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IN THIS ISSUE

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AUGUST 2007
VOL. 10, NO. 10

Woman dies waiting to be seen, ED nurse to be sued — Are you at risk?

Case is wake-up call for emergency nurses

It may sound unthinkable: Emergency nurses ignoring a woman's pleas for help as she bleeds to death on the floor of their waiting room. But that is what the family of a Los Angeles woman claim happened on May 9, 2007, in the ED at Martin Luther King Jr. — Harbor Hospital.

According to a report released by the Centers for Medicare & Medicaid Services, six ED staff members failed to assist the woman, who died of a perforated bowel. The hospital was cited for violating the Emergency Medical Treatment and Labor Act, and the family has announced they will file a wrongful death and medical malpractice lawsuit against the hospital and the ED nurse involved.

Although all the facts of this particular case are unknown, it has sounded an alarm for emergency nurses caring for increased volumes of sicker patients.

"Almost every ED has times when overcrowding is a concern. This case does increase my concerns of an overcrowded waiting room," says **Marianne Fournie**, RN, BSN, MBA, corporate director for emergency services at Methodist LeBonheur Healthcare in Memphis, TN.

Crowding, a nursing shortage, an increasingly elderly population, and a growing number of underinsured or uninsured patients has pushed many EDs to the very edge of their capacity, says **Donna L. Mason**, RN, MS, CEN, nurse manager of adult emergency services at Vanderbilt University Medical Center

EXECUTIVE SUMMARY

An ED nurse is being targeted for a lawsuit along with the hospital, after a woman allegedly went untreated as she bled to death on the floor of the ED waiting room. It is becoming more common for individual nurses to be named in lawsuits. To reduce risks:

- Be sure that every patient is reassessed in the waiting room.
- Position triage so that the nurse can see the entire waiting room.
- Use a separate form for reassessments and document objectively.

in Nashville, TN, and president of the Emergency Nurses Association. "Crowding does contribute to the risk of adverse outcomes, and in my opinion, the risk of liability for all the health care professionals in the ED including the triage nurse," she says.

Whatever the facts of this particular case, an incident such as this "must serve as a wake-up call," according to Mason. "Every incident that gets into the news media is of concern to each and every emergency nurse who has the responsibility of triage and the waiting room," she says. "We are all concerned about liability. But more than liability, we are concerned that patients are not getting the care and attention they need for their illness or injury."

Whenever a sensational ED case hits the media, it's not unusual to see the "blame game" played out, says **Mary Ann Shea**, JD, RN, a St. Louis-based registered nurse, attorney at law, and former emergency nurse.

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ED Nursing® (ISSN# 1096-4304) is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. GA. POSTMASTER: Send address changes to ED Nursing®, P.O. Box 740059, Atlanta, GA 30374-9815.

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This activity has been approved for 10 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 10 Contact Hours.

This program has been approved by the American Association of Critical-Care Nurses (AACN) for 9 Contact Hours, Category A, file number 10852.

This activity is authorized for nursing contact hours for 24 months following the date of publication.

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"The finger has been pointed pretty directly at the triage nurse," she says. However, the facts can only be evaluated by spending time talking to all who were involved, and it takes time to complete such an investigation, Shea says. "I doubt that this case is as simple and clear cut as it sounds when presented on the news," she says.

What is clear, however, is that all triage nurses must follow ED policies and procedures for triage, identify patients with potential life-threatening conditions, and then ensure that those patients are seen as soon as possible, says Shea. "How do we define the term 'possible?' It depends on what else was going on in the ED at the time and how many staff were available," says Shea. "There are too many unanswered questions to warrant anyone passing judgment at this point."

Suit to raise awareness

Whether the nurse and hospital are found liable for wrongful death, ED nurses might be more likely to be sued for "overlooking" patients, notes Shea. "Anytime there is a high-profile case such as this one, it encourages others to consider these types of issues if the fact scenarios mirror this case," she says. "It also raises awareness of issues that others might not have considered before hearing about a case like this."

It has become fairly common for individual nurses to be named in lawsuits, especially if they have played a prominent role in the patient's care, according to **Kathleen A. Catalano**, RN, JD, director of health care transformation support for Perot Systems, a Plano, TX-based provider of information technology services and business solutions, and a former ED nurse.

"We see this in the intensive care unit and the perioperative areas; I'm not surprised to see it in the ED," she says. "I believe the liability risks will continue to increase if overcrowding in waiting rooms is not addressed." **(See related story on p. 111 about patients with multiple visits to the ED.)**

To reduce legal risks, do the following:

• **Be sure that *all* patients are reassessed in the waiting room.**

At Methodist LeBonheur, a computerized tracking and documentation system reminds nurses to record patients' vital signs every two hours. "Reassessment includes rechecking vital signs and obtaining a statement of the patient's condition for Emergency Severity Index levels two and three," says Fournie. "If anything has worsened, the triage level can be changed."

In addition, triage areas were moved within the waiting room to give the nurse a full view of the waiting area so that patients with worsening conditions can easily be seen, says Fournie.

Other EDs have paramedics or technicians in waiting

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areas to ensure patients are being watched and attended to, says Mason. "This observation is noted on the ED record or nurses notes, along with other pertinent information for a particular condition," she says. **(For more information about reassessment, see "Are patients with life-threatening conditions in your waiting room?" *ED Nursing*, August 2005, p. 109.)**

• Document reassessments.

If a patient's initial symptoms are worsening, fully document this to protect yourself legally, says Catalano. "Include a statement regarding the fact that the physician was advised and his/her response," she says. "Make sure the chain of command is well known and followed."

Consider creating a separate form to document reassessments and list the patient's name, signs and symptoms, vital signs, and time of the assessment and reassessments, advises Catalano. Documentation in the medical record is the only way you can prove that you assessed and reassessed a patient, emphasizes Shea. "Failing to document it raises a presumption that it was not done," she says. "It is highly unlikely that a nurse can convince a jury that an action was performed when it is not documented in the medical record."

Use objective documentation — what you see, hear, smell, or touch — instead of subjective documentation such as "patient doing better," or "patient is stable," recommends Shea. "Neither of these comments communicates information sufficiently for another person to get a picture of the patient's condition," she says.

Shea gives two examples of objective documentation that clearly communicate a patient's condition: "Patient states his pain has gone down from 7 to 2 on a scale with 10 being the worst," and "patient's lips are cyanotic, and she is guarding her abdomen and grimacing in pain."

"Describing a patient's skin coloration, posturing, and facial expressions gives the reader a much clearer picture of what is happening," she says.

• Keep charge nurse informed.

The triage nurse must inform the charge nurse about patients needing to come in immediately, even if no beds are available, says Mason.

"Because of the large number of patients without health insurance, EDs see a lot of people who have waited until the last minute to seek help, and often times they are quite sick," she says. "EDs need to have an experienced person out in triage to wade through the sick, sicker, and sickest." ■

Frequent ED visits: Treat each as the patient's first

Don't let multiple visits lead to complacency

Imagine a patient coming to your ED dozens of times with no emergent condition identified — always with the same complaint of chest or abdominal pain. Would you be just as vigilant with your assessment on his 49th visit?

"This patient had literally been in this ED 48 times since Jan. 1 of this year," says **Julia S. Florea**, RN, BSN, CCRN, CEN, emergency services manager at Providence Newberg (OR) Medical Center. "We continually worked him up for his complaints even though

EXECUTIVE SUMMARY

If a patient returns to your ED with the same complaint multiple times, you must do a thorough evaluation each time.

- Never assume that a patient is just seeking medications.
- Avoid judging patients as "drug seekers."
- Follow protocols regardless of how many times the patient has been seen.

they are always the same."

When the patient came to the ED for the 49th time, again reporting chest pain, nurses took him seriously, worked him up correctly — and found that he was having an acute myocardial infarction, says Florea. "Protocol was followed, and the patient was rapidly transferred for cardiac cath," she says. "If we had just looked at this patient as a 'frequent flier,' the result could have been disastrous."

Some ED nurses argue that the May 2007 case of a Los Angeles woman who died waiting to be seen wasn't a case of overcrowding preventing an overburdened triage nurse from making a good assessment. Instead, they point to the fact that the woman had been seen multiple times in the ED for the same complaint and had a history of substance abuse.

"This was a case, in my opinion, of prejudicial tunnel vision and lack of assessment related to the well-known utilization of the frequent-flier tag," says **Pamela Rowse**, RN, quality/risk consultant and former ED nurse manager at St. Rose Dominican Hospital in Henderson, NV.

The Los Angeles triage nurse should have signed the patient in, obtained a set of current vital signs, and evaluated her current clinical status, says Rowse. "Although this wouldn't have prevented her being named in the lawsuit, it would have protected her from individual scrutiny related to the bad outcome."

Instead, the nurse reportedly told police officers who returned the woman to the ED to put her in a wheelchair and failed to intervene. "The woman subsequently slumped to the floor from the chair and was vomiting blood with excruciating abdominal pain," says Rowse. "This was all videotaped, including the janitor who was mopping around the woman because of the blood that she was vomiting."

The woman died shortly afterward of a perforated bowel and, to the public eye, there was a total lack of empathy from ED nurses, says Rowse. There were three visits in three days with the same complaint, she points out. "To the public, it appears as if her drug history precluded normal precautionary intervention, and I'm not so sure that isn't what happened," she says.

Don't judge patients

ED nurses see many difficult patients, including individuals who do not tell the truth and individuals who are just looking for medications, says Florea.

"In many EDs, when a frequent flier comes through the doors, we get our backs up," she says. Nurses are tired of drug seekers, Florea says. "We are harsh and often rude to this patient and have no problem making this patient wait because we 'know' why they are here," she says. "In reality, we do not."

It is part of the culture at Providence Newberg's ED to avoid judging *any* patient, says Florea. "This sounds idealistic, but it is not," she says. "It is a culture and must be built." Her ED has made this effort a major initiative, she says. "We do not say, 'Oh, John is back again and just wants narcotics,'" she says. "Every patient is treated as if this is their first time to the ED."

Avoid having 'disastrous event'

Without doing a thorough assessment, you are opening the door to adverse outcomes and liability suits, says Florea. "If we do not change our thoughts and beliefs about this type of patient, we will certainly have a disastrous event at some point," she says.

Even if the patient has come to your ED the same day with the same complaint, it is the responsibility of the triage nurse to re-evaluate and determine if there is a significant change and the potential for further decline, says Rowse. "In the Los Angeles case, there wasn't a set of vital signs done when the patient presented to the ED," she says. "This would be a difficult position to defend in a court of law."

Treating frequent ED visitors with kindness and respect is key, says Florea. "We approach every patient with these values no matter why they are here," says Florea. "I do not believe that this event would have occurred in our ED because we would have responded to the person — not just the behavior or the disease entity." ■

SOURCES

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Change practice to comply with new 2008 safety goals

Only three new National Patient Safety Goals (NPSGs) were added this year by The Joint Commission, but all of them will have a big impact on emergency nurses.

"The biggest challenge in our ED will be getting staff educated about these new goals and also doing follow-up and monitoring to be sure we are in compliance," says **Karen Shipman**, RN, director of nursing for the ED at CJW Medical Center — Johnston-Willis Campus in Richmond, VA.

Here are the new goals, effective Jan. 1, 2008:

• Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

At CJW's ED, evidence-based cardiac and noncardiac heparin protocols are used. "Right now we are looking at whether there is something else we need to be doing as an ED, to make sure that we are reducing harm," says Shipman. "We will be reinforcing education and ensuring that our patients are safely receiving heparin.

Currently, nurses have access to online calculators that compute the dosage of anticoagulant therapy, which is reviewed by a second nurse.

At the ED at Einstein at Elkins Park (PA), nurses are taking a closer look at the details of past incidents to determine if changes are needed, says **Teri Jackson**, RN, nurse manager of the ED. "We will be looking at historical data as to causes, processes, or analysis of previous episodes and seek to refine the process," she says.

• Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Previously, hospitals had to adhere to the CDC guidelines, but now you have the option of using the WHO's guidelines instead. **(For more information on the WHO hand hygiene guidelines, go to the Joint Commission International Center for Patient Safety web site at www.jcipatientsafety.org. Click on "WHO Collaborating Centre for Patient Safety Solutions" and "View Solutions.")**

"Our nurses are all already in tune to hand hygiene, but continued reinforcement is in order," says Jackson. "We will give nurses friendly reminders with posters, newsletters, and quality data."

• Improve recognition and response to changes in a patient's condition: The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.

At CJW, a rapid response team is being developed that will comply with this goal, says Shipman. "We are in the process of looking at who should respond from what unit," she reports. For example, if an inpatient nurse notices a patient's blood pressure is 70/40, the nurse can get a team to respond immediately so the patient can be treated before it becomes a critical event, says Shipman.

Currently, when a code blue occurs on a medical/surgical unit or other clinical area, both a nurse and physician respond from the ED. "Right now we are not sure if that practice will continue or whether we will pull staff from other areas," she says. ■

SOURCES

For more information on The Joint Commission's 2008 National Patient Safety Goals, contact:

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Don't overlook cases of pediatric stroke in your ED

Many cases go undetected

More than 3,200 children have "brain attacks" each year, but these often go unrecognized in the ED, since nurses don't suspect stroke in children, says **Lori Jordan**, MD, a pediatric neurologist who specializes in stroke at the Baltimore-based Johns Hopkins Children's

EXECUTIVE SUMMARY

Emergency nurses often don't suspect stroke in children, but 3,200 of these cases occur each year. Arterial dissection, which often is trauma-related, causes one-fourth of these cases.

- Neck pain on one side and a one-sided headache are symptoms of neck trauma.
- Check for asymmetrical papillary size.
- Perform a head computerized tomography scan rapidly.

Center. Strokes in children may occur even more often than brain tumors, Jordan adds.

"But unlike cancer, sadly, strokes in children are sometimes not recognized and treated, or at least not as early as they should be," she says. "Half of these cases end up with permanent neurological damage."

Arterial dissection, which often is trauma-related, causes one-fourth of all strokes in children, says Jordan. Other common causes of stroke in children include congenital heart disease and sickle cell disease, and rarer causes include blood-clotting disorders and abnormalities of the blood vessels, she adds. "We have seen several cases of pediatric stroke in our ED over the last year."

Strokes may occur after a traumatic injury to arteries in the neck or spine, commonly caused by whiplash sustained during a car accident or injuries from high-contact sports, says Jordan. "Carotid or vertebral artery injury can lead to small tears, which generate blood clots that travel to the brain," she explains.

A common symptom of trauma-related pediatric stroke is neck pain on one side, accompanied by a one-sided headache, possibly with numbness and weakness on that side of the body, says Jordan.

If a child or young adult complains of weakness and/or numbness on one side of the body, often involving the face and arm — or face, arm, and leg — consider stroke as one possibility, advises Jordan. "Specifically, the patient should be asked about trauma to their neck, neck pain, and unilateral headache," she says. Pupillary size should be checked, Jordan says. "Asymmetry is a rare but worrisome sign," she says.

Take these steps if you suspect pediatric stroke, says Jordan:

• Perform a head computerized tomography (CT) rapidly. In some cases, a brain magnetic resonance imaging of the brain and blood vessels of the head and neck should also be performed.

• Start intravenous fluids and have the patient lie flat on a stretcher to maintain blood flow to the brain.

SOURCES

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• After a head CT has been done to make sure that the stroke is not hemorrhagic, then aspirin may be given.

Don't miss signs at triage

ED triage nurses must recognize signs and symptoms of stroke in children, and they must be familiar with the anatomic and physiologic differences of children, says **Mary Ellen Wilson**, RN, BSN, CEN, nurse clinician at the pediatric ED at Johns Hopkins Children's Center. Signs such as hemiparesis, impaired speech, impaired comprehension, or neurologic deficits may be difficult to assess in the young child who is unable developmentally to communicate or follow commands, says Wilson.

For example, a newborn infant may exhibit seizure activity with lip smacking or eye deviation and fluttering, says Wilson. "The triage nurse is challenged to recognize the subtle cues and abnormal assessment findings, since early recognition and treatment are critical in optimizing outcomes," she says. ■

Know limitations of weight estimation tools

Weight may be underestimated

Two commonly used tools may underestimate a child's weight in the ED, according to a new study. Researchers obtained weight estimates with the Broselow-Luten tape and the devised weight estimation method (DWEM), and compared them with

EXECUTIVE SUMMARY

The Broselow-Luten tape and the devised weight estimation method underestimated weights of children in the ED in a recent published study.

- Risk of harm is increased for interventions with a small therapeutic index.
- Obese children are at high risk for underestimated weights.
- Be sure that emergency nurses are aware of limitations of weight estimation tools.

actual weights of 100 children.[1]

The Broselow-Luten tape underestimated weights in all weight classes, and the DWEM underestimated weights for children weighing more than 20 kg.

Unfortunately, a child's weight can't always be measured in the ED, notes **Steven T. Baldwin**, MD, an ED physician at Children's Health System in Birmingham, AL, and one of the study's authors. "Some interventions have a sufficiently small therapeutic index such that even modest errors in estimating a patient's size can significantly increase the risk of harm due to undertreating or overtreating the patient," he says.

The dramatic increase in numbers of obese children may lead to an increased risk, he notes. **(For more information on this topic, see "Obese children at risk for wrong weight estimation," *ED Nursing*, February 2007, p. 43.)**

However, the biggest risk is to infants, says Baldwin. He gives the example of incorrectly estimating body weight by 2 kg for a 5-kg baby vs. a 100-kg adolescent. "The relative error is 40% of the patient's body weight for the baby but is only 2% for the older child," he says.

To reduce risks, know each method's limitations for obese children or those who have other conditions that may make weight estimates incorrect, says Baldwin. One example is a condition that may change the usual relationship between body height and weight, such as limb deformities or amputations, he says. "Although such cases are infrequent, advance consideration should be given to developing a strategy for dealing with such cases when they require emergent interventions," Baldwin says.

He recommends increasing the weight estimated by a length-based tool by 25% for moderately obese patients and by 50% for profoundly obese patients. "Similarly, the estimated weight could be reduced by 25% for a severely malnourished patient," says Baldwin.

Another option for very obese patients is to plot the child's age on a growth chart and then use the weight at or above the 95th percentile line, says Baldwin.

If he child has a condition which makes measurement of body length difficult, then a flexible tape measure may be useful to get a more accurate measurement, says Baldwin. "If the issue is a condition that invalidates the usual relationship between body length and body weight, then perhaps a crude but tolerable estimate can be made by trying to estimate a correction factor that compensates for the patient's condition that is invalidating the usual length vs. weight relationship," he add.

You also can alter the estimated value for a patient's weight up or down based on their clinical response to interventions, says Baldwin. "Awareness of interventions that have a narrow therapeutic index will allow providers to pay particular attention to the risk of a weight estimation error," says Baldwin. "It will often be best to start low and titrate upward if the weight estimate may be a significant issue."

ED nurses at Children's Medical Center Dallas use the Broselow-Luten tape for any child who cannot be weighed on a scale due to an emergency, says **Lanie St. Claire**, RN, ED nurse and pre-hospital liaison at Childrens Medical Center Dallas. "All weight is written in kilograms," says St. Claire.

Be familiar with the use of the tool and its limitations, she advises. "Many times drug dosage mistakes occur because the concentration of the drug utilized is not the same as the one on the Broselow," says St.

SOURCES/RESOURCE

For more estimation about weight estimation tools, contact:

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To download a free educational packet on the Broselow-Luten 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."

Claire. "It should be not be used as a quick drug reference guide unless you have taken the time to learn how to use it." **(For more information, see "Use color-coded tapes correctly or risk errors, *ED Nursing*, September 2003, p. 130.)**

Reference

1. DuBois D, Baldwin S, King W. Accuracy of weight estimation methods for children. *Ped Emerg Care* 2007; 23:227-230. ■

Dangerous heat injuries need special attention

At Carondelet St. Mary's Hospital in Tucson, AZ, ED nurses often see the life-threatening consequences of heat stroke and hyperthermia, says **Diana Platt Lopez**, RN, BSN, CCRN, CEN, clinical educator for the emergency center.

"Every year we see multiple patients, often our desert crossers, who are brought here in extremis," says Lopez. "Sometimes they survive intact, but other times they survive after a long hospital course including rhabdomyolysis and organ failure."

Hyperthermic patients who present to the ED with higher initial temperatures, hypotension, or a low Glasgow Coma Scale score are more likely to die, says a new study.[1] Researchers looked at 52 patients who came to the ED at Banner Good Samaritan Regional Poison Control Center in Phoenix, from 2003 to 2005.

Initial management of the severely hyperthermic patient starts with airway, breathing, and circulation, and correction of urgent problems including hypoxemia, severe hyper/hypokalemia, and acidosis, says Lopez. **(See steps taken by ED nurses on p. 117.)** "Patients can developed rebound hyperthermia in three to six hours, and it is treated the same way as initial treatment," she adds.

EXECUTIVE SUMMARY

Hyperthermic patients who come to the ED with higher initial temperatures, hypotension, or low Glasgow Coma Scale scores are more likely to die. To cool patients:
- Use evaporation cooling.
- Avoid alcohol sponge baths due to risk of drug absorption.
- Avoid antipyretic agents because they are not effective.

Five steps to better care

To improve care of patients with heat injuries, do the following:

• Understand the different types of heat stroke.

Heat stroke is defined as a core body temperature in excess of 105° F, with associated central nervous system dysfunction in the presence of environmental heat loads that cannot be dissipated, says **Steve Rasmussen**, RN, CEN, clinical coordinator for the ED at Virginia Commonwealth University Medical Center in Richmond. Frequently encountered complications include acute respiratory distress syndrome, hypoglycemia, multiorgan system failure, disseminated intravascular coagulation (DIC), seizures, and rhabdomyolysis, he says.

Exertional heat stroke generally occurs in healthy persons who engage in strenuous activities during hot temperatures, says Rasmussen. Symptoms may include cutaneous vasodilation, tachypnea, altered level of consciousness, seizures, excessive bleeding due to DIC, and/or rales due to noncardiac pulmonary edema, he says.

"Skin may be dry or moist, depending on underlying medical conditions and hydration status, and the speed at which the heat stroke developed," says Rasmussen. Effects of heat stroke may include the following, says Lopez:

— neurologic dysfunction due to metabolic disturbances leading to seizure activity and changes in level of consciousness and uncoordinated movements;

— compromise of cardiovascular system due to dehydration and vasoconstriction that limits effectiveness of heat loss mechanisms;

— tachyarrhythmias such as atrial fibrillation and supraventricular tachycardia;

— hypotension due to shunting of the blood to the periphery to aid with heat dissipation.

— rhabdomyolysis due to breakdown of skeletal muscle and the release of myoglobin leading to acute/chronic renal failure, coagulopathy, and DIC;

— conduction defects such as prolonged QT interval and nonspecific ST changes. "The patient develops lactic acidosis and hypovolemic shock," says Lopez. "The risk of gut ischemia due to re-distribution of the blood to the periphery is significant."

• Identify factors that decrease the patient's ability to disperse heat.

Underlying chronic conditions may impair thermoregulation, such as cardiovascular disease, extreme age, obesity, use of drugs, and neurologic or psychiatric disorders, says Rasmussen. Diuretics, beta-blockers,

Take these steps for hyperthermia

Here are the steps taken by ED nurses at Carondelet St. Mary's Hospital in Tucson for severely hyperthermic patients:

• Assess vital signs including blood pressure and oxygen saturation.

• Establish patient's baseline level of consciousness.

• Prompt fluid resuscitation with a crystalloid solution (isotonic sodium chloride solution). Correct the total fluid deficit slowly. Give approximately half of the deficit in the first three to six hours, and give the remaining deficit within the first nine hours after initial resuscitation was started.

• Start cooling the patient immediately with radiation, convection, conduction, and evaporation. Apply ice to the patient's groin, neck, and axilla, and use cooling blanket and fan. The physician may order iced gastric lavage, iced peritoneal lavage, iced bladder irrigation, or cooling of infused intravenous fluids. ■

and phenothiazines impair thermoregulation, and dietary supplements containing ephedra, cocaine, ecstasy, amphetamines, and benztropine increase metabolic heat production, says Lopez.

• **Use appropriate methods to cool patients.**

The goal is to decrease the core temperature to less than 36.9° C within 30 minutes, says Lopez. "This improves survival and minimizes end organ damage," she says. "Lactated Ringer's is not a good choice because it may worsen lactic acidosis."

Evaporation cooling is considered the modality of choice because it is effective, noninvasive, and easily preformed, says Rasmussen. The naked patient is sprayed with lukewarm water and placed under fans, and benzodiazepines or lorazepam may be used to suppress shivering, he explains. "Ice packs to the axillae, neck, and groin are effective but poorly tolerated in conscious alert patients," he says. "Cold oxygen, cooling blankets, and cold [intravenous] fluid can be used."

Cold peritoneal lavage also can be used but it is an invasive technique and not well tolerated in awake patients, says Rasmussen. "Alcohol sponge baths should be avoided because large amounts of the drug may be absorbed and produce toxicity," he says. "Antipyretic agents should not be used since the underlying cause does not involve the hypothalamus."

• **Don't overlook hyperthermia.**

Hyperthermia can mimic other conditions such as abdominal and neurological illnesses, says **Frank LoVecchio**, DO, MPH, the study's author and research director in the Department of Emergency Medicine at Maricopa Medical Center in Phoenix. "Even if the patient's temperature is not elevated, it may have been prior," says LoVecchio. To avoid overlooking hyperthermia, take a thorough history, he recommends. "Be aware of what occurred prior to the event, and remember that old and very young patients are more prone to the disorder," LoVecchio says

• **Don't miss atypical symptoms.**

Not all patients present with classic signs of heat stroke, warns **Toni Colvard**, RN, ED manager at Atlanta Medical Center. "They either may not feel it is heat related if the symptoms are not extreme, or confuse it with heat exhaustion which is less serious," says Colvard. "Either way, nurses may not act upon it aggressively or quickly enough."

Reference

1. LoVecchio F, Pizon AF, Berrett C, et al. Outcomes after environmental hyperthermia. *Amer J Emerg Med* 2007; 25:442-444. ■

SOURCES

For more information about heat injuries in the ED, contact:

- **Toni Colvard**, RN, Manager, Emergency Department, Atlanta Medical Center, 303 Parkway Drive N.E., Atlanta, GA 30312.
- **Diana Platt Lopez**, RN, BSN, CCRN, CEN, Clinical Educator, Emergency Center, Carondelet St Mary's Hospital, 1601 W. St. Mary's Road, Tucson, AZ 85745. Phone: (520) 740-6193. Fax: (520) 872-6922. E-mail: dplopez@carondelet.org.
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Focus is on education for restraint and seclusion

Protect yourself and your patient

Emergency nurses must receive more rigorous training in the use of restraint and seclusion to control violent or self-destructive behavior to comply with new standards from the Centers for Medicare & Medicaid Services (CMS).

"The training for managing aggressive behavior is done for the protection of the staff as well as the safety of the patient," notes **Patti Muller-Smith,** RN, EdD, CPHQ, a Shawnee, OK-based consultant working with hospitals on performance improvement and regulatory compliance.

Examine your ED's existing policies, your current education and when it was last presented, and documentation requirements for when a patient is put in restraints, recommends Muller-Smith. This documentation should include description of the patient's behavior, other methods used and the patient's response, and why restraint was needed, she says.

At Methodist Hospital in Indianapolis, nurses use a computer-based training module on restraint and seclusion, which includes documentation, interventions, and policies and procedures, says **Sandra Pavey**, RN, clinical educator in the emergency medicine and trauma center.

The computer based training was created internally based on Clarian policy and The Joint Commission requirements.

"We have a systemwide restraint committee that reviews all changes to restraint standards, changes policy as needed, and develops the educational plan," says Pavey. "We currently have not implemented anything in respect to the latest changes but will be as soon as the committee finalizes the plan."

ED nurses will now be required to demonstrate the proper application of restraints, says Pavey. "The current online module that we use for education will be updated and will be a mandatory requirement for staff," she adds.

New ED nurses are given a specific lecture on psychological emergencies, which covers appropriate use of restraint and seclusion, says **Ron Kraus**, RN, BSN, CEN, the ED's clinical orientation coordinator at Methodist.

At Rogue Valley Medical Center in Medford, OR, restraint education was added into a mandatory four-hour class on management of aggressive behavior class given by two ED nurses, developed by the hospital's behavioral health clinical nurse specialist, says **Heather Freiheit**, RN, BSN, EMT-P, clinical manager of emergency services. "Oregon statues require that any staff member who may care for these patients, including monitoring the patient via a camera or window, have training in restraints," she says.

The class covers stress reactions, how to apply restraints, how to enter rooms safely, signs that a patient or family member is beginning to escalate, nonverbal cues, how to diffuse a situation, and when to call for assistance, says Freiheit.

At St. Joseph's/Candler Hospital in Savannah, GA, ED nurses are required to attend a nonviolent physical crisis intervention class within one year of hire, says **Karen Hust**, RN-CEN, MSN, BSN, ADN, advanced clinical educator for the ED. The classes are given by the Brookfield, WI-based Crisis Prevention Institute.

EXECUTIVE SUMMARY

EDs must comply with new federal requirements for training in restraint and seclusion for potentially violent patients.

- Have nurses demonstrate the proper use of restraints.
- Add restraint education to training on management of aggressive behavior.
- Document that alternatives were tried.

Try these before using restraints

Here is a list of items contained in the "alternative therapies" kit used by ED nurses at St. Joseph's/Candler in Savannah, GA:

- coil-shaped toy;
- stress balls;
- plastic dinosaurs
- dolls;
- plastic bending toys;
- magnetic whiskers;
- a sketching toy;
- portable games, including travel chess/checkers;
- rain noisemaker;
- paper and pencil and drawings to color;
- word searches or crossword puzzles;
- journal to write in;
- playing cards (regular and large);
- videos of travel or nature scenes;
- humorous videotapes such as sports or TV bloopers, *Laurel & Hardy* and *Little Rascals*. ■

(To obtain contact information for the institute, see resource box, right.)

"We have been requiring this for years, and the staff is 100% compliant," she says.

The training covers:

• how to recognize and respond to signs of physical and psychological distress in the restrained patient;

• clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;

• techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion;

• staff behaviors that can affect the behavior of the patient;

• nonphysical intervention skills such as de-escalation, mediation, self-protection, and other techniques;

• the requirement that patients placed in behavioral restraints have continuous in-person observation for the first hour by a competently trained staff member, and assessment of the patient's physical and emotional status occurs at least every 15 minutes.

The new CMS requirements have a strong focus on verbal de-escalation before resorting to physical or chemical restraints, says Muller-Smith.

"The general rule of thumb is to go from least restrictive to more restrictive as the patient's behavior escalates," she says.

Documentation of what occurred before restraints were used probably will come under more scrutiny because of the new regulations, says Muller-Smith.

Training at St. Josephs/Candler emphasizes that the intervention be based on an individualized assessment of the patient's medical or behavioral status or condition, says Hust. "Seclusion is utilized using the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm," she says. The ED's focus always has been on limiting use of restraints and seclusion, adds Hust. "Alternative methods are considered first, and efficacy is documented in

CE instructions

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

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

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

SOURCES/RESOURCE

For more information on education on restraint use in the ED, contact:

- **Ron Kraus**, RN, BSN, CEN, Clinical Orientation Coordinator, Emergency Medicine and Trauma Center, Methodist Hospital, I-65 at 21st, P.O. Box 1367, Indianapolis, IN 46206. Telephone: (317) 962-8504. E-mail: rkraus@clarian.org.
- **Patti Muller-Smith**, RN, EdD, CPHQ, Administrative Consulting Service, Box 3368, Shawnee, OK 74802. Telephone: (405) 878-0118. E-mail: mullsmi@aol.com.
- **Sandra Pavey**, RN, Clinical Educator, Emergency Medicine and Trauma Center, Methodist Hospital, I-65 at 21st, P.O. Box 1367, Indianapolis, IN 46206. E-mail: spavey@clarian.org.

The Nonviolent Crisis Intervention training program teaches emergency department staff to respond effectively to the warning signs that an individual is beginning to lose control. A one-day seminar costs $399, a two-day workshop costs $749, and a four-day instructor certification program is $1,199. For more information, contact:

- **Crisis Prevention Institute**, 3315-K N. 124th St., Brookfield, WI 53005. Phone: (800) 558-8976 or (262) 783-5787. Fax: (262) 783-5906. E-mail: info@crisisprevention.com. Web: www.crisis prevention.com.

COMING IN FUTURE MONTHS

■ Proven strategies for stroke education

■ Stop dangerous delays for psychiatric patients

■ Prevent unsuccessful lumbar punctures

■ Encourage nurses to report near-miss errors

the patient's medical record," she says.

ED nurses created an "alternative therapies" kit with items such as playing cards and puzzles that can help to distract an agitated patient, adds Hust. **(See list of kit's contents on p. 118.)** The items are stored in a large plastic box.

Some of the items are disposable, and other items may be laundered or cleaned with a wipe, says Hust. Many of the items were bought at the local dollar store. "This can sometimes negate the escalation of patient behavior that would otherwise have required restraints," she says. ■

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 intervention is recommended if you suspect pediatric stroke, according to Lori Jordan, MD?
A. Give aspirin before the head computed tomography scan is done.
B. Start intravenous fluids.
C. Have the patient remain standing.
D. Disregard pupillary size.

6. Which of the following are likely to have weight underestimated in the ED, according to a study published in *Pediatric Emergency Care?*
A. Obese children
B. Children with limb deformities
C. Children with amputations
D. All of the above

7. Which is recommended for cooling hyperthermic patients, according to Steve Rasmussen, RN, CEN?
A. Use evaporation cooling.
B. Use alcohol sponge baths.
C. Use antipyretic agents.
D. Use Ringer's lactate.

8. Which is recommended to reduce risks of restraint and seclusion in the ED, according to Patti Muller-Smith, RN, EdD, CPHQ?
A. Avoid documenting what occurred before restraints were used.
B. Do not make crisis intervention training mandatory for nurses.
C. Always document alternatives that were used before restraint.
D. Do not attempt to use verbal de-escalation.

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