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Survey: Most ED staff victimized by violence never report incident

Almost one-third of respondents in New Jersey say they have been assaulted

Several years ago in an ED in Virginia, a triage nurse was taking a patient's history when the family member of another patient approached her. Angered that his relative had not received care quickly enough, this individual pulled a gun on the nurse and demanded immediate care. The nurse complied, no shooting occurred, and security subdued the violent individual.

"However, that nurse could never work in the ED again," notes **Mary Pat McKay**, MD, MPH, director of the Center for Injury Prevention and Control at The George Washington University, Washington, DC, and an ED physician at The George Washington University Hospital.

Such long-term effects often are the result of a traumatic experience such as that — especially when the events are not reported and the victims must deal with the memories alone, experts say. As a new survey conducted by the New Jersey Department of Health and Senior Services shows, this happens far too often.

The recently released report, "Workplace Violence and Prevention in New Jersey Hospital Emergency Departments," said workers in New Jersey hospital EDs are routinely subjected to verbal abuse and almost one-third have been assaulted. **(For information on how to access the report, see resource box, p. 111.)** It also found that 72% of those who were verbally or physically assaulted *never report the event*.

Executive Summary

Staff members who are victims of violence and fail to report the incident may remain traumatized and unable to perform at their normal level of proficiency; some may not even be able to return to the ED. As a manager, there are steps you can take:

- Have reporting processes available, and regularly update your staff on what they are and how they are to be used.
- Be a role model for your staff. Take every event seriously, and follow up with the victim to make sure they receive the help they seek.
- Be sure to include staff-on-staff verbal abuse as part of your violence-reporting policies and procedures.

IN THIS ISSUE

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Here are other survey findings:

• Nurses are at highest risk for being victims of verbal or physical assault.

• Verbal abuse at least once per year was reported by 90% of the respondents, with 27% reporting verbal abuse more than 96 times per year.

• Only 6% reported no verbal abuse.

• Threats were reported by 61% of employees, with most being threatened between one and 12 times per year.

• Almost one-third of workers who responded to the state survey reported being assaulted, and 12% reported three or more assaults per year.

A critical issue

Beyond the obvious threat to the physical well-being of ED staff members, the psychological repercussions can affect the job performance of the victims — possibly tainting their attitudes toward patients or even making them afraid to return to work, say experts. For all of these reasons, they agree, ED managers must be proactive in their efforts to empower and encourage their staff to come forward when such incidents occur.

Recognize the problem to bring attention to it, advises **Donna L. Mason**, RN, MS, CEN, president of the Emergency Nurses Association and nurse manager of adult emergency services at Vanderbilt University Medical Center in Nashville, TN. "You have to educate every member of your team — nurses, doctors, registration people, transporters, and volunteers — that violence is *never* OK, and that for their own safety they must do something about it," she says.

By the very nature of their jobs, ED professionals deal with a lot of angry people, Mason notes. Most individuals do not come to the ED in their normal state of mind. "When they come to the ED they are stressed, and everyone handles stress differently," she says. "Teach your staff that this is normal for some people, but that it's *not* normal to accept demeaning language."

ED managers "have got to be the absolute best role model to support their staff," she says. For example, she says, if a VIP comes into the ED and starts pushing one of the nurses around, the manager cannot accept such behavior. "You have to follow up with the employee through the system," Mason says. "If charges need to be filed, you go with them, and if they need the EAP [employee assistance program], you help them make contact. If they fear the manager will not help, they will not report."

You have to continually follow through on your commitment, she says. "Bring the issue up at staff meetings, and send information out at least quarterly about violence or safety," she says. "Keep it in the forefront, so the staff will know you think it is important."

Have processes in place

As an ED manager and director, you want to have an environment that is open and honest enough so your staff can report their concerns — whether it is a

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quality, safety, or environmental issue, says **Leon L. Haley Jr.**, MD, MHSA, chief of emergency medicine and vice chairman of clinical affairs for Grady Health System and associate professor in the Department of Emergency Medicine at Emory University, both in Atlanta.

"You must have a process by which the staff can bring their concerns — whether it is a suggestion box, open office hours, regular staff meetings or forums," he says.

Structure staff meetings around this issue, Haley advises. If you have access to a good mental health or crisis staff, you also can conduct inservices, says Haley. "We use our mental health staff to do regular inservices to make sure the staff know how to report and what to report," he says. "This creates that open comfort zone."

Haley's approach is similar to the one he takes when addressing ED crowding: an "input, throughput, output" model, he says. "In terms of input, you want resources available for protection, like security guards, metal detectors, and a process by which you can monitor things," Haley explains. "Once [a potentially violent person is] in the ED, what are the tools you can use to help reduce patient and family stress, and if they are in need of mental health assistance, how quickly can they get it?" The third phase, he says, are the policies and processes for reporting incidents if something does happen.

In the Virginia ED mentioned above, for example, the "input" phase was strongly addressed after the gun-toting incident. "The whole ED was redesigned, and the first thing they did was enclose the triage area in bulletproof glass," she says.

Sources/Resources

For more information on reporting incidents of violence in the ED, contact:

- **Leon L. Haley Jr.**, MD, MHSA, Chief of Emergency Medicine, Vice Chairman of Clinical Affairs, Grady Health System, Atlanta, and Associate Professor, Department of Emergency Medicine, Emory University, Atlanta. Phone: (404) 616-6419. E-mail: Leon_Haley@emoryhealthcare.org.
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- **Mary Pat McKay**, MD, MPH, Director, Center for Injury Prevention and Control, The George Washington University, Washington, DC. Phone: (202) 741-2947.

To obtain a free copy of *Workplace Violence and Prevention in New Jersey Hospital Emergency Departments*, go to www.state.nj.us/health/eoh/survweb/documents/njhospsec_rpt.pdf.

The New Jersey State Assembly is considering Bill No. 3027, The "Violence Prevention in Health Care facilities Act," aimed at requiring health care facilities to establish violence prevention planning, programs, and training, and state reporting processes. For more information, go to www.GovNetNJ.com, or contact the sponsor, Assemblyman Herb Conaway, MD, at (856) 461-3997. E-mail: AsmConaway@njleg.org.

The manager's role

It's impossible to overemphasize the role of the ED manager in creating an environment that encourages reporting incidents of violence, says Mason.

Be aware of the different *types* of violence, she says. "Nurse managers are key — not just in the case of violence by a patient or family member, but in lateral incidents where nurses demean other nurses, or doctors belittle someone," she says. "That's just as bad as a patient calling you names." It is the manager's job to let the staff know that this kind of behavior is also unacceptable, she says.

"I have a chair of emergency medicine who will absolutely not tolerate any kind of [demeaning talk from] doctors to nurses," Mason says. Vanderbilt has a professional practice program, she says. "If a doctor is verbally abusive to a nurse, they can report it to the professional practice program, and it will go in their file," she says. "All the physicians know this."

Tech threatens to 'go postal'

In staff-on-staff incidents, adds McKay, the appropriate managers must get involved. "Last week, at another institution, I heard the story of a nurse who called a lab tech to add on a test to a tube of blood, and for whatever reason, the tech threatened to come up to the ED and 'go postal,'" she recalls. "Clearly, the managers of those two people needed to get involved so the incident would not continue."

There's no substitute for having such reporting policies and providing appropriate managerial response, says McKay. "One of the reasons people do not report incidents is they see no benefit," she says. "That's when you need a process, or an EAP, or whatever behavioral supports there are. As a group in the ED, we probably don't avail ourselves of that kind of support as much as we should." ■

'Low-tech' whiteboard is still highly effective

Study lists key aspects of communications

As we move ever more rapidly into the age of electronic patient tracking systems, ED managers would be well advised to keep in mind the communication lessons offered by the low-tech whiteboard, say the co-authors of a new paper published online by the *Annals of Emergency Medicine*.[1]

What makes the lowly whiteboard such an effective communication device? "One thing we learned is that nothing on a whiteboard is useless, while on an electronic board you can't say that," says **Yan Xiao**, PhD, lead author and associate professor in the Department of Anesthesiology and director of research in patient safety, program in trauma at the University of Maryland School of Medicine, Baltimore.

"It's not that we are taking an anti-technology stance, but we want to stress how communications should be viewed," Xiao says. The whiteboard notations are not simply a listing of the number of patients, he says. "People communicate tasks to each other, as well as handoffs, challenges, and opportunities for finding additional resources." Because the whiteboard is so easy to use, a lot of people can provide input, Xiao says.

Mercy Medical Center in Baltimore now uses a computer, says **Stephen Schenkel**, MD, MPP, chair of the Maryland Patient Safety Center ED Collaborative, assistant professor in emergency medicine at the University of Maryland School of Medicine, and an attending ED physician at Mercy. "But one of the key lessons in this paper is the incredible flexibility of a handwritten system," Schenkel says. "For anybody to be able to reach up and modify, tracking gives it incredible versatility."

Executive Summary

A new study to evaluate the effectiveness of the whiteboard as a communications device contains valuable lessons concerning attributes of any communications device.

- Make sure the most important facts being communicated are highlighted in some fashion with asterisks, boldface type, underlines, etc.
- Create a system that allows the most important patient information to be effectively communicated from shift to shift.
- Place your computers side by side with other communications devices to enhance their value.

There are also social lessons taught by the whiteboard, he says. "In the ED, everyone is gathered around the white board; it becomes a social center," Schenkel says. "The benefit of a computer is that it disseminates information effectively, but you lose that social opportunity."

The study, which was conducted in a trauma center operating suite, uncovered several key principles of communication that are enhanced by the use of a whiteboard, including:

- **Task management.** "The whiteboard gives you the ability to delineate what needs to be done," says Schenkel.
- **Team attention management.** This is the ability to highly important facts. "You can put an item on top, and with an asterisk or circle, you can draw the attention of more than one person," Schenkel explains.
- **Task status tracking.**
- **Task articulation.** This is a list of what needs to be done.
- **Resource planning and tracking.** "The goal is to always see what the whole 'stage' looks like," says Schenkel.
- **Synchronous and asynchronous communication.** This requires being able to communicate important information from shift to shift.
- **Multidisciplinary problem solving and negotiation.** "The whiteboard brings people together, since different people can go by the board and enter notes," Schenkel says. "It exists almost as a chart in miniature."

Forget electronics?

The authors do not argue that EDs should keep their whiteboards and eschew electronic tracking systems; rather, they say, ED managers should be aware of the strengths and weaknesses of the new systems to ensure optimal effectiveness.

If your ED is looking at an electronic system, Schenkel advises, "Think about your whiteboard, and know that these [principles] are things you are still going to want." Not everything can be duplicated, he concedes. "Very few people would say an electronic system creates a sense of camaraderie," he says.

Xiao says, "In the paper we describe a method of looking at how people communicate. You can use the same method to look at your own environment, which means looking at more than just hardware."

Also consider what is surrounding the display, how accessible it is, and how people use that display, Xiao says. "In the ED, for example, you must consider which bed has what patient and who is assigned to that patient," he says. "The other consideration is progress of care, which has implications for your co-workers."

Sources

For more information on effective communications in the ED, contact:

- **Stephen Schenkel**, MD, MPP, Assistant Professor, Emergency Medicine, University of Maryland School of Medicine, Baltimore. E-mail: ssche002@umaryland.edu.
- **Yan Xiao**, PhD, Division of Research in Patient Safety, Program in Trauma, University of Maryland, 22 S. Greene St., Baltimore, MD 21201. Phone: (410) 328-7179. Fax: (410) 328-7230. E-mail: yxiao@umaryland.edu.

In other words, he says, you do not want to look solely at individual decision making, "but at how one person's work is connected with others."

How can electronic boards be made even more useful? "For one thing, you can place it side by side with other communication devices," Xiao advises. "If there is information that cannot be displayed electronically, perhaps you can use 'stickies' on the computer, as you might on a whiteboard."

Another important consideration, Xiao continues, would be the location of the screens, "so people can see these displays at as many cross angles as possible."

In addition, he says, your communication tools must be compatible with your work force. "This is especially true in the ED, where people are stressed and can have a high-intensity workload," he says. "A cumbersome tool may work at low-workload place, but definitely not in an ED."

Finally, Xiao cautions, "Don't underestimate seemingly low-tech devices."

Reference

1. Xiao Y, Schenkel S, Faraj S, et al. What whiteboards in a trauma center operating suite can teach us about emergency department communication. *Ann Emerg Med* DOI: 10.1016/j.annemergmed.2007.03.027. ■

'Medical tourists' are unique ED challenge

Different meds, no records, problematic follow-up

They call them "medical tourists." They may be in the United States on a vacation, or they may be here for a specific procedure, but either way they can end up in your EDs. You and your staff must be prepared to deal with the incredible constellation of unique treatment issues they raise.

Managers tell *ED Management* that the challenges presented by medical tourists go far beyond the obvious language and cultural issues. Here are just a few of the issues they cite:

- ensuring follow-up care when medical issues are not completely resolved;
- treating a disease not normally seen in the United States;
- finding the right specialists;
- overcoming different naming systems for medications;
- completing a history without medical records, or records written in a language for which a translator is not readily available;
- addressing housing and transportation issues for family members.

Even if people from other countries are in the United States for a specific procedure, they still can end up in the ED, notes **Frank Peacock**, MD, FACEP, vice chairman of the ED at the Cleveland Clinic. "They may fly in the day before [and become ill or injured], or perhaps they had a procedure and are in the follow-up period, and developed a problem," Peacock says. "Just because they are here for reconstructive surgery on their foot does not mean they can't get appendicitis."

The clinic owns three nearby hotels that can house these visitors, and ambulance service is provided, but that convenience can be a problem for the ED. "They are all told *exactly* where the ED is, and I bemoan that sometimes," Peacock says. These patients can be brought in from their hotel at 4 a.m. for the same conditions as typical ED patients. If they have a cold, they go back to the hotel, Peacock says. "But if their scrips run out, we have to try and fill them," he says

Mayo Clinic Hospital in Phoenix, sees patients from outside the country who come in for routine things such as a blood pressure check, says **Laurie Zessin**, RN, BSN, MBA, manager of the ED. "They may have

Executive Summary

When foreign visitors present in your ED, treating their immediate medical complaints may be the least of your problems, say ED managers who regularly treat "medical tourists." You must be prepared to:

- Help arrange for housing if patients or family members must remain in town until their follow-up visit.
- Make sure to have access not only to verbal translation services, but to individuals who can read drug labels and medical histories that are written in foreign languages.

Sources

For more information on how to treat medical tourists, contact:

- **Frank Peacock**, MD, FACEP, Vice Chairman, Emergency Department, The Cleveland Clinic. E-mail: peacocw@ccf.org.
- **Laurie Zessin**, RN, BSN, MBA, ED Manager, Mayo Clinic Hospital, Phoenix. Phone: (480) 342-1738.

a problem at home and just want to make sure everything is OK," she says. "If it's high, we'll treat them like anyone else who comes in [with hypertension]."

The biggest challenges

Zessin says that follow-up and arranging for specialist care are among her greatest challenges. "We are here to see and treat and stabilize the patients so as to not cause harm to life and limb, but we are often not able to totally resolve the problem," she says. "The patient might need more tests done or a follow-up visit to see how they are doing."

Getting patients to the right specialists can be very challenging, Zessin adds. "The patient may have a complex set of problems and need to have several specialists providing service," she explains.

Local specialists try to accommodate those needs, "but sometimes we need the patient to be seen within two days and they can't see them for a month," she notes. What usually happens in those cases is "they bounce back to the ED, and we make sure nothing untoward has happened."

Peacock and Zessin note that sometimes these patients will have diseases not normally seen in their EDs. "Some patients are from the Third World and will have diseases I have never seen," notes Peacock. For example, U.S. EDs don't see dengue fever, he says. "This makes treatment decisions difficult," Peacock says.

A lot of the Mayo patients present with malaria, "and we do not normally see that," says Zessin, who adds that she has taken steps to overcome this challenge. "First of all, your staff needs to be able to recognize signs and symptoms, and what tests to order," she says. To make sure they are prepared, she has held an inservice on diseases such as this one.

While most language barriers are overcome today with the use of on-site interpreters and phone line translations, Peacock notes that some issues still remain.

"I had one patient who came in with a 50-page chart, but it was all in Italian," he recalls.

In addition, he says, some countries have completely different naming systems for medications. "Sometimes we can figure them out, or they are generic [drugs] and we then understand what they are," he says. "But if they are written in Arabic, you can't do that."

In such a case, he says, they obtain an Arabic translator, although it can take one-half hour for them to reach the ED. The hospital has a large list of translators, many of whom work on-site. Others may be called at home.

For several more mundane issues, both hospitals have separate departments that can address housing, transportation, and other issues for patients. The Cleveland Clinic has a Global Patient Services Department, while Mayo has a Regional Medicine Department. At Cleveland Clinic, for example, the ED simply contacts the department and an advocate is provided for the patient.

Finally says Peacock, some of his greatest challenges have been the result of cultural differences. For example, many of his patients are from the Middle East, where modesty is of particular concern. "I have examined some women completely through their clothes while being watched by a guard," he shares. ■

Preplanning critical for freestanding ED

Pre-existing staff help with fluctuating demand

If you're planning to open a freestanding ED, you won't have any history on which to base your staffing, equipment, and other basics of operations. Nonetheless, say those who have done it, it is essential that you plan ahead as carefully as possible, and you won't necessarily be entirely in the dark.

"A freestanding ED can treat more complex cases on-site vs. immediately transporting patients to a hospital," explains **Becky Vasse**, BSN, MAS, director of emergency services for the new Shady Grove Adventist Emergency Center in Germantown, MD, and Shady Grove Adventist Hospital in Rockville, MD. Freestanding ED physicians are board-certified in emergency medicine, and lab and radiology services are more comprehensive than in an urgent care center, she says.

"One of the bigger challenges was to get a real objective sense of what the volume was going to be, says **Michael Cetta**, MD, medical director of the Shady Grove Adventist Emergency Center in Germantown, MD. The center, which opened in

Executive Summary

If your system is planning to create a freestanding ED, it's important to project your patient demand and staffing and equipment needs as accurately as possible. However, it is equally important that you build flexibility into your staffing plans.

- Take note of the patient census in your main ED, and determine which subpopulation most likely will be predominant in the new facility.
- Using your patient demand projections, seek to maintain the same staff to patient ratios as in the main ED.
- As much as possible, use the same staff in both facilities to maintain optimal flexibility to meet daily demand shifts.

August 2006, saw 22,000 patients in its first year of operation, which was 5,000 more than originally anticipated. **(For more on freestanding EDs, see "Number of freestanding EDs up, ED *Management,* September 2005, p. 98.)**

With nurses and hospital beds in short supply, says Cetta, "we wanted to do all we could to optimize staffing and be flexible enough to grow." From a physician standpoint, that meant starting with single coverage, which was one doc 24 hours a day. "As we swung into operation and volume gradually increased, we added a midlevel practitioner [a nurse practitioner or a physician assistant]," he says.

In terms of nurse staffing, they looked at the type of patients they thought they might see, based on what they see at the main facility at Shady Grove Adventist Hospital and what group of those patients they thought would go to Germantown, says Vasse. "We knew based on our location next to a 'SoccerPlex' and Germantown that orthopedics would be our strongest base," Vasse says. "We get about 13% of our patients coming by ambulance." That prediction, she says, was "right on."

Beyond that, says Vasse, she attempted to keep the same ratios that existed at the hospital for the same types of patients. "If you look at the acute area, the average is four patients per nurse, and eight in fast track," she says. "There is a blend [of acute and fast track-type] patients at Germantown, depending on the time of day."

Demand was monitored, and changes were made as needed. For example, she says, "at the five-month mark, we added a nurse from 3 p.m. to 3 a.m."

Cetta says having a hospital within 10 miles of the new facility added flexibility to their staffing.

"Out parent hospital has a very large staff, so we were fortunate enough to have built-in buffers," says Cetta. "We hired three new physicians and a few [physician] extenders, but we started them before we opened; they were all trained at Shady Grove Adventist Hospital, and everyone works at both places now."

Therefore, "it's not unusual for us to pull a physician or an extender from Shady Grove Hospital when needed," he says. That was an element of his planning for the start, Cetta says. "A key element of our design was to have the parent hospital so close that all docs

Staff buy-in is key with freestanding ED

If you've never opened a freestanding ED before, there will be a number of lessons learned, and that was certainly the case for **Michael Cetta**, MD, medical director of the Shady Grove Adventist Emergency Center in Germantown, MD.

"Lesson No. 1 is: Get buy-in from your medical staff and consultant staff — orthopedics, plastics, and so forth," he says. "It's very important that they are on board, accepting of the new facility and willing to support it."

How did he obtain this support? "I did a lot of 'propaganda' to them and to the EMS folks," he says. In addition, he brought several of the specialists through the facility before it opened, to get their input. "For example, we bought a portable C-arm because an orthopedist who toured the facility said we needed it if we wanted him to come up and do a wrist reduction," Cetta says. In addition, the main Shady Grove hospital has a very complex plastics closure tray, so he purchased those as well. "The ENT docs also have particular trays, and once we found that out, we got those," he adds. The same was true for slit lamps. "The doctors at Shady Grove know how to use that type, so it was a simple, logical choice, and a very good decision," says Cetta.

All of this groundwork was extremely beneficial, and necessary, Cetta says. "If we had just thrown this thing out there and not prepared people for it, regardless of how beneficial it was, they would only have seen it as something that would affect their comfortable lifestyle," he says. "People don't necessarily see change as good — even if it is really *very* good." ■

Sources

For more information on opening a freestanding ED, contact:

- **Michael Cetta**, MD, Medical Director; and **Becky Vasse**, BSN, MAS, Director of Emergency Services, Shady Grove Adventist Emergency Center, Germantown, MD. Phone: (301) 279-6004.

and extenders were prepared to work at either," he says. "If you did not have that flexibility, things would be a lot bumpier."

Cetta also used existing relationships when planning for equipment and ancillary services. "We went into partnership with the [hospital] radiology group, and they did a tremendous job of outfitting the facility," says Cetta, noting that X-ray and CT equipment are available 24/7.

They don't have comprehensive blood banking capability, he says. "We can't run drug levels for dilantin, digoxin, and so forth," Cetta says. However, that limitation is not a hindrance because Shady Grove Hospital provides a courier service, he says. "Within two hours we have whatever we need," he says. As for meds themselves, "they are readily available and at our fingertips; we have 100% of what's in the ED at Shady Grove Hospital," Cetta says.

What's more, says Vasse, since she is not struggling with other departments for lab and radiology services, the turnaround time is faster. For example, "our target goal at the hospital for labs is an hour," she says. "In Germantown, it's more typical [to get results in] a half-hour."

Management is different

There are clear differences between managing a freestanding ED and one inside a hospital, says Cetta. "The scale is different, because it's a smaller facility with a smaller staff," he notes. "Therefore, implementing a process change is much simpler."

With a freestanding facility, adds Vasse, "You must be prepared to take care of anything that walks in the front door." So, for example, transfers for trauma or labor must be arranged very quickly. "It's of paramount importance to have those arrangements and contacts very accessible," she says. "We have arrangements with other [nearby] facilities that say they are willing to take them, and since the physicians at Germantown also work at Shady Grove Hospital, they know all the local contacts."

The staff at the Emergency Center "are prepared to handle any type of injuries/illness/condition that comes through the door," notes Vasse, and in some cases, this can be a patient with a serious condition who must be transferred to an appropriate hospital very quickly. Since the building is too small to accommodate a helicopter landing pad, Germantown even had to make arrangements with nearby Montgomery College (less than a mile away) to land on their property, she says. **(For some important lessons as you go forward, see the story, p. 115.)** ■

Urgent care clinics post wait times on web

Could this be the wave of the future?

To improve patient service, Park Nicollet Health Services in Minneapolis has begun posting the wait times in its urgent care clinics on its web site (www.parknicollet.com/clinic). The times are posted in 30 minute "ranges," such as 0-60 minutes, 60-90 minutes, and 90-120 minutes, and also indicates if the center is closed.

If administrators also hoped to ease the burden on their ED, however, experts say they are barking up the wrong tree. On the other hand, they add, this public posting of wait times may be a glimpse into the future of ED patient satisfaction efforts.

"We have six urgent care centers in our health system, and when patients would arrive at the one nearest their home they might find they had a two- or three-hour wait," recalls **Shannon Mindt**, RN, BSN, urgent care manager for Park Nicollet. "We felt that if they could see where the best wait was while they were still

Executive Summary

Posting wait times in an urgent care center certainly can make patients happier — but don't expect it to shorten the waiting times in your ED.

- Patient populations in EDs and urgent care centers are entirely different, and they rarely will overlap in terms of where they seek care.
- Some EDs post waiting times in their lobbies, but this can be a two-edged sword as patients will take those times literally.
- With technology advancing and more patients becoming Internet-savvy, web postings of ED waits may be just a matter of time.

Sources

For more information on posting waiting times, contact:
- **Richard O'Brien**, MD, FACEP, Scranton, PA. Phone: (570) 340-2900.
- **Alfred Sacchetti**, MD, FACEP, Chief of Emergency Services, Our Lady of Lourdes Medical Center, Camden, NJ. Phone: (856) 757-3803. Fax: (856) 365-7773.

in their house, it would give them more choices."

This approach, which has been used for about two years, has contributed to greater patient satisfaction, says Mindt, although no formal survey has been conducted. "We have heard positive feedback from patients, and they are using the site more frequently," she says.

Mindt says that she has not heard whether the postings have made any impact on the ED at the system's main hospital. "In general, the ED waits tend to be a lot longer anyway, except during flu season," she says.

The ED does post its waiting times at the triage desk, Mindt says. "The sign tells you when the last patient was roomed and approximately how long you will likely have to wait until you are roomed."

Experts skeptical

ED experts don't see a direct connection between wait times in urgent care centers and those in the ED. **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center in Camden, NJ, says he isn't sure posting times in an urgent care center can decrease ED waits. "Patients who are shopping around on the Internet for the best waiting times are generally not the ones who are presenting to the ED for care, urgent or emergent," he says.

Richard O'Brien, MD, FACEP, an emergency physician in Scranton, PA, and a spokesman for the American College of Emergency Physicians, agrees. "I truly believe urgent care clinics and emergency departments serve a vastly different group of patients, by and large," he says.

Still, Sacchetti thinks the concept has some value for patients of urgent care clinics. "I think that idea works if someone has already decided that he or she is going to go to that urgent care center and is just waiting for the best time to show up," he says. "It would probably be even better if they did it like the Hair Cuttery and allowed the patients to sign in ahead of time and then show up in 30 minutes."

Sacchetti and O'Brien agree that this approach eventually may be adopted by EDs as well, although they are not sure how well it will work.

"I do know of one ED that posted times in patients' treatment rooms for estimates on how long it would take a test's results to come back," says Sacchetti. "They've stopped the process now because the patients took the times literally."

O'Brien says, "Many years ago, I worked in a small — new at the time — urgent care clinic, and I could *never* have envisioned the need to post waiting times in such a facility." However, waiting an hour or even two is the new "normal" in health care, even in a so-called convenience clinic, he says. "I think postings like this may become the norm, even for EDs, but it will do little to change the destination of a person who has the acute onset of significant symptoms and needs emergency services," O'Brien adds.

At present, he says, he knows of no ED that posts waiting times, "Perhaps due to liability concerns or most likely because our volume can change literally in a heart beat." However, O'Brien adds, such a move could be inevitable. "We now live in the era of instant information via cell phone, text messaging, and the Internet," he explains. "And with state-of-the-art ED patient tracking systems, this kind of 'estimated waiting time' information is at least theoretically available in real time."

It is this advancement in technology, and the public knowledge of such advancement, that at least opens the possibility of such a change, says O'Brien. "We may find some requirement to do so at some point, or the public may demand it," he says. "We will just have to 'wait' — no pun intended — and see." ■

ED adds business center to wait area

Check reservations, learn about condition, or 'surf'

Patients and family members in the ED waiting room at Florida Hospital Celebration (FL) Health have more than each other's company to help pass the time while waiting to be seen by a doctor. Since March of this year, they can now e-mail friends or business colleagues, check on airline reservations, or educate themselves about the patient's condition in the business center provided by the hospital.

While the "center" is basically two computers and a printer, it has made a significant difference to people waiting in the triage area. "I have heard patients talk about it in the lobby," says **Sandra Devore**, RN, an ED nurse. "They absolutely *love* it — especially our business travelers. When they come in and wait in the

Executive Summary

Providing your patients with Internet access in the waiting area can do wonders for their attitudes and make them much more understanding of long wait times. What's more, it doesn't take a fortune to create a business center.

- The ED at Florida Hospital Celebration (FL) Health made a world of difference with just a couple of computers and a printer.
- Have your information technology staff set the computers up to preserve the privacy of your internal computer system, and block out offensive sites.
- Access to medical sites can help reinforce your patient education efforts.

lobby, they can keep up with e-mails and other business-related things."

Since the hospital is near Orlando, there are a large number of vacationing visitors and business travelers who present to the ED, says **Deborah Laughon**, RN, BSN, MS, DBA, CCRN, director of emergency services. "This has a lot to do with Disney[world]," she says. "A lot of folks come off the plane with a sick kid, and a lot of folks travel here."

While she and her staff continually work to reduce wait times, "we always welcome an opportunity to provide a distraction," she says. The opportunity to provide this new distraction presented itself when the lobby was renovated to meet the growing demand in the ED. In three years, the annual volume had grown from 35,000 to 50,000.

Nothing fancy

The center is located in a small area just off the lobby. "We have found it is used more than we ever thought it would be," says Laughon. In fact, she says, the demand has been such that the staff has been forced to put up a sign that says, "Please respect all our visitors and limit your time to 30 minutes."

The information technology (IT) department of the hospital helped set up the computers with a firewall so that Internet access was possible without jeopardizing the confidentiality of the hospital's own systems. Nevertheless, there is much they can do on the computers. "Patients or families waiting can get seat reservations or communicate with people all over the world in real time," says Laughon. "They will also be able to play games." In addition, she notes, the IT department has blocked out any sites that would be inappropriate for children to visit.

Patients also can go on the Internet and look up "whatever we tell them is wrong," adds Laughon. This action reinforces one of the hospital's main missions: patient education, she says. "If you're not sure you believe what our docs told you, you can 'Google' it and find what you need," she says. "That's a big positive."

A marketing tool

Each computer in the center also is a not-so-subtle marketing tool for the hospital. The home page is the facility's web site. "They can learn about all our services and who we are," Laughon says.

In fact, she says, marketing was a key element of the center from the beginning. The hospital marketing department arranged for local TV coverage before the center opened. "One of the key messages was that now you have the ability to make a reservation and get a seat assignment while waiting to see the ED doctor," Laughon says.

Laughon was interviewed for the story. "It is part of my job, because we are part of the community," she says.

Meeting the mission

While initial research told Laughon that very few EDs had a center like this, she believes it fits in nicely with her department's mission. "We want to do all we can, for example, to educate kids who come here," she says. The department's goal is 'door to doc' in 60 minutes, but that goal is not always met," she concedes.

Thus, distractions are important for younger patients. "We have little treehouses the kids can climb under, and some toy bodies — models of a boy and a girl — which, when you rub their bodies, show the organs underneath," she notes.

While making a world of difference for patients, the center has had little impact on the ED staff. "When something breaks, we call the IT people," Laughon says. "Once a day we turn it off and on. We've not had any issues other than [running out of] paper."

Part of that was by design, says Laughon, who notes that originally DVD players were considered as well. "We just could not use nursing staff to run it or help

Sources

For more information on ED business centers, contact:

- **Sandra Devore**, RN, ED nurse, **Deborah Laughon**, RN, BSN, MS, DBA, CCRN, Director of Emergency Services, Florida Hospital Celebration Health, 400 Celebration Place, Celebration, FL 34747. Phone: (407) 303-4000.

people use it," she explains.

The business center takes nothing away from their duties, adds Devore. "Plus, it absolutely helps the attitudes of patients and family members in terms of getting mad about waiting," she says. While no formal survey has been taken, "we've gotten a lot of positive feedback," Devore says. ■

Guide helps EDs implement HIV testing

The Health Research and Educational Trust (HRET), an affiliate of the American Hospital Association, has released an online guide to help EDs plan and implement HIV testing programs.

According to HRET, multiple approaches to HIV testing are being employed in hospital EDs across the United States; however, there are limited data about which approaches work best in different circumstances. HRET has developed the guide for clinicians and administrators who want to incorporate routine HIV testing in their EDs.

Based on interviews and site visits with EDs that have pioneered HIV testing, the guide outlines approaches, considerations, and resources for making HIV testing routine in ED care. It was developed with support from the Centers for Disease Control and Prevention, which in September 2006 recommended voluntary HIV screening be a routine part of medical care. The guide helps health care providers overcome some of the barriers to routine HIV testing, including legal and reimbursement concerns.

"Emergency departments are the predominant point of care among patients who have limited access to care," said **Gretchen Williams Torres**, director of research at HRET. "ED-based testing can be a great opportunity to screen a wide population of patients who would not normally be tested."

The guide, which can be downloaded free of charge at www.edhivtestguide.org, includes topic areas that can be navigated using a drop-down menu. You may print sections or the entire guide. Each section contains links and information on additional resources. Sample menus are also provided to help first-time users get started. ■

CNE/CME instructions

Physicians and nurses participate in this continuing medical education/continuing education program by reading the articles, using the provided references for further research, and studying the questions at the end of the articles.

Participants should select what they believe to be the correct answers and 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 the semester's activity with the **March 2008** 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.

For information on the CE/CME program, contact customer service at (800) 688-2421 or customer service@ahcmedia.com. ■

CNE/CME objectives

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

CNE/CME *questions*

1. According to Donna L. Mason, RN, MS, CEN, ED managers can help empower their staff members to report an incidence of violence by:

A. Demonstrating that their safety is important to you.
B. Educating the staff about violence and reporting options.
C. Being a good role model.
D. All of the above

2. According to Stephen Schenkel, MD, MPP, which of the following does a whiteboard accomplish more effectively than a computerized ED system?

A. Highlight important facts.

COMING IN FUTURE MONTHS

- New chest pain protocol incorporates outpatient stress testing
- New findings may help relieve ED overcrowding
- The most effective strategies for monitoring potentially suicidal patients
- Ultrasound in emergency medicine: Why are we falling short?

B. Communicate important patient information from shift to shift.
C. Create a sense of camaraderie.
D. Track the status of different patient care activities.

3. According to Frank Peacock, MD, FACEP, which of the following issues is *not* a unique aspect of caring for foreign tourists?
A. Finding housing for family members.
B. Visiting the ED to seek primary care.
C. Presentation of diseases rarely, if ever, seen in the United States.
D. Unique names for various medications that are unfamiliar to the ED staff.

4. According to Michael Cetta, MD, the fact that his freestanding ED does not have a comprehensive blood banking capability is compensated for by:
A. A courier service to the main Shady Grove hospital.
B. Digital transmission of lab results.
C. The elimination of certain labs tests.
D. A short-wave radio connection to the main laboratory.

5. According to Richard O'Brien, MD FACEP, web postings of ED wait times may someday become the norm because:
A. Current technology provides the ability to offer the information in real time.
B. Internet-savvy patients may begin to demand it.
C. EDs will be required to provide such a service.
D. All of the above

6. According to Deborah Laughon, RN, BSN, MS, DBA, CCRN, which of the following service is *not* available to users of the ED's business center?
A. Access to medical sites where they can learn more about their condition.
B. Access to the hospital intranet.
C. The ability to e-mail friends and business colleagues.
D. The ability to make and confirm airline reservations and seat assignments.

CNE/CME answers

1. D; 2. C; 3. B; 4. A; 5. D; 6. B.