizure come emergently to the ED by EMS, with appropriately 'freaked-out' parents," says Hampers. "But, really the approach to these kids shouldn't be any different than for the febrile toddler waiting quietly in triage."

Take these steps in your ED

The majority of children with febrile seizures arrive at an ED via ambulance, says **Cheryl Stiles**, RN, Clinical Director for the ED at The Children's Hospital in

EXECUTIVE SUMMARY

Some EDs still are giving children with febrile seizure head CT scans even though these aren't recommended for these patients.

- Children with febrile seizure are at no greater risk for serious bacterial illness.
- Children may need to be suctioned.
- Alleviate parental fears of possible brain damage.

SOURCES

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Denver. "This is not something that most parents have ever dealt with—and it is a very scary thing to see your child have a seizure, so they usually call 911," she explains. "At the time of arrival, most children are not actively seizing."

During the initial assessment of a child presenting with a history of febrile seizure, these steps occur:

• The airway is assessed for patency, and the child is suctioned if needed. "The first thing we think is, 'Is the airway compromised?'" says Stiles. "Sometimes children will present with a lot of secretions and they need to be suctioned, or you may just need to reposition their head."

• Breathing is assessed next. "If a child is actively seizing when they arrive in the ED, we place them on oxygen," says Stiles. All emergency equipment is kept at the bedside, including an anesthesia bag and mask connected to the oxygen source and equipment to suction — so if the child seizes again, the supplies are at the nurses' fingertips.

• Next, the circulatory status is quickly assessed and the child is placed on a cardiac monitor.

• Blankets or padding may be placed on the side rails to protect the child from injury that might occur during a seizure.

• Nurses continue to monitor the child's airway, breathing and circulation.

Most children don't have another febrile seizure while in the ED and are discharged to their home, says Stiles. "If there is an obvious source that caused the fever that led to the seizure, then we treat the cause of the infection if possible," she says.

Always take the opportunity to educate parents, says Stiles. "There is a misconception that if you have a really high temperature or a febrile seizure that brain damage might occur," she says. Also, explain to parents that it is not so much the height of the temperature as the speed at which the temperature increases, so you can have a febrile seizure with a temperature of 102°, Stiles explains. "Always comfort and reassure the parents, as they are appropriately frightened," she says.

Explain the importance of giving an appropriate dose of an antipyretic for the child's weight, so they can keep their temperature down and potentially avoid another seizure, says Stiles.

When obtaining the history, ask whether the child has been sick, what their complaints were prior to the seizure, and whether there is a family history of seizures, says Stiles. "Ask whether the child has been exposed to contagious illnesses like chicken pox or strep," she says. "The answers to these questions can often help the provider."

References

1. Hampers LC, Thompson DA, Bajaj L, et al. Febrile seizure: Measuring adherence to AAP guidelines among community ED physicians. *Ped Emerg Care* 2006; 22:465-469.
2. American Academy of Pediatrics, Provisional Committee on Quality Improvement, Subcommittee on Febrile Seizures. Practice parameter: The neurodiagnostic evaluation of the child with a first simple febrile seizure. *Pediatrics* 1996; 97:769-772. ■

Visits for cough medicine ODs dramatically rising

Monitor for life-threatening conditions

A teenager comes to your ED with euphoria, paranoia, and hallucinations. Would you suspect psychotropic drugs, such as phencyclidine (PCP) . . . or common cough medicine that you can buy in any drugstore?

EXECUTIVE SUMMARY

During 2004, 12,584 ED visits involved use of dextromethorphan, an ingredient in cough medicine, with 5,581 of the visits due to nonmedical use. Patients may have blurred vision, loss of coordination, abdominal pain, and rapid heartbeat.

- Risks are higher when the drug is taken along with antidepressants.
- Because cold medicines may contain acetaminophen, patients taking high doses risk permanent liver damage.
- If the patient's respiratory system is severely depressed, mechanical ventilation may be needed.

According to a new report from the Substance Abuse and Mental Health Services Administration, an ingredient in cough medicines was a contributing factor in 12,584 ED visits during 2004, and 5,581 of those visits were attributed to nonmedical use. (For a copy of the report, go to www.dawninfo.samhsa.gov. Click on "Emergency Department Visits Involving Dextromethorphan.")

When taken in large amounts, dextromethorphan (DXM) can produce hallucinations and a "high" similar to PCP. Side effects include blurred vision, loss of physical coordination, abdominal pain, and rapid heartbeat.

At Avera McKennan Hospital in Sioux Falls, SD, ED nurses have been seeing more of these cases recently, reports **Linda March**, RN, clinical educator for the ED. "I have personally cared for a teenager with this type of ingestion. He had consumed an entire box of Coricidin tablets," she says. ED nurses monitored vital signs frequently, gave oxygen and intravenous fluid therapy, and the patient was admitted for continued care and monitoring, says March.

Ask the patient what type of preparation they consumed; what dose; the amount consumed; when taken; if they have vomited since consuming the medication; and if they have taken anything else with it, such as alcohol, antidepressants, or other drugs, says March.

There is a tendency to think that because a medication is available over the counter, it's safe, says March. "Parents don't realize the potential danger of its use, and it lacks the stigma of cocaine or heroin." (For educational information about dextromethorphan to give parents or patients, go to www.family.samhsa.gov. Click on "Get involved" and then "Legal but Lethal: The Danger of Abusing Over-the-Counter Drugs.")

The drug is particularly dangerous when used along with antidepressants or the club drug ecstasy, says March. "The other danger is that many of these cold preparations contain acetaminophen, and there is risk of permanent liver damage when taken in high doses," she says.

Whenever you have a patient whose behavior is bizarre, and you have no history of head injury or trauma, suspect an overdose or chemical abuse, says **Teri Howick**, RN, nurse educator for the ED at McKay Dee Hospital in Ogden, UT. "Rule out high or low blood sugars, and ultimately brain tumors, but nine out of 10 times, it's going to be drugs," she says. "Once you've determined that, it's important to try and isolate the drug, but often you have a polypharmacy."

The rule of thumb is to give supportive care, such as using vasopressors if the patient develops low blood pressure, says Howick. "Treat and support the systems until whatever chemicals have been used wear off, and hope no permanent damage was done," she says.

Patients require diligent monitoring for respiratory depression and cardiovascular collapse, says March. "Sometimes Narcan, a narcotic antagonist, has been used with intermittent success to reverse the respiratory depression," she says. "But if the patient is severely depressed, they may require mechanical ventilation on the respirator." ■

Comply with new restraint and seclusion regulations

More rigorous training is required for staff who use restraints and seclusion to curb violent or self-destructive behavior, says a final rule published by the Centers for Medicare & Medicaid Services (CMS), effective Jan. 8, 2007.[1]

The rule also adds trained registered nurses and physician assistants to the category of practitioners who may conduct the "face-to-face" evaluation required within an hour of a patient being restrained or secluded. A nurse or physician's assistant who performs the evaluation must consult a physician or other licensed independent practitioner as soon as possible, however. **(To download a complete copy of the final rule, go to www.cpidirections.com/AA/Advisories.htm and at the CMS logo, click on "Medicare/Medicaid Final Rule: Patients' Rights — Restraints & Seclusion.")**

At Harborview Medical Center in Seattle, ED nurses receive training in restraint and seclusion, including documentation requirements, during orientation. "Then our ED clinical educator intensively reviews those requirements with all new hires," says **Ed Dwyer-O'Connor**, RN, psychiatric emergency services manager. "We also have unit-based trainings with regard to restraint management within the ED, which are led by me."

In addition to that training, ED nurses receive eight hours of nonviolent crisis intervention, based on a module from the Brookfield, WI-based Crisis Prevention Institute. The training emphasizes de-escalation and other restraint alternatives, with physical intervention and restraints used only as a last resort.

"We also do an hour of training at the end of this, to review with staff what their roles are if we need to put hands on the patient to keep them and us safe," says Dwyer-O'Connor. All nurses are familiar with the continuous 1:1 monitoring of patients in restraints when they are used, and restraint use is regularly audited in the ED, he adds.

"I think we are well placed to handle all changes put forth by CMS," says Dwyer-O'Connor. "With regard to the one hour face-to-face evaluation, we have access to plenty of physicians on-site, so we have not

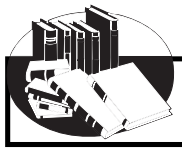
RESOURCE

For more information on the Nonviolent Crisis Intervention training program, contact: Crisis Prevention Institute, 3315-H N. 124th St., Brookfield, WI 53005. Telephone: (800) 558-8976. Fax: (262) 783-5906. E-mail: info@crisisprevention.com.

trained our nurses for that. So it will not change our ability to comply."

Reference

1. 71 *Fed Reg* 71,377-71,428 (Dec. 8, 2006). ■



JOURNAL REVIEW

Smith-Coggins R, Howard SK, Mac DT. **Improving alertness and performance in emergency department physicians and nurses: The use of planned naps.** *Ann Emerg Med* 2006; 48:596-604.

If you work the night shift in your ED and think that taking a nap would improve your performance, there is new research that backs up this claim. When 49 ED nurses and physicians took a 40-minute nap at 3 a.m. during a 12-hour night shift, they had faster reaction times at 7:30 a.m. and started a simulated intravenous catheter more quickly at the end of their shift than those who did not nap.

Night shifts interfere with circadian rhythms and can impair motor functioning and mental alertness, but the study's findings show that integrating a nap into a night work schedule can produce some performance improvements, say the researchers. However, they note that nurses who napped performed worse on a memory test taken at 4 a.m. Since this is probably a result of sleep inertia, the researchers recommend including a "wake-up" period into the time allowed for the nap.

The ED was able to implement nap periods by using staff to cover for nurses while they napped, but they say it might be necessary to add one or more nurses on the night shift to give rotating nap coverage. "Evaluating the costs and safety of napping will be difficult and will depend on the work and staffing demands of each clinical setting," wrote the researchers. ■

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

- How to identify adverse drug events at triage
- Avoid liability risks with patients who leave without being seen
- Stop triage delays for pediatric patients
- Creative training tips for ECG interpretation

specifically to explain the new standards so that you can plan appropriately.

To get your free copy of *The Joint Commission: What Hospitals Can Expect in 2007*, type www.ahcmediawhitepaper.com into your browser, and follow the instructions.

Thank you again for subscribing. ■

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.

9. Which of the following is recommended if a woman presents with chest pain but no visible obstructive coronary artery disease, according to Rhonda Cooper-DeHoff, PharmD?

A. Give the patient a thorough cardiac work-up.
B. Do not give the patient an ECG.
C. Avoid discussing management of risk factors.
D. Tell the patient not to worry.

10. Which is now required by The Joint Commission for pharmacy review of ED medication orders?

A. Pharmacy must review all ED medication orders concurrently.
B. Pharmacy must review all ED medication orders within 48 hours if concurrent review is not possible.
C. Only emergent orders must be reviewed.
D. Pharmacists are no longer required to review ED medication orders.

11. Which is recommended for children with febrile seizures, according to Louis Hampers, MD?

A. Computerized tomography scans should be given in all cases.
B. Lumbar punctures should be done for all patients.
C. Invasive work-ups are discouraged.
D. Nurses should address the child's greater risk for serious bacterial illness.

12. Which is true regarding patients who come to the ED as a result of nonmedical use of over-the-counter cough medications?

A. Side effects may include blurred vision, loss of physical coordination, abdominal pain, and rapid heartbeat.
B. Risks do not increase if patients are taking antidepressants.
C. There is no risk of permanent liver damage.
D. The medication can't cause serious symptoms such as seizures and psychosis.

Answers: 9. A; 10. B; 11. C; 12. A.