Rising to the Challenge of ED Triage

Challenges are mounting for emergency departments (EDs) across the nation. The AHA News reports that the annual number of ED visits rose by 16.8 million from 1997 to 2004, while the number of hospitals with 24-hour EDs fell 12%. Along with increased patient visits and fewer EDs, the nursing shortage may help account for the fact that the average ED wait to see a physician jumped from 22 minutes to 30 minutes—and from 8 to 20 minutes for patients with myocardial infarction (MI).

According to renowned triage expert, Jeff Solheim, RN, BRE, CEN, CFRN, “The nursing shortage is making it difficult to fill positions with experienced nurses. Increasingly, less experienced nurses are being slated to work in triage, one of the most demanding areas in the ED.”

“Inexperience affects the entire department by leading to undertriage or overtriage. Both can be dangerous.”

Jeff Solheim, RN, BRE, CEN, CFRN
Renowned triage expert

“...and Ready RN: Disaster Nursing Orientation online courses. Do you offer any other courses for emergency nursing staff?”

A. What a timely question! The Emergency Nurses Association and MC Strategies are putting the finishing touches on an online course called Emergency Nursing Triage. This course offers the same quality content as the others, along with a wide variety of interactive, fun, learning activities. It’s designed to help orient nurses who are new to triage, but will also appeal to experienced nurses who...
want to stay current in emergency nursing practice. Any nurse who successfully completes each lesson in the course can earn continuing education contact hours through Elsevier/Mosby. For more information about Emergency Nursing Triage, e-mail Booker Kidd, Product Specialist, at bkidd@mcsstrategies.com.

Q. Our staff educators are reviewing Mosby’s Essential Nursing CE. Why is it described as applicable for all nurses in a hospital?

A. Its lesson topics are based on Joint Commission standards directly applicable to hospital nurses regardless of their specialty. Plus, the course includes a series of lessons on subjects that have value to all nurses. For example, pain management has a series of 10 lessons; infection control, 10; patient safety, 19; assessment, 6; and end-of-life care, 4.

Reducing the Costs of Wound Care

For healthcare organizations, preventing new wounds and protecting existing ones has become a priority—one that significantly affects the bottom line. Beginning in October 2008, Medicare will no longer pay for care associated with hospital-acquired pressure ulcers, surgical site infections, and injuries such as burns. And Medicare will prohibit all healthcare organizations from billing patients for these and other preventable conditions. A few states already do.

Yet across all areas of patient care, healthcare professionals increasingly see arterial, venous, neuropathic, and pressure wounds. And these common wounds are costly to treat. (See “Fast Facts on Wounds.”) The cost to the patient’s quality of life can be even higher when wounds lead to pain, body image changes, patient and family stress, financial strain, and reduced functional mobility and independence.

STUDIES LEAD TO EVIDENCE-BASED CARE

To help reduce costs, many studies have investigated wound management. Surprisingly, they found several traditional interventions did not promote wound healing. As a result, the studies led to these recommendations for evidence-based care:

- Avoid transparent film dressings for skin tears in elderly patients. Instead, use hydrogel sheet and silicone-backed foam dressings, which optimize moisture balance during healing and don’t cause further skin tears when removed.
- Skip wet-to-dry dressings for debridement and dry wound maintenance. Use alternatives, such as dressings to maintain moisture balance and promote cellular and collagen synthesis (which improves wound healing), or occlusive dressings with or without

EXPERIENCE AND KNOWLEDGE ARE KEY

Solheim believes “Experience is the best preparation for emergency nursing triage.” With ED experience, nurses know what conditions do—and don’t—deteriorate rapidly, which lets them prioritize patients appropriately. They can anticipate what patients need and expedite their care.

Solheim adds, “Besides experience, a truly effective triage nurse needs a strong knowledge base.” However, the nursing shortage may prevent some facilities from sending staff for classroom training in triage. Others may not have the money or time to provide it.

So Solheim recommends an alternative to classroom teaching, such as the online course Emergency Nursing Triage, authored by the Emergency Nurses Association. Unlike other programs, which provide generic instruction, Solheim says, “This course provides typical and atypical patient presentations to help prevent undertriaging and overtriaging. It also has exercises that nurses can print and review with preceptors so that it’s applicable to each individual institution.”

According to Solheim, “Nursing organizations can help rise to their ED challenges by providing nurses with the knowledge they need to triage expertly. And one of the best ways to do that is through Emergency Nursing Triage.”
antimicrobial agents (which prevent the spread of hospital-acquired infections).

- Replace whirlpool therapy with pulsed lavage and suction to clean and debride wounds, which reduces their bacterial load more effectively.
- Explore the use of negative-pressure wound therapy along with other methods to promote wound healing, especially in cavity-shaped wounds, such as diabetic foot ulcers after surgical debridement and Stage IV pressure ulcers.

According to Eileen Robinson, Director, Nursing Continuing Education at Elsevier/Mosby, “Healthcare practitioners in all disciplines and specialties must stay informed about the latest evidence-based practices, through multidisciplinary inservice or education programs, such as Wound Management. This will help achieve the goal of consistent wound management and optimum patient outcomes.”

The overarching concept for these five components, Global Issues in Nursing and Healthcare, requires Magnet organizations to take the lead in addressing the challenges that face nursing and healthcare.

For more information about the new model, see http://www.nursecredentialing.org/model/index.htm. To learn about each of the forces of magnetism, look for this column in upcoming issues.
Managing Chronic Heart Failure

With the U.S. population aging, chronic heart failure is on the rise. Now healthcare professionals must diagnose and manage this complex, life-threatening syndrome more effectively than ever. To help, the American College of Cardiology and American Heart Association provide complete practice guidelines for the four stages of heart failure. (See “Identifying the Stages of Heart Failure.”)

According to the guidelines, possibly the most effective and least followed general measures are close attention and follow-up. These require regular assessment, patient teaching, monitoring of adherence to the plan of care, and evaluation of the patient’s response. To help you and your colleagues align your practice with current guidelines, the following list summarizes teaching for patients with stage C heart failure.

**GENERAL TEACHING**

Review and reinforce the following with the patient and family:

- The prescribed treatment plan for hypertension, lipid disorders, and diabetes mellitus, if appropriate. As needed, encourage the patient to discuss weight-loss options with the healthcare provider.
- Smoking cessation. Provide options for quitting and emphasize its health benefits.
- Regular exercise program recommended by the healthcare provider. Discourage heavy physical labor or exhaustive sports.
- Avoidance of alcohol and illicit drugs. Describe options for support, such as Alcoholic Anonymous, if needed.
- Restriction of dietary sodium intake to a moderate level. Describe ways to do this, such as reading food labels and substituting herbs for salt. As needed, involve the dietitian in the treatment plan.
- Daily weight measurement, using the same scale at the same time of day and wearing the same amount of clothing. Instruct the patient to report a gain of 2 lb in 1 day or 3 lb in 1 week.
- Staying alert for minor changes in symptoms. Instruct the patient and family to report any changes and seek treatment promptly.
- Influenza and pneumococcal immunizations to reduce the risk of respiratory infection.
- Blood tests to monitor the serum potassium level. Explain that too much or too little potassium can affect the heart rhythm and may lead to sudden death.

**TEACHING ABOUT DRUGS AND OTHER TREATMENTS**

- Instruct the patient to take medications exactly as prescribed. A diuretic, angiotensin-converting enzyme inhibitor, and beta blocker may be ordered. An aldosterone antagonist, angiotensin receptor blocker, digoxin, hydralazine, or nitrate may also be prescribed. If side effects or other problems interfere with the regimen, instruct the patient to notify you or the physician.
- Advise the patient that some medications can exacerbate heart failure symptoms and require more vigilance in monitoring. Such medications include antiarrhythmics (other than amiodarone and dofetilide), calcium channel blockers (other than vasoselective ones), and nonsteroidal anti-inflammatory drugs (with the possible exception of aspirin).
- If the patient has an implantable defibrillator or biventricular pacemaker, explain how it works. Also discuss routine device testing and related safety precautions.

For complete guidelines, visit the website at http://circ.ahajournals.org/cgi/content/full/112/12/e154.

**IDENTIFYING THE STAGES OF HEART FAILURE**

The American Heart Association has identified these four stages of heart failure (HF), which complement the NYHA classifications:

<table>
<thead>
<tr>
<th>STAGE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>At high risk for HF but no structural heart disease or HF symptoms</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Structural heart disease but no HF signs or symptoms</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Structural heart disease and prior or current HF symptoms</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Refractory HF that requires specialized interventions</td>
</tr>
</tbody>
</table>

For complete guidelines, visit the website at http://circ.ahajournals.org/cgi/content/full/112/12/e154.
A cross the hospital, acute pain is a major health concern, and you and your colleagues face the challenge of managing your patients' highly individualized experiences of pain. You know that patients have a right to appropriate pain assessment and management. You also recognize that poorly controlled pain can slow patient recovery, reduce the sense of well-being, and distress family members and friends.

Yet certain barriers can affect the best outcome for pain management because of a patient’s fear of opioids and addiction, fear that analgesic overuse may delay recovery, and beliefs about pain and suffering. To overcome these barriers and relieve pain effectively and consistently, try following these practices based on recent research:

**ASSESSMENT**

- At least once every shift, assess for the presence of pain. If the patient is being managed for pain, evaluate the effectiveness of the treatment plan.
- Consistently use a validated pain scale, such as a numeric or visual analog scale.
- Systematically assess for physiologic signs and symptoms of pain.
- Identify cultural factors that may affect the patient’s pain perception.
- Observe for signs and symptoms of physical dependence on pain medication.

**PLANNING AND IMPLEMENTATION**

- Teach the patient and family members about reporting pain, and develop an intervention plan with them.
- Administer nonopioid drugs as prescribed, even during opioid therapy.
- Treat constant pain by giving pain medications around-the-clock as prescribed and administering breakthrough medications as needed.
- Administer aspirin for moderate to severe pain, and use acetaminophen for postoperative pain, as prescribed.
- Follow patient-controlled analgesia (PCA) protocols for postoperative pain.
- Use the oral route whenever possible. For parenteral administration, the intravenous or subcutaneous route is preferred. Question orders for intramuscular medication, particularly for meperidine.
- Recognize and treat adverse effects. For example, start a regimen to prevent constipation during opioid therapy.
- Use nonpharmacologic interventions, such as relaxation techniques, distraction, massage, guided imagery, and art or music therapy.

**EVALUATION**

- Reassess the patient 30 minutes after providing pain-relief measures and evaluate their effectiveness.
- Observe for a decrease in or elimination of signs and symptoms of pain.
- Revise the pain-management plan if pain is not controlled.

For research details and additional information, check out Evidence-Based Nursing Monographs: Acute Pain in Mosby’s NursingConsult at www.nursingconsult.com.
SII SEEKS YOUR INPUT

To make the new standards as relevant and clear as possible for the 15,000-plus organizations that rely on them, The Joint Commission continues to seek input on the standards. By the end of the first quarter of 2008, Phase One feedback was completed for ambulatory, critical access hospital, home care, hospital, and office-based surgery programs on these chapters:

- Emergency Management
- Improving Organization Performance
- Life Safety Code
- Leadership
- Management of the Environment of Care (EC)
- Management of Human Resources
- Management of Information
- Medication Management
- Provision of Care, Treatment, and Services
- Patient Rights and Responsibilities
- Surveillance, Prevention, and Control of Infection
- Nursing
- Documentation of Care.

Phase Two feedback is still under way for the behavioral health care, laboratory, and long-term care accreditation programs. For Phase Two, the SII wants feedback from accredited and non-accredited healthcare organizations as well as payers, purchasers, consumers, governmental agencies, experts, and Joint Commission advisory groups and surveyors. Comments and suggestions are gathered through on-line surveys, meetings, one-on-one interviews, and focus groups.

To provide input on any proposed changes, simply complete the surveys as they become available at http://www.jointcommission.org/Standards/SII/. Or e-mail your ideas or questions to standardsimprovement@jointcommission.org.