Cutting-edge Discussions of Management, Policy, and Program Issues in Emergency Care

AAEM Staffing Ratio

What recommendations are included in the American Academy of Emergency Medicine (AAEM) position statement on nurse-to-patient ED staffing ratios?

Answer 1:
The AAEM issued an Emergency Nurse–to-Patient ED Staffing Ratios Position Statement in February 2001. Part of the Statement says, “AAEM asserts that, as a guideline for comprehensive, moderate acuity emergency departments, the minimum emergency nurse-to-patient staffing ratio should be 1:3 or based on the rate of patient influx such that the rate of 1.25 patients per nurse per hour is not exceeded. In addition, dedicated triage and charge nurses are necessary in higher volume departments.” The entire Position Statement is available at the following Web site:

The AAEM also asserts that the emergency physician staffing ratio should be based on the rate of patient influx so that the rate of 2.5 patients per physician per hour is not exceeded. Rate of influx means, on average, how many patients arrive in the emergency department in any given hour.

Having physicians advocate for reasonable emergency nurse staffing is one way to advocate for our patients. Already one medical director has indicated that the AAEM position benefited his staffing proposal.1—Tom Scaletta, MD, FAAEM, Chairperson, Department of Emergency Medicine, West Suburban Health Care, Oak Park, Ill; E-mail: tscalett@rush.edu

REFERENCE
Answer 2:
I appreciate the support of emergency physicians for emergency nurses, especially when it comes to our efforts to promote appropriate nurse-to-patient staffing plans. Two membership organizations represent emergency physicians. The American College of Emergency Physicians (ACEP), formed in 1968, represents more than 21,000 emergency physicians. It has supported ENA’s endeavors to benchmark ED nurse staffing and has not published any nurse staffing recommendations. The AAEM, founded in 1993 and representing about 2700 emergency physicians, adopted an emergency nurse staffing position statement in February 2001.

I believe that the AAEM nurse staffing position statement has some shortcomings, including the following:
1. The AAEM 1:3 ratio does not address “holding” patients. Admitted patients held in the emergency department should be provided the same level of care that would be provided on the inpatient unit, which could mean 1:1 or even 2:1 registered nurse (RN)-to-patient ratios.
2. The RN-to-patient ratio should address multiple variables including acuity, patient census, demographics, departmental needs, and clinical staff needs.
3. All direct caregivers—RNs, licensed vocational nurses/licensed practical nurses, and unlicensed assistive personnel—are a factor and must be considered.
4. I believe that the decision to exclude charge nurses and triage nurses from the ratio should be based on census.

I encourage ED nurses to continue to work with our membership organization, ENA, toward an ENA-developed formula that would consider these aspects of staffing.

—Diana S. Contino, RN, MBA, CEN, CCRN, President, Emergency Management Systems, Inc, Laguna Niguel, Calif; E-mail: diana@ConsultingEMS.com; www.ConsultingEMS.com

Answer 1:
JCAHO has identified pain relief as a patient’s right and required facilities to implement specific procedures for pain assessment and management by 2001. These procedures include assessing measures of pain intensity and quality (pain characteristics, frequency, location, and duration), documenting in a manner that facilitates regular assessment, and providing staff education on pain assessment and management.

Our hospital actually began work on these issues several years ago with a hospital-wide Pain Committee and a mandatory pain in-service session with a video series. This year we developed a hospital-wide pain policy, a copy of which all ED RNs read and sign.

It is a myth that elderly persons have decreased pain sensation and that cognitively impaired elderly persons do not feel pain.

Our triage sheet has a printed 1 to 10 pain scale for adults and the Wong faces scale and CRIES scale for pediatric patients. I regularly perform chart audits for pain assessments at triage, before medication is administered, after medication is administered, and at discharge, and provide feedback. Not surprisingly, I have found that the longer the expected assessment is part of the protocol, the better the compliance. We have excellent compliance with pain assessment at triage (our oldest component); our poorest compliance is with pain assessment at discharge (our newest component).

To improve compliance, the next time we revise our charts, I hope to add specific areas for medication and discharge pain assessments. My experience is that documentation is more complete when specific lines or boxes are provided to record the information as opposed to when staff are expected to remember to include the information in their general nursing narrative.

As a side note, the research literature reveals that some common misconceptions about pain still exist, particularly for elderly persons and members of minority groups.

It is a myth that elderly persons have decreased pain sensation and that cognitively impaired elderly persons do not feel pain. It has also been found that the pain of persons who belong to minority groups is (largely unintentionally) undertreated. I believe it is important to report
these findings when educating staff about pain management.—Cindy Bruns, RN, MSN, CEN, Emergency Care QA Management Coordinator, Tallahassee Memorial Hospital, Tallahassee, Fla; E-mail: bruns-c@mail.tmh.org

REFERENCES

Answer 2:
At my institution, the pain level of patients initially is determined in triage. While patients are in triage, we also give them a pamphlet and a pain scale (with both faces and numbers). We have a box for pain documentation next to the space for vital signs (the “fifth vital sign”) on the chart. A place is also provided to check yes/no to indicate that the patient was given a pamphlet.

Our chart also includes boxes that identify the following pain characteristics: location, level, duration, quality, and aggravating factors.

If the patient arrives by ambulance, pain assessment and distribution of the materials occur at the bedside. Pamphlets and pain scales are kept at each bedside.

Our chart also includes boxes that identify the following pain characteristics: location, level, duration, quality, and aggravating factors. This part of the chart is completed by the treating nurse at the patient’s bedside during the nursing admission assessment.

We have good compliance with initial pain assessment and management, although the follow-up numerical rating is not always recorded. Anecdotally, I believe our compliance with pain assessment is best with cardiac patients.—Cindy Tibbett, RN, ED Staff Nurse, St John’s Medical Center, Anderson, Ind; E-mail: Cintibb@aol.com

Many thanks to David Polstra, RN, for his help with this column.

G E N E R A T I O N Y

What can you tell me about the “Generation Y” I have been hearing about?

Answer:
The newest generation (after Generation X), which includes persons born from about 1980 to 2000, is sometimes called Generation Y. It is also called the Nintendo Generation, the Digital Generation, or Generation Next. “Millennials” was the winning name among the suggestions that several thousand persons sent to Peter Jennings at abcnews.com.

We are just beginning to understand the characteristics of this generation. Currently, it looks like the members of Generation Y are collaborative, civic-minded, goal-oriented, achievement-oriented, and sociable. Experts compare them with the World War II generation. They tend to be more optimistic and altruistic than Generation Xers. Therefore, some persons think that members of Generation Y may be attracted to nursing careers and might provide a partial solution to the nursing shortage.1,2—Claire Raines, MA, author and expert about generations, Denver, Colo; E-mail: ClaireRain@aol.com

REFERENCES
IDENTIFYING DISASTER PERSONNEL

What techniques do other departments use to easily identify persons with individual roles during a disaster drill?

Answer 1:
In several departments I have managed, I have used baseball caps with excellent success. The caps come in a rainbow of colors, are inexpensive, and can be marked easily on the front and sides with initials such as MD, RN, TRI (triage), and COM (command). Each disaster classification is assigned a color; for example, triage is white, emergent is red, and the charge nurse and physician in charge are neon orange. Ancillary services have their own colors too, such as blue for social services and purple for clergy.

The beauty of this system is that you can see the caps from across the department, and they are rarely obstructed. In an actual disaster, nobody really cares if they get their hair messed up (although that is not necessarily true during a disaster drill).—Steve Weinman, RN, BSN, CEN, Director, Office of Continuing Medical Education and The Center for Nursing Education, Excerpta Medica, Inc, Hillsborough, NJ; E-mail: rescsteve@aol.com

REFERENCE

Answer 2:
We use vests/cover with ties on the side. ED Evening Supervisor Cheryl Probst ordered them from a craft store in appropriate colors and with monograms—for example, team leader, triage, etc. This system works well because the vests can be easily laundered. We also laminated a pocket guide including some of the responsibilities and tasks for the various roles.—Debbie Enicke, RN, CEN, Day Supervisor, Emergency Department, Our Lady of the Lake Regional Medical Center, Baton Rouge, La; E-mail: denicke1@home.com

Answer 3:
I have yet to find a national vendor whose marking system adequately reflects a hospital’s needs. Some vendors on the West Coast have done some work with Hospital Emergency Incident Command System as espoused by the California EMS Authority. They can be reached at the following Web site: http://www.emsa.ca.gov/download.htm.

For the most part, I recommend looking in your local community for options. Here are a couple of points to remember about whatever you choose:

- Make sure your color scheme interfaces with the one used by fire, police, and EMS personnel in your community. Nationally, a tremendous amount of work has been done to standardize incident command.
- Choose materials that can be cleaned easily. Vinyl works well except in extreme cold. I have found that baseball caps are great for visibility and portability, but some staff are reluctant to wear a cap previously worn by someone else.
- Make sure you have something that is truly “one size fits all.” The system does not work if someone cannot wear the apparel.
- Keep it simple. Some programs have too many people running around wearing a rainbow of colors; after a while, nobody can keep track of who’s who. Limit your marking system to essential, well-defined positions.

—Dennis R. Hudson, RN, CEN, Clinical Manager, Emergency Services, Jefferson Regional Medical Center, Pine Bluff, Ark; E-mail: HudsonD@jrmc.org; Operations Officer Arkansas-1 Disaster Medical Assistance Team, National Disaster Medical System, US Public Health Service

RETURN CALLS FROM PHYSICIANS

What is a reasonable length of time to wait for a managed care physician to return a call regarding the patient’s hospitalization?

Answer:
Federal law under the Consolidated Omnibus Reconciliation Act (COBRA), then under the Emergency Medical Treatment and Labor Act (EMTALA), has repeatedly said that patients must be seen and stabilized without regard to their method of payment. Whereas this law originally guaranteed the rights of persons without medical insurance to emergency care and treatment of active labor, its interpretation extends to any barrier between the patient and initial assessment and treatment. This initial care is called the “emergency screening examination.” Once the patient is
stabilized, the screening examination has ended, and the form of payment can be considered.

The most recent EMTALA law specifically cites the obligation of the emergency physician to contact the patient’s managed care plan for poststabilization treatment. However, if someone from the managed care plan does not respond within 30 minutes, there should be no obligation to the plan. You should proceed to admit the patient just as you would if the patient was not covered under the managed care plan.1—Robert D. Herr, MD, MBA, CMCE, Medical Director, Utilization Management, Group Health Cooperative of Puget Sound, Seattle, Wash; E-mail: herr.rd@GHC.org

REFERENCE

DETERMINING FUTURE ED CENSUS

Soon we will be renovating and enlarging our emergency department. How do we determine the type and number of patients we are likely to have in the future?

Answer 1:
First, determine the current usage patterns of your emergency department. Count how many patients are in the department at various intervals during the day. You cannot build a department for peak census—rather, the rule of thumb is an 80% to 85% occupancy rate. This approach will identify the total number of beds you need.

Next, determine what type of beds are needed. The number of dedicated cardiac/truma resuscitation bays and telemetry, pediatric, or obstetrics-gynecology beds the new unit should have can be determined by a detailed analysis of your current and projected population. Look at data for a minimum of 1 year. The medical records department can run a volume report of specific discharge diagnoses for your unit to help define the actual need.

Analyze the demographics of your community or service area. Review your source of admissions during the past 5 years. A zip code analysis of the previous year of patients who were admitted to the emergency department will indicate geographically where your patients came from. A finance department can furnish you with a payor mix report, which breaks down by percent each source of reimbursement.

Contact local community planners about proposed development in your service area. For example, a new 400-house residential development being built in your service area will have a significant impact on your census. The effect will be different depending on whether the development is a retirement community or will include 3- to 4-bedroom homes for families.

Obtain a population growth rate of your community from the city or county commissioner’s officer. Another option is to seek information from your state’s division of vital statistics, which is usually located within the Department of Public Health. Have certain trends been projected, such as a declining birth rate or increasing numbers of people older than 65 years?

Ask your state hospital association for assistance. It is a source of population data as well as health care trends, such as managed care penetration rates, that could have an impact on your hospital.1—Nancy Bonalumi, RN, MS, CEN, Director, Emergency Services, Pinnacle Health Hospitals, Harrisburg, Pa; E-mail: nbonalumi@pinnaclehealth.org

REFERENCE

Answer 2:
I have worked on at least 25 ED design and building projects. All these emergency departments experienced a dramatic rise in their patient volume during their “opening months.” This rise is usually around 10% to 15%, but it will depend on the emergency department’s current market share at the time. Generally the surge tends to lessen after 90 days or so, but not always.

I attribute this rise to marketing efforts and the perception by the public that the new emergency department is more accessible and provides faster service.—Mike Williams, MPA/HSA, The Abaris Group, Walnut Creek, Calif; E-mail: TheAbaris@aol.com; www.theabaris.com
CHEST TUBE STORAGE

How do other emergency departments store their supply of chest tubes?

Answer:
At one place where I worked, empty indwelling (Foley) catheter boxes are used to store chest tubes, and they work great. The staff relabel the boxes according to the chest tube size and place them underneath a shelf. You pull out what you need, just as you would with the catheters. Using these boxes is economical, and they keep the chest tubes neatly organized.—Karen G. Schilling, RN, BSN, per diem ED Staff nurse, Coventry, Conn; Staff RN, Cardiac Intensive Care (Open Heart), St Francis Hospital and Medical Center, Hartford, Conn; E-mail: RNbratt@aol.com

UNSOLICITED APPLICATIONS/RESUMES

I am new to management. At times I receive a resume in the mail for a position in our unit for which I do not currently have an opening. How should I handle this situation?

Answer:
Check with your human resources department. In many organizations, all resumes and applications received are centrally maintained, often in the human resources department. Generally speaking, most employers keep all applications and resumes for 1 year.

I recommend that candidates for any open position be informed how long their application/resume will be kept on file before being discarded.—John Vicik, MSIR, SPHR, Director, Human Resources, Mather LifeWays, Evanston, Ill; E-mail: jvicik@matherlifeways.com

REFERENCE

FUTURE TRENDS PREDICTED

It is hard to make long-range plans since I lost my crystal ball. What are expert predictions for future trends in health care?

Answer 1:
Some trends I would forecast include the following:

• **Upsizing the system.** Planning for the future will replace surviving for a moment, despite continuing woes with reduced government reimbursement. How long can we have emergency departments on diversion when hospitals are filled to capacity? Managed care contracts will be renegotiated with a clearer understanding of what reimbursement is viable.

• **Hiring and/or developing nurse managers.** The savage downsizing of managers in the 1990s left the ranks overworked and underresourced. “Self-directed work teams” have not been the solution. I believe that managers will go back to a more manageable workload of fewer direct reports (eg, 25 to 75 people compared with the current level of 75 to 100 people).

• **Reforming human resources.** The nursing shortage is hitting. Recruitment and retention will be forefront. Unpopular policies such as mandatory overtime or stripped benefits will change quickly.

• **Moving services back inside or on campus.** Diffusing services takes more, not fewer, personnel. With today’s staffing shortage, some services (like “Docs-in-the-Box”) will need to go back to a central location.

• **Private sector muscle.** The Leapfrog Group, a coalition of major employers representing 20,000,000 Americans, is calling for safe care for their employees. They intend to obtain improvements such as a computerized physician order entry system and likely to look at nurse staffing levels next.

• **New regulations and legislation.** The drive to legislate nurse/patient ratios will increase, in lock step with the
growth of the union movement. The new JCAHO staffing initiative test phase will not go away. I predict less overtime and efforts to limit the number of consecutive hours professionals are allowed to work, voluntarily or involuntarily.

- **Reduced government reimbursement.** The amount of uncompensated care that is provided will grow rapidly. George W. Bush's administration will not increase Medicare, Medicaid, or medication spending.

- **HIPAA.** The Health Insurance Portability and Accountability Act (HIPAA) is the single most important piece of health care legislation since Medicare, which was passed in the 1960s. I believe this legislation is going to change everything.

- **Measuring and ensuring staff competence.** I see competence moving beyond a measurement of knowledge, skills, credentials, and experience to a measurement of the effects of fatigue on performance. This issue is significant with the growing workforce of part-timers, contingency worker, and new graduates.

- **Patient safety.** The issue of patient safety is now in the public's consciousness. It will include the “blunt end” analysis, for example, the impact that decisions made in the board room have on the errors made at the bedside.¹

—Leah Curtin, RN, FAAN, author, editor, and speaker, CurtinCalls, Denville, NJ; E-mail: curtncal@one.net

REFERENCE


**Answer 2:**

Some of my predictions include the following:

- **Growing use of technology.** For example, the following will be implemented: electronic documentation, digitalized assistance with caregiving with built-in safety checks, palm pilots with resource information, and facility-networked information systems.

- **Outcomes-based research.** Outcomes-based research will involve national clinical practice guidelines and pathways. Some Web sites related to this area include the following:

  - [www.guideline.gov](http://www.guideline.gov): Web site for the national guideline clearinghouse.¹

—Linda S. Smith, DSN, RN, Assistant Professor, Oregon Health and Science University, Klamath Falls, Ore; E-mail: smithli@oit.edu

REFERENCE


**ED DOT DRUG PROGRAM**

I am considering marketing the emergency department to local businesses for Department of Transportation (DOT) urine drug testing as a moneymaker. Is there anything I should know as we plan?

**Answer 1:**

New DOT CFR 49 Part 40 regulations went into effect on August 1, 2001. These new regulations will require the implementation of new drug testing policies and procedures that mandate random breath and alcohol testing of safety-sensitive employees in the various transportation fields.

*Even a minor irregularity can jeopardize the security and integrity of the urine specimen, making it vulnerable to an employee’s challenge and possible reversal of a positive result.*

Important changes in the rules that will affect emergency departments are new requirements for collector training. Persons who collect specimens for DOT-mandated collections need:

- training on specific subjects, such as problem collections including shy bladder, attempted adulteration, etc.
- to perform 5 error-free consecutive mock collections under the evaluation of a qualified trainer.
- error correction training within 30 days if a collector error causes a test to be canceled and the performance of 3 consecutive error-free mock collections under a trainer’s evaluation.
- 24-hour availability of an appropriate designated employer representative whom the collector can contact about problems or issues that arise during a collection.
This collector training must be done by a certified professional collector trainer. To obtain this credential, one must be active in specimen collection for 6 months, complete at least 100 specimen collections, and pass a training course with a written examination.

It is important to understand the exacting, error-free, consistent manner in which the DOT collection process must be done. Even a minor irregularity can jeopardize the security and integrity of the urine specimen, making it vulnerable to an employee’s challenge and possible reversal of a positive result. Your services will not be marketable if you cannot guarantee timely, precise, error-free collection.

Private employers are not subject to the DOT drug testing regulations; however, many employers elect to use DOT collection procedures because they have proved to be the “gold standard” of the industry.

I believe that drug-testing collections work best where there is a consistent staff and a manageable, controllable client flow. In my personal experience, most emergency departments prefer that an outside vendor or a select group of personnel perform the procedures.

For more information, contact the Drug and Alcohol Testing Industry Association at www.datia.org and www.drugtestingnews.com.—Sherri Vogler, RN, President, Houston Medical Testing Services, Houston, Tex; phone: (713)665-HMTS; E-mail: sherri@hmts.com; www.HMTS.com

**Answer 2:**

My experience has been that using an outside vendor or trained specific laboratory personnel works well for an emergency department’s needs. At the facility where I previously worked, we used an on-call outside vendor exclusively. At my present hospital, we use our laboratory’s chain of custody testing area, which is located by their department. It has a modified rest room and is staffed with their personnel during the regular day and afternoon shifts. A laboratory on-call person comes in if a test collection is needed during the night.—Tracy Edwards, EMT-P, RN, BS, 11-7 Charge Nurse, Emergency Department, St Anthony Hospital, Oklahoma City, Okla; E-mail: trauma@home.com

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**CHOOSING STAFF TO CONDUCT TOURS**

I need staff to provide department tours to interested community groups (eg, scouts, nursing students, etc). How do I choose the best person for this job?

**Answer:**

First, consider using more than one person. It is unlikely that one person always will be available when needed. I recommend considering 2 factors:

- **personal appearance.** The public has a preconceived notion of how a professional nurse should look. I once watched a nurse dressed in mismatched scrubs who had fly-away hair and dried blood on her shoes give a terse, hurried tour. It seemed to leave the visitors confused.
- **ability to communicate in a positive manner.** Every unit needs improvements. However, there are still positive aspects that can be emphasized, such as new equipment or the fact that all staff have the ACLS certification. It is in poor judgment to tell visitors about problems, such as radiology is always slow or there is no time for staff lunch breaks.¹

—Mary E. Fecht Gramley, PhD, RN, Assistant Professor, School of Nursing, Aurora University, Aurora, Ill; E-mail: mgramley@aurora.edu

**REFERENCE**


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**ALCOHOL- OR DRUG-IMPAIRED NURSES**

I wonder sometimes if any of the nurses in my department are impaired by alcohol or drug use, but I feel uncomfortable dealing with that topic. How do other persons handle it?

**Answer:**

Approximately 10% of the general population has an addiction problem, with arguably a higher percentage present in the “helping professions.” This means that 10% of any nursing population could have such a problem. When I was a vice-president for nursing, I would sometimes wonder where the impaired nurses were in my organization.

Many of today’s impaired nurses use drugs, either alone or with alcohol. You cannot rely on problem job...
performance to identify these nurses. The persons misusing drugs are usually known as “hard workers”; that is, they are seldom absent from work because their drug source is at the hospital.

Intervention early in the course of the addiction is key but difficult to accomplish. To safeguard patient care, it is critical to identify the addicted nurse as soon as possible and remove him or her from patient care. The institution's approach can have a major impact in helping someone choose treatment. Periodically we showed a video emphasizing our attitude that addiction was a disease and that we wanted to help addicted nurses get treatment and remain in the profession (if possible). It is essential to provide continuing education in light of the ever-present turnover of staff and managers.

*For at least 2 years, random urine tests, mandatory attendance at appropriate meetings (such as Alcoholics Anonymous), and no access to narcotics are recommended.*

In Illinois, the Nurse Practice Act requires mandatory reporting of addicted nurses unless the nurse enters treatment and remains employed with a return-to-work agreement. Of course, this assumes no criminal act is involved and no patient has been harmed. Employers can offer nurses the choice of either dismissal and reporting to the Department of Regulation or treatment. Employer involvement increases the likelihood of a successful rehabilitation.

Before this pivotal confrontation occurs, it is important to have a good deal of evidence should the impaired nurse deny the charges. The nurse could be at risk for suicide at this point, because the initial acknowledgment is usually accompanied by a great deal of shame. Therefore, it is important to be prepared to get the nurse into treatment immediately.

After the nurse completes his or her treatment program, structuring the nurse’s return to work is important. For at least 2 years, random urine tests, mandatory attendance at appropriate meetings (such as Alcoholics Anonymous), and no access to narcotics are recommended. Scheduling the nurse to work during the day shift, in an area where supervision is present, is desirable. Of course, the nurse’s professional performance must be satisfactory. At times, moving the nurse to a different role within the hospital, such as quality assurance, is a good idea.

Returning nurses are encouraged to tell peers that they have been in treatment in order to gain support. Communicating this information has prevented resentment from other staff for what could be perceived as preferential treatment. It actually communicates to everyone that persons with needs are given help rather than judgment or punishment.

It is important to remember that untreated addiction is a progressive, fatal disease. There are many success stories of recovered nurses. In the end, you must have the courage to deal with this issue because the lives of nurses, as well as patients, are on the line.—*Suzanne Durburg, RN, MEd, Executive Director, Illinois Organization of Nurse Leaders, Park Ridge, Ill*

*Management questions* from nurses are welcome, as are names and addresses of nurses in management who are interested in answering questions. Submit to:

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