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Risk Assessment of Self-Injurious Behavior and Suicide Presentation in the Emergency Department: An Integrative Review: JEN

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ABSTRACT (ENGLISH)

Introduction

Globally, there is a lack of clarity regarding the best practice to distinguish patients at the highest risk of suicide. This review explores the use of risk assessment tools in emergency departments to identify patients at high risk of repeat self-harm, suicide attempts, or death by suicide.

Methods

The review question ("Does the use of risk assessment tools in emergency departments identify patients at high risk of repeat self-harm, suicide attempts, or death by suicide?") focused on exposure and outcome. Studies of any design were included. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines were used. Study characteristics and concepts were extracted, compared, and verified. An integrative approach was used for reporting through narrative synthesis.

Results

Nine studies were identified for inclusion. Two risk assessment tools were found to have good predictive ability for suicide ideation and self-harm. Three had modest prediction of patient disposition, but in one study, the clinical impression of nurses had higher predictive ability. One tool showed modest predictive ability for patients requiring admission.

Discussion

This review found no strong evidence to indicate that any particular risk tool has a superior predictive ability to identify repeat self-harm, suicide attempts, or death by suicide. Best practice lacks clarity to determine patients at highest risk of suicide, but the use of risk assessment tools has been recommended. Nevertheless, such tools should not be used in isolation from clinical judgment and experience to evaluate patients at risk. Education and training to augment risk assessment within the emergency department are recommended.

FULL TEXT

Contribution to Emergency Nursing Practice

•• Suicide is preventable; therefore, it is vital that evidence-based tools are used for identification, treatment, and prevention.

•• This review indicates no evidence that any particular risk tool has a high predictive ability aimed at indicating future self-harm or suicide. The use of risk assessment tools has been recommended, despite lack of clarity regarding best practice to identify patients at the highest risk of suicide.

•• Risk assessment tools should not be used in isolation from clinical judgment and experience to evaluate patient risk for future self-harm and suicide. Staff education and training are paramount for suicide prevention, especially during the coronavirus disease pandemic.

Introduction

Commonly misclassified and underreported, suicide remains highly stigmatized and is still an illegal act in many countries.[1] The World Health Organization (WHO)[1] defines suicide as "the act of deliberately killing oneself" (Supplementary Appendix 1). It is the 15th most common cause of mortality, accounting for 1.4% of deaths across the worldwide population.[1,2] In 2013, the WHO[1] launched their inaugural mental health action plan with the aim of reducing the rate of suicide in all countries by 2020.

Patients who attempt suicide present through an emergency care pathway, of which the emergency department is just one part. The emergency department is time-bound, with competing priorities arising from patient intensity and the need to rapidly determine disposition and move patients.[3] These factors can create barriers to effective holistic assessment and care, which may result in missed opportunities to identify suicidal intentions.[4]

Risk assessment tools should ensure that patients at high risk of death by suicide are identified in emergency departments to reduce mortality by suicide after visit to a health care setting.[5] Despite assessment tools advocated by WHO[1] and The Joint Commission,[6] globally, there is a lack of clarity regarding best practice to identify which patients are at highest risk of suicide. Prevention of suicide typically employs standardized, systematic assessment tools to guide clinicians and supplement clinical evaluation to identify those at highest suicide risk,[7] the aim being to decrease any unnecessary interventions, redirect scarce resources, and expedite care delivery to appropriate treatment.[8]

In 2017, a total of 13 goals for suicide prevention were released by the US Surgeon General and the Actional Alliance forming a national strategy for suicide prevention.[9] One key goal of the national strategy is to reduce access to lethal means.[9] Screening is valuable in the identification of identifying lethal means and could put time and distance between lethal means and individuals who are in crisis, preventing suicide and saving lives.[9]

Yet, suicide mortality has not decreased drastically over the last 25 years, especially compared with other leading causes of death worldwide.[10] In 2012, 804 000 people worldwide died by suicide, compared with 793 823 in 2017—a decrease of only 1.27%.[11] For each one of these deaths from suicides, it is estimated that there are an additional 20 people who have attempted suicide.[1] Disability caused by nonfatal suicide attempts account for 39 million adjusted life years or the loss of 39 million years of full health.[12] Furthermore, approximately 6 close relatives will be bereaved by a family member's suicide, putting them at greater risk of suicide themselves.[13]

More recently, the COVID-19 pandemic may also lead to a further increase in suicide rates.[14] COVID-19 has already negatively affected psychological and sociological factors for many individuals, which means that the prevention of suicide needs urgent consideration, now even more so than ever.[15]

The National Institute for Health and Care Excellence encourages risk and needs assessment of patients but does not recommend the use of risk assessment tools to determine patient disposition or treatment.[16] In contrast, The Joint Commission[6] requires all patients who are being evaluated or treated for behavioral health conditions to be screened for suicide ideation using a validated screening tool. Despite nearly all practice guidelines stating the need for assessment, evidence suggests that only 60% of people who harm themselves receive a mental health assessment at the point of their presentation in the emergency department.[17] This reiterates missed opportunities as the emergency department represents a conduit for those at risk of suicide and other health care settings where contact with health care providers occurs.[2]

Chock et al[18] determined that each year, 70-80% of patients who present to the emergency department with suicidal intentions die by suicide. Suicidal ideation is present in around 8.7% of ED patients in the United States, but only 6.5% of current screens are positive.[19,20] Around 16-24% of ED patients who present with self-harm will repeat attempts with more lethal methods.[21,22] Nearly 4% of people presenting to hospitals in the United Kingdom die by

suicide in the 5 years after presentation (rates 16-60 times higher than in the general population).[21,22] Suicide is preventable; therefore, it is vital that appropriate, evidenced-based practice is used for the identification, treatment, and concurrently, the prevention of suicide worldwide.[1]

The purpose of this integrative review was to investigate how effectively risk assessment tools identify those at high risk of repeat self-harm, suicide attempts, or death by suicide. Our primary question was, "Does the use of risk assessment tools in emergency departments identify patients at high risk of repeat self-harm, suicide attempts, or death by suicide?' Additional review questions used to structure review findings were as follows:

1. What tools are currently being used in practice?

2. What outcomes are used to measure the effectiveness of risk assessment tools?

3. Do any specific tools have greater predictive ability for specific outcomes compared with other tools?

4. What risk items are identified within tools?

5. What other factors are reported to aid the identification of patients at risk?

Methods Design

The integrative approach to this review enabled amalgamation of diverse methodologies.[23] Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines were used.[24] The Population, Exposure, and Outcome framework was applied to the primary review question.[25]

Search Strategy Databases

Multiple electronic databases were selected to ensure that elements of the topic were not omitted by limiting the field of practice. Through Ovid, the following were accessed: CINAHL (1937 onwards), Embase (1974 onwards), MEDLINE (1946 onwards), PsychINFO (1967 onwards), PubMed, and Proquest. Reference list searching was carried out on all papers selected for full text reading.

Search Terms and Eligibility Criteria

Medical Subject Heading index was used to identify search terms. Eligibility criteria for inclusion/exclusion were developed using current literature to provide rationale ([Table 1]).

Critical Appraisal

Relevant checklists from Joanna Briggs Institute were used to critically appraise each piece of literature. The critical appraisal results are available as online supplemental material ([Supplementary Appendix 2]).[26]

Data Synthesis

Qualitative data synthesis was achieved by grouping the outcome measures and identification of commonalities and connections between studies.[27] Data were tabulated using Microsoft Excel to organize and manage data extracted. Comparisons were made across items according to the characteristics. Owing to the diversity of study methodologies, outcome measures, and heterogeneity of risk items on tools, quantitative results could not be combined.[28]

Results Search Outcomes

This process is demonstrated by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis flow diagram ([Figure 1]).[24]

Summary of Critical Appraisal

No studies were excluded from critical appraisal. A decision was reached that qualitative data may generate new insights at the point of synthesis.

Study Characteristics

Nine studies were included: 5 American, 2 Canadian, 1 English, and 1 Taiwanese. This review includes 7 multi-site ED studies ranging from 2 to 32 sites, with 2 studies conducted in singular urban hospitals. Sample sizes ranged from 51 to 6442. A plethora of different risk assessment tools were used: most commonly the SAD PERSONS scale (n = 5) and the Columbia-Suicide Severity Rating Scale (n = 3).

Seven studies provided data for a response rate, and this ranged from 47.7% to 84%. All studies included 2 or more outcome measures, namely, a repeat incidence of self-injurious behavior (n = 7), revisit to the emergency department due to self-injurious behavior (n = 2), or admission to a psychiatric hospital (n = 2) (Table 2).

Data Synthesis

Five studies evaluated single tools, and 4 evaluated multiple synthesized risk assessment tools.[29–37] In total, 15 heterogeneous tools and 23 risk items were identified across the 9 studies. The different types of assessment tools are listed in Table 3.

Reported Predictive Ability and Outcomes of Risk Assessment Tools

To measure the predictive ability, 3 principal review outcomes were identified: self-harm or suicide incidences, admissions to hospital, and patient disposition. Other outcomes were self-harm service quality, suicide risk screening frequency, and adverse events occurring in the ED setting (Table 3).

Only 3 tools were investigated by more than 1 study, which found the Columbia-Suicide Severity Rating Scale (C-SSRS) to have poor predictive value of suicide, self-harm, admission, and adverse events in the emergency department, with modest predictive value for discharges.[20,30] The SAD PERSONS Scale (SPS) was found to be slightly more effective at predicting admissions and discharges than the C-SSRS but does not predict suicide or self-harm.[29,31,32] The Modified SAD PERSONS Scale (MSPS) does not effectively predict self-harm or suicide but, like the C-SSRS, had moderate predictive value for patient disposition.[30,32]

Risk Items

Across the tools, 23 risk items—other factors that could potentially aid in the identification of patients at risk—were heterogeneous, indicating the wide spectrum of risk factors associated with suicide. The risk items most commonly recurring were hopelessness; suicide ideation, attempts, or plans; and drug and alcohol abuse. The SAD PERSONS scale contains 3 risk items (suicidal thoughts, suicide attempt, and suicide plans) that appear to create the foundation for the Beck Scale for Suicidal Ideation (BSSI), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), and Suicide Risk Screener (SRS).[5,33,38,39] The Psychiatric Emergency Research Collaboration (PERC) screener is composed of questions from the Patient Health Questionnaire-9 (PHQ-9) and the C-SSRS (Supplementary Appendix 3).[34]

Self-Harm or Suicide Incidences

Seven studies included self-harm incidences or suicidal behavior as a risk identification outcome. Self-harm incidences included engaging in self-harm, repeat self-harm, intentional self-harm, or another event of undetermined intention. Suicidal behavior included death by suicide, suicide attempts, or a suicide preparatory event. Many studies did not differentiate between self-harming with intent to die (suicide attempt or suicide) and nonsuicidal self-inflicted injury.

The PERC screener and CSPS reported high sensitivity at predicting suicidal ideation or self-harm.[34,35] The SPS and nonvalidated, locally developed tools had good predictive values for self-harm repetition, but this correlation was not seen when adjustments were made for differences in the case mix.[31] The Beck Hopelessness Scale, Brief Symptom Inventory, Barrett Impulsiveness Scale, and Drug Abuse Screening Test-10 were also found to be significant predictors of self-harm but did not exhibit strong predictive ability when used in isolation.[36]

The CAGE questionnaire and MSPS did not predict self-harm or suicide.[30,34] The studies found that the predictive value of SRS, C-SSRS, and SAFE-T scale (for death by suicide and suicide attempts) was unclear as only a small percentage of individuals who went on to die by suicide were identified by these tools.[30,33,37]

Overall, results show that there is no significant evidence to demonstrate that any of the tools have a strong predictive ability for repeat self-harm or suicide. These results also show that risk assessment tools do not have a strong predictive ability when used without clinical judgment to predict suicide or repeat self-harm and therefore may not have an impact on risk of death by suicide.

Admissions to Psychiatric Services

Only one study directly related the outcome of admissions to demonstrate or evaluate the predictive value of tools. Four studies included a need or request for clinical intervention as a secondary outcome.[29,30,33,34] Secondary outcomes included need for psychiatric admission or subsequent clinical invention of any type. The C-SSRS, PHQ-9, and BSSI poorly predicted any admissions to psychiatric services, with the SPS having better predictive ability for predicting admissions.[29] Use of the SPS therefore may have a positive impact on patient mortality due to suicide.

Patient Disposition

Two studies included patient disposition as their outcomes, highlighting discharge to the patient's home. These studies found that the MSPS, C-SSRS, and SAFE-T are modest at predicting safe discharge.[30] The PHQ-9, BSSI, and C-SSRS had poor prediction of a prolonged stay in psychiatric services (>5 days), with the SPS only having better predictive ability for prolonged stays.[29] The clinical impression (alone) of nurses had high predictive ability of prolonged hospital admissions compared with attending physicians, whose results were not statically significant at predicting these outcomes.[29] Overall, none of the studies demonstrated that these tools had a clear strong predictive ability for patient discharge and therefore are unlikely to affect suicide death rate or repeat self-harm.

Additional Outcome Measures: Service Quality, Screening Frequency, and Adverse Events in the Emergency Department

Throughout the studies, 3 other main outcomes were measured. No difference was seen in service quality score between hospitals that did and did not use tools as a component of risk assessment.[31] The implementation of universal SRS in the emergency department led to a 53% increase in patient screening.[33] Finally, the C-SSRS, PHQ-9, SPS, and BSSI poorly predict adverse events in the ED setting.[29] The implementation of compulsory screening does increase the number of people screened but does not alter the C-SSRS, PHQ-9, SPS, and BSSI's poor predictive ability of adverse outcomes, demonstrating that these tools are not expected to positively affect suicide rates.[29]

Discussion

It is incredibly difficult to ascertain the risk of a future event such as completed suicide; hence risk of repeated self-harm is the outcome most frequently measured.[29] Across the tools examined, no significant evidence was found that indicates any particular risk tool had a high predictive ability aimed at indicating future self-harm or suicide. Moreover, the intent behind self-harm is difficult to determine. It can be challenging to classify if a presentation of self-harm does or does not have suicidal intent.[40] Given this, Carroll, Metcalfe and Gunnell[41] and Karasouli et al[22] asserted that previous self-harm is one of the clearest risk factors for assessing risk of completed suicide. These findings are supported by other systematic reviews conducted in the ED setting and other secondary health care settings.[7,42,43] Conversely, in community and outpatient settings, research suggests the PHQ-9 tool to be a strong predictor of suicide attempt or death from suicide.[44,45] It is most likely that in community environments, patients at highest risk of suicide are reassessed, enabling comparison with baseline assessments, permitting the PHQ-9 to be more effective.[3]

Throughout the tools examined, a diverse range of risk items were identified. Research demonstrates that there were originally only 3 risk factors for suicide recognized.[46] Over time, decreased stigma has led to increased research surrounding mental illness, hence an increase in the number of known risk factors.[47] In practice, the emergency department is a conduit for most initial patient assessments, and consequently, the implementation of briefer tools has prevailed. For example, cognitive assessment of older patients presenting to the emergency department has been focused over time from 30 questions to 4.[48,49] Hence increasing the number of risk factors on assessment tools may inadvertently cause difficulties in the identification of patients at highest risk. Henceforward, if developed, briefer risk tools populated with evidence-based, relevant risk factors could be more effective in identifying patients at high risk of suicide.[32,35,36]

Similarly, studies examined demonstrate that throughout various health organizations, there is a multiplicity of tools being used to assess suicide risk ([Table 3]). Owing to the lack of supporting evidence, it is difficult to establish the most effective tool. Therefore, this review recommends no single tool for use in clinical practice.[31,42,50,51] Moreover, Harris et al[52] also established this situation regarding tools to predict future self-harm or suicide in adolescents. It is generally believed that standardized tools could promote widespread screening across all organizations, thus supporting repeated assessment of patients and safer patient transitions, improving care, and reducing risk of death by suicide.[1,6,53]

Emergency nurses perceive risk assessment tools as useful guides to assess patients, reporting that these tools bring suicide risk factors to the forefront and aid timely and effective referrals.[35] Emergency clinicians state that a completed risk assessment tool may provide supportive evidence of their clinical judgment.[51] Some nursing staff feel that completed risk assessments can be used as a source of useful information by other professionals caring for the patient.[54] Despite this, emergency clinicians report using risk assessment tools as an "aide-memoire" but do not usually use the scoring systems to aid referral.[51] Emergency nurses and providers report finding risk assessment of patients at high risk of suicide as challenging and time consuming.[35,51,54] These staff disclose the need for adequate training to ensure accurate risk assessment of patients at high risk of suicide.[35,51,54]

The Joint Commission advocates only 3 validated suicide risk assessment tools. This includes the SAFE-T with C-SSRS, the Scale for Suicidal Ideations-Worst, and the Beck Scale for Suicide Ideation.[6] Despite this, globally there is still a lack of evidence to suggest best practice to identify which patients are at highest risk of suicide, and therefore it is hard to advocate a single risk assessment tool.[51] Alongside staff attitudes and the high costs of risk assessments (including training on how to use them), organizations are reluctant to implement a tool which is not evidence based.[54]

Despite recommendations and requirements, risk assessment tools still may not effectively identify those at risk of suicide because of the complexity of psychiatric diseases.[2,32,55] This highlights the importance of directing patients to specialist care such as psychiatric liaison teams. Psychiatric liaison teams complete comprehensive assessments and provide clinical education for staff to enhance their clinical knowledge and judgment.[56,57] To assist identification of those patients at risk, Wolf et al[58] identified that education must include recognizing nonverbal behaviors, emergency department presentation patterns, and mismatch between injury and complaints. Consequently, nurses must understand how to use tools to guide their questions to patients carefully; in particular, to be aware of identifying any questions that result in a lack of eye contact or hesitation.[58]

Pessimism regarding follow-up interventions after acute assessment means that staff may not refer patients to the appropriate resources or create safety plans.[50] Thus, it is also important for clinicians to link risk assessment and intervention within the emergency department, which are essentially the clinician's duty of care.[50,59] Educational interventions should incorporate the importance of the continuity of care between health care providers and effective

communication.[60] Naylor et al[61] argue that clinical leadership training to develop partnerships between the emergency department and mental health care providers should be a focus. Both must regard prevention of suicide as a key service, enabling collaboration between services for suicide prevention.[61] Implementation of training on counseling regarding access to lethal means is also paramount.[62] Only 3 of the 15 risk assessment tools evaluated in this review contained items that focused on access to lethal means.[33,39] Training should focus on misconceptions about prevention of suicide to ensure that training is continued into practice.[62,63] This will facilitate the identification of patients at high risk of suicide and promote the implementation of interventions.

An incidental finding of this review was the importance of appropriate and timely interventions (in emergency department and outpatient settings). This has the potential to lead to the biggest decrease in suicide risk, particularly with regards to access to lethal means.[39,44,62–64] Suggested interventions include a secondary assessment within 6 months of initial assessment, provision of a self-administered safety plan, a year of telephone review calls, and direct treatment options.[32,39] Over time, tools have placed slightly more focus on the importance of an intervention after initial screening and incorporating this into the risk screening and assessment steps. The SAD PERSONS scale, C-SSRS, SAFE-T, and SRS, all include an extensive list of potential interventions for each scoring category.[33,38,64,65] In addition, the CAGE questionnaire and Drug Abuse Screening Test-10 recommend that patients who score highly on the tools require further detailed assessment.[66–68] This can be compared with the Barrett Impulsiveness Scale, Brief Symptom Inventory, Beck Hopelessness Scale, BSSI, PHQ-9, and PERC assessment tools, which do not list any suggestions to consider after initial screening.[34,39,69–73]

Unfortunately, intervention administration is multifaceted and interdependent on environment, leading to barriers for patients to receive an adequate intervention within the ED setting.[4,61] Therefore, most patients deemed to be at the highest risk may not be provided evidence-based interventions.[38] Barriers include insufficient mental health provider staffing, competing emergency department priorities, unavailability of psychiatrist, and patient and family refusal.[21,50] Further research is needed to understand whether and how the use of risk assessment tools for ED patients at high risk of suicide affects their assessment, interventions, disposition, and outcome. Policy relating to expected clinical standards and care pathways are needed to create clinical parity for this group of patients. If developed, this would have the potential to educate health care professionals and connect high-risk patients with targeted support and care beyond the emergency department.

Strengths and Limitations

Time and resource restraints meant that this review includes only studies written in the English language. Although a single reviewer introduces potential researcher bias, regular research supervision was in place throughout.[74] The heterogeneity of study methodologies prevented combination of results to precisely determine what impact risk assessment tools have on suicide risk. In addition, the outcomes of admission and patient disposition (used by some of the studies included) have the potential to be strongly influenced by other contributing factors (i.e., hospital crowding and staffing levels) and therefore have weak validity and reliability.[42] There is potential for publication bias to have occurred, because studies with negative outcomes were not located. The original purpose of this study and time restrictions mean that the diagnostic accuracy of each tool was not assessed in this review. Therefore, the risk of bias within each individual tool was not considered in the methodology. Only risk assessment tools that had been used within the ED setting were reviewed for this review. However, this review includes the most up-to-date and relevant worldwide literature from within the past 8 years.

Implications for Emergency Clinical Practice

Risk assessment tools should not be used in isolation from clinical judgment and experience to evaluate patient risk for future self-harm and suicide. Within the emergency department, education of staff, including staff attitudes toward

suicide, should become a key focus to enable suicide prevention. Training should aid discrimination between impulsive and premeditated suicide attempts as this is paramount to alerting health care staff to the level of suicide risk. In addition, training should focus on continuity of care between health care providers and effective staff communication.

Conclusion

We found insufficient evidence to demonstrate the impact of risk assessment tools to reduce the risk of suicide in high-risk patients who present to the emergency department. Studies indicate that tools may be useful to guide health care professionals' assessment of patients at risk of suicide, but they should not be used in isolation from experienced clinical judgment. No relationship was seen between the proliferation of risk items that a tool includes and its predictive ability. To improve current ED practice in identification of patients at high risk of suicide and self-harm, it is recommended that relevant training of clinicians occurs. Education should raise awareness of confounding factors of suicide. It should also focus on the importance of clinical judgment and recognizing the different types of body language and nonverbal communication expressed in those at risk of suicide. There is a need to develop new and simple tools in the future, which incorporate the known risk factors. Primary research should include diagnostic test accuracy.

Supplementary Data

Supplementary Appendix 1Supplementary Appendix 2Supplementary Appendix 3

Supplementary

Tool/risk item	Barret impulsiveness scale	Brief symptom inventory	Drug abuse screening test	SADPERSONS scale	Cut down, Annoyed, Guilt, Eyeopener questionnaire	Beck hopelessness scale	Beck scale for suicidal ideation	Patient health questionnaire 9	Columbia-suicide severity rating scale	Psychiatric Emergency Research Collaboration Screener	Suicide Assessment Five-Step Evaluation and Triage	Suicide risk screener
Year of introduction	1959	1975	1982	1983	1984	1988	1991	2001	2007	2009	2009	2015
Hopelessness/depression						✓		✓	✓	✓		

Suicidal thoughts				✓			✓	✓	✓		✓	✓
Suicide attempt				✓			✓				✓	✓
Suicide plans				✓			✓		✓		✓	✓
Impulsiveness	✓								✓			
Cognitive instability	✓			✓				✓				✓
Mental health illness		✓							✓			✓
Somatization		✓										
Hostility		✓										
Drug and alcohol abuse			✓	✓	✓							✓
Insomnia								✓	✓			

Family history								✓			
Stressor event								✓			
Change in treatment								✓			
Gender			✓								
Age			✓								
Social isolation			✓					✓			
Physical illness			✓					✓			
Appetite changes											✓
Lack of protective factors										✓	
Agitation										✓	
Self-harm										✓	

									✓		
Anhe donia									✓		

Supplementary Data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.jen.2021.10.002.

Conce pts	Search terms	Inclusion	Exclusion
Popul ation	Suicide (MeSH term) Self-murder Self-immolation OR End own life Self-harm AND Death (MeSH term) Mortality (MeSH term) Dying OR Fatality AND Emergency service (MeSH term) ED Emergency Department A and E OR Accident and emergency Casualty A + E A&E Emergency Room ER AND	-Participants over 18 years -Patients presenting to the emergency department at high risk of death by suicide/ repeat self-harm (presenting with many risk factors) -Worldwide studies	-Participants under 18 years -Patients outside of the ED setting -Patients who are not at high risk of suicide/ repeat self-harm (unless controls)

	Search Terms	Inclusion	Exclusion
Expos ure	Ask suicide screening questions ASQ Beck fast scan Beck scale for suicide ideation Colombia suicide severity rating scale C-SSRS OR Depression scale Health resources (MeSH term) Mass Screening (MeSH term) Patient health questionnaire (MeSH term) Patient safety screener PHQ-9	-Risk assessment tools that identify suicide or self-harm risk	-Tools that do not identify suicide or self-harm risk -Tools that only identify single mental health disorders in isolation
Conce pts	Search Terms	Inclusion	Exclusion
Expos ure	Prevention resources PSS-3 Risk assessment (MeSH term) Risk assessment tools SAFE-T SBQ-R Scale for suicide ideation Screening tools OR SSI-W Suicide behavior questionnaire revised Suicide risk screen Universal screening Tools Instruments AND		
Outco me	Decline Decrease Minimi*e OR Reduction	-Use of above outcomes highlighted to demonstrate the effectiveness of tools to identify patients at risk	-Does not use outcomes that demonstrated the effectiveness of risk assessment tools -No outcomes shown -Incomplete studies
Types of studie s		-Any primary research	-Reviews -Meta-analysis -Discussion papers -Commentaries
Langu age		-English language	-Not written in the English language

Year					-Studies published after 2010	-Studies published before 2010

Author and year	Country	Total of EDs	Sample size	Response rate	Outcomes measured	Assessments	Key findings	Follow-up	Critical Appraisal score, %
Randall et al[37] 2012	Canada	2	157	Stage 1- 67% Stage 2- 86.7% Stage 3- 82.0%	1. Engaging in self-harm 2. Visit to ED due to self-harm	1. Beck Hopelessness Scale 2. Barrett Impulsiveness Scale 3. Brief Symptom Inventory 4. Drug Abuse Screening Test 5. CAGE questionnaire	The diagnostic use of tools is limited.	3 mo	36%
Allen et al[35] 2015	USA	6	1068	47.70%	1. Prevalence 2. Correlations 3. Subsequent clinical interventions	Psychiatric Emergency Research Collaboration Screener	The tools questions present might capture suicide risk.	None	33%
Wu et al[36] 2014	Taiwan	1	147284 (control)	74.8%	1. Self-harm repetition 2. Change in score	Chinese SAD PERSONS scale	Nurses found this tool to raise awareness of suicide risk.	6 mo	78%
Quinlivan et al[32] 2014	England	32	6442	n/a	1. Repetition of self-harm 2. Self-harm service quality	1. SAD PERSONS scale 2. Nonvalidated, locally developed tool	Tools decreased repeat self-harm and therefore decreased suicide risk, but when data adjusted for case mix differences, association attenuated.	6 mo	55%

Study	Country		N		Outcomes	Tools	Conclusion		
Chang and Tan[30] 2015	USA	1	50	n/a	1. Need for psychiatric admission 2. Prolonged stay at a psychiatric facility >5 days 3. Adverse events in the ED	1. Columbia-Suicide Severity Rating scale 2. SAD PERSONS scale 3. Patient Health Questionnaire 9 4. Beck Scale for Suicidal Ideation 5. Clinical Impression	Tools show poor predictive value for adverse outcomes.	2 wk	62.5%
Stuck et al[34] 2014	USA	1	224	n/a	1. Frequency of ED visits vs clinic visits 2. Suicide risk screening frequency 3. The frequency of such visits before and after the 2011 implementation of universal screening	Suicide Risk screener	Unclear whether it helps prevent suicide.	None	75%
Katz et al[33] 2017	Canada	2	5462	60.70%	1. Intentional self-harm 2. Late effects of intentional self-harm 3. Poisoning of undetermined intent 4. Other events of undetermined intent	Modified SAD PERSONS scale	Modified SAD PERSONS scale does not predict suicide risk.	1 y	62.5%
Miller et al[38] 2017	USA	8	1376	84%	1. Suicidal behavior 2. Death by suicide 3. Suicide attempt, interrupted or aborted attempts 4. Suicide preparatory acts	Columbia-Suicide Severity Rating scale	Tools may identify more patients but do not reduce suicide risk.	1 year	78%
Mullinax et al[31] 2018	USA	1	267	n/a	1. Discharge following enrollment visit 2. Death by suicide within 1 month or 1 year of enrollment 3. Patient disposition	1. Modified SAD PERSONS scale 2. Columbia-Suicide Severity Rating Scale 3. Suicide Assessment 5-Step Evaluation and Triage scale	Does not recommend use of tools owing to missed deaths.	1 year	62.5%

Tool	Year introduced	Number of studies included in	Reported predictive value and measured outcome(s)
Barret impulsiveness scale	1959	1	Good predictive value of self-harm but not in isolation
Brief symptom inventory	1975	1	Good predictive value of self-harm but not in isolation
Drug abuse screening test	1982	1	Good predictive value of self-harm but not in isolation
SAD PERSONS scale	1983	3	Poor predictive value for suicide Alternative studies good predictive value for self-harm but only a weak association when adjusting for differences in the case mix Moderate predictive values for admission, discharge Poor prediction for adverse outcomes in the ED
Cut down, Annoyed, Guilt, Eyeopener questionnaire	1984	1	Did not predict self-harm or suicide
Beck Hopelessness Scale	1988	1	Good predictive value of self-harm but not in isolation
Beck scale for suicidal ideation	1991	1	Poor predictive value for admissions, prolonged stay, and adverse events in the ED
Patient health questionnaire 9	2001	1	Poor predictive value for admission, prolonged stay, and adverse events
Columbia-suicide severity rating scale	2007	2	Unclear of predictive value for self-harm or suicide Poor predictive values for admissions and adverse events in the ED Modest predictive value for discharges
Psychiatric Emergency Research Collaboration Screener	2009	1	Good predictive value for suicide ideation
Suicide Assessment Five-Step Evaluation and Triage	2009	1	Unclear of predictive value for self-harm or suicide ideation Modest predictive value for discharge

Suicide risk screening	2015	1	Unclear of predictive value for self-harm or suicide ideation
Chinese SAD PERSONS scale	n/a	1	Good predictive value for self-harm
Modified SAD PERSONS scale	n/a	2	Does not predict self-harm or suicide Moderate predictive value for patient disposition
Nonvalidated locally developed tool	n/a	1	Good predictive value for self-harm but only a weak association when adjusting for differences in the case mix

DETAILS

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The Effect of Music-Moving Toys to Reduce Fear and Anxiety in Preschool Children Undergoing Intravenous Insertion in a Pediatric Emergency Department: A Randomized Clinical Trial: JEN

🔗 ProQuest document link

ABSTRACT (ENGLISH)

Introduction

Intravenous catheter insertion is a highly invasive medical procedure that causes fear and anxiety in children. This study aimed to analyze the effect of a toy (with music and movement) distraction method on fear and anxiety in children aged 4 to 6 years.

Methods

This experimental, randomized clinical trial used parallel trial design guided by the Consolidated Standards of Reporting Trials checklist. Using simple randomization, eligible children (age 4-6; N = 60) were assigned to the intervention group (n = 30), who received the toy distraction method, or to the control group (n = 30), who received standard care. The Children's Fear Scale was used to evaluate the fear levels, and Children's State Anxiety Scale was used to evaluate anxiety levels. Physiological parameters (pulse, oxygen saturation) and crying time were monitored by the researcher as indicators of fear and anxiety. The chi-square test, repeated measures analysis of variance, Friedman test, t test, the Mann-Whitney U test, Wilcoxon test, and the intraclass correlation test were used for data analysis.

Results

There was no statistically significant difference in terms of fear and anxiety scores, physiological parameters, and crying time during the procedure between the children in the intervention and control group.

Discussion

We found that this method of toy distraction was not effective in reducing fear or anxiety during the intravenous catheter insertion procedure. Accordingly, we recommend that this distraction method be performed in different age groups and with larger samples in various painful and stressful practices in the future and that comparison be made with various distraction methods.

FULL TEXT

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Document 4 of 19

NCPD Earn Up to 11.5 Contact Hours: JEN

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The Path Ahead and the Promise of the Future: JEN

ABSTRACT (ENGLISH)

Today, I'm the Chief Nursing Officer at the same hospital and about to embark on my year as the ENA President. ENA continues to be here to support you in many ways: advocating for a healthy nursing work environment, creating ENA University for your continuing education and skill development, and offering volunteer opportunities to help you grow within the organization. With that goal in mind, if we each push forward down the path toward our highest hopes and aspirations, the momentum of the emergency nursing community will build toward positive change.

FULL TEXT

It is an incredible honor to be the incoming 2022 ENA President and one I never dreamed would be a reality for me. Often, we don't see what may be possible in our future when we're busy standing in the moment. I'm here now as proof you can create your own path and do anything you desire.

Nearly twenty years ago, I started as a new nurse in the emergency department. Today, I'm the Chief Nursing Officer at the same hospital and about to embark on my year as the ENA President. While anything is possible, it takes grit. It takes persistence. It takes a true belief that something bigger, something better, is always out there if you seek it and work for it.

The last two years have tested us like no other time. We persist with the hope of brighter days and a drive to learn from this experience so that we are better educated, better prepared, and better equipped for the next challenge. To make that happen, and borrowing from my predecessors Mike Hastings and Ron Kraus, we must believe that each of us, as individuals, can make a difference and know that we can elevate ourselves and the people around us.

We have seen and dealt with so much during this pandemic. We are tired, we are all struggling with something, and we are all trying to figure out how to keep moving forward. The forward motion requires us to rekindle the inner fire that drives emergency nurses to be the amazing people you all are. Moving forward means using that take-charge, get-it-done attitude that we all have and applying it to our own careers and lives. Most importantly, moving forward requires a little help, and our willingness to seek it out no matter the circumstances. We all know we can do these things ourselves, but that doesn't mean we have to.

ENA continues to be here to support you in many ways: advocating for a healthy nursing work environment, creating ENA University for your continuing education and skill development, and offering volunteer opportunities to help you grow within the organization. Your emergency nursing peers are also here. This community is built on shared experiences, deep bonds and colleagues who are like family. Use those around you and offer your support to others. We need one another, and our patients need us. ENA is uniquely positioned to help you build these connections.

We all know that 2022 will continue to bring new challenges, and plenty of old ones, to our profession. We should look to what is ahead and use the struggles we have endured over the last two years as motivation to plot a course. This should happen both individually and together, and reinforce what emergency nurses need to be successful, to amplify our voices about what's most important in health care, and to continually demonstrate how this community is the epitome of exceptional.

With that goal in mind, if we each push forward down the path toward our highest hopes and aspirations, the momentum of the emergency nursing community will build toward positive change. It starts for each of us today. Find your inner fire and prove to yourself that persistence pays off. Choose your journey and follow your dreams. Maybe you'll end up somewhere you never would have imagined, too.

DETAILS

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Document 6 of 19

Implementing a Novel Nursing Site Manager Role in the Pediatric Emergency Department for Patient and Staff Safety During the COVID-19 Pandemic: JEN

ABSTRACT (ENGLISH)

1 Much of the worldwide severe acute respiratory syndrome outbreak was hospital based, and health care workers were a significant portion (37%-63%) of suspected cases in affected countries.2 There are limited data on infection and mortality rate from coronavirus disease 2019 (COVID-19) among health care workers in the United States and around the world. Among 6760 adults hospitalized from March 1 to May 21, 2020, 5.9% were health care providers, with nursing-related occupations (36.3%) representing the largest portion of hospitalized providers.3 In the US and Mexico, health care workers represent 1 in every 7 COVID-19 cases.4 Notably, "these two countries account for nearly 85% of all the COVID-19 deaths among health care workers in the [Pan American Health Organization] region.4 This reality, along with the idea that "there can be no patient safety without health worker safety,"5 made it immediately apparent that programs supporting the emergent and unprecedented educational needs of emergency nurses had to be implemented in a rapid, sustainable manner. Key stakeholders involved during the initial development and implementation of the site manager program included hospital-wide biocontainment team leaders, infection control experts, emergency department physician and nursing leadership, and staff nurses, clinical assistants, environmental services, and administrative staff. Because strict isolation was necessary for these patients, site managers enlisted the assistance of child life specialists to help with distraction techniques to decrease the patient's fears and anxiety.

FULL TEXT

Contribution to Emergency Nursing Practice

••A pandemic response requires agile systems and rapid dissemination of biocontainment policies and procedures. Emergency nurses are uniquely positioned in their front-line role to convene multidisciplinary health care teams for safety and well-being.

••We designed a novel nursing role to ensure safety and disseminate rapidly evolving policy and environmental changes.

••Site managers foster the adaptive capacity and resilience of the multidisciplinary team by serving as real time resources for current evidence-based science, rapidly changing policies, personal protective equipment donning and doffing techniques, use of innovative communication technologies, and identification of staff burnout, severe stress, and compassion fatigue.

••This role may be replicated and individualized to meet the needs of other institutions.

Constituting the majority of the health care workforce, nurses are the front-line defense in response to an infectious disease outbreak and are at high risk for infection themselves. Given their crucial role of emergency nurses in the management of prevailing epidemics, it is imperative that nurses receive adequate support and protection. Epidemics such as the West African Ebola outbreak from 2014 to 2016 have demonstrated the consequences for not protecting health care workers and emergency staff. Lessons learned include severe physical and mental health consequences for health care workers and the community at large. In the Ebola epidemic, "most healthcare worker deaths could have been prevented with simple interventions such as diagnostic testing, proper equipment and training, which makes this loss especially devastating."[1] Much of the worldwide severe acute respiratory syndrome outbreak was hospital based, and health care workers were a significant portion (37%-63%) of suspected cases in affected countries.[2]

There are limited data on infection and mortality rate from coronavirus disease 2019 (COVID-19) among health care workers in the United States and around the world. Among 6760 adults hospitalized from March 1 to May 21, 2020, 5.9% were health care providers, with nursing-related occupations (36.3%) representing the largest portion of hospitalized providers.[3] In the US and Mexico, health care workers represent 1 in every 7 COVID-19 cases.[4] Notably, "these two countries account for nearly 85% of all the COVID-19 deaths among health care workers in the [Pan American Health Organization] region.[4] This reality, along with the idea that "there can be no patient safety without health worker safety,"[5] made it immediately apparent that programs supporting the emergent and unprecedented educational needs of emergency nurses had to be implemented in a rapid, sustainable manner. Emerging from this call to action, we developed a nursing site manager program.

Our site manager program created a nursing role to support the multifaceted physical and psychological needs of staff during a pandemic. The setting was a 52-bed emergency department with an annual census of 60 000 visits in an urban, quaternary-care, freestanding pediatric hospital. The urgent needs of staff included rapid roll out of personal protective equipment (PPE) education, expertise in current COVID-19 research, adaptability with quickly evolving policies and procedures, and peer-to-peer coaching to support coping and resilience.

The site manager team was intentionally composed of nurses who volunteered to participate, not selected "leaders" or senior staff. The team consisted of 40 nurses whose experience ranged from novice to expert. This demonstrated the value of all nurses regardless of where they were along their career journey. Site managers created and fostered an environment of teamwork and inclusivity, encouraging each individual to share and celebrate their unique strengths and talents. This self-selected team, by nature of its diversity, had balanced skills, complementary abilities, and individual strengths such as emotional intelligence, resilience, adaptability, technical skills, and communication skills. Site managers became a unified team navigating uncharted waters during a time of fear and uncertainty.

Key stakeholders involved during the initial development and implementation of the site manager program included hospital-wide biocontainment team leaders, infection control experts, emergency department physician and nursing leadership, and staff nurses, clinical assistants, environmental services, and administrative staff. The group acknowledged any questions or concerns that arose and addressed them in real time or within 24 hours during the daily COVID-19 leadership meetings.

Site Manager Orientation Program

Site manager orientation included a 2-hour course focused on the knowledge and skills needed to support multidisciplinary staff in the provision of safe, timely care of patients with symptoms concerning for COVID-19. Two departmental nursing leaders implemented this curriculum in collaboration: the global health fellow and the professional development specialist. Course content included modules highlighting infection control basics, PPE donning and doffing practices, and psychological first aid principles (Table 1).

Learning methods combined high-yield didactic sessions with hands-on training, including skill practice with PPE donning and doffing, current COVID-19 management, and relevant research findings. Application of public health principles emphasized the rationale behind the adaptations to existing policies, procedures, and the environment of care. Learners achieved competency validation in the ability to don and doff PPE during a demonstration against a skills objective checklist (Centers for Disease Control resources found at website link in the reference list).[6]

Unique to this site manager program was the addition of coping and resiliency education and principles of providing psychological first aid to staff during this unprecedented pandemic. Site managers received education to support the mental health and well-being of their colleagues. This approach involved humane, supportive, and practical interventions for staff suffering trauma and stress in ways that respect their dignity, culture, and abilities. The aim was to support staff resilience and adaptation to prevent or mitigate burnout and compassion fatigue. Site managers

received resources on healthy coping strategies and methods to build resiliency to use and to share with staff. Education focused on identification of those at risk and referral to department leadership or our hospital's Office of Clinician Support for expert services as needed.

At the conclusion of the program, nurses were oriented to the 17-bed cohort area reserved for patients suspected of or confirmed with COVID-19. This orientation included incorporating available resources and discussing potential scenarios to allow for immediate application of the course content and skills. One such scenario was the presentation of a pediatric patient arriving by ambulance whose chief complaint was fever and shortness of breath. Site managers quickly identified these symptoms as potential COVID-19 and initiated airborne, contact, and droplet precautions. They facilitated patient placement into one of the COVID-19 cohort bedspaces and educated accompanying family members on the need for such precautions. Because strict isolation was necessary for these patients, site managers enlisted the assistance of child life specialists to help with distraction techniques to decrease the patient's fears and anxiety.

Evaluation of the effectiveness of the orientation program included a knowledge-based postcohort survey. In this survey, each of the 40 participants (100%) stated this experience expanded their knowledge of COVID-19 and confidence in their clinical practice and assessment skills. Each participant demonstrated to the instructors the ability to safely don and doff PPE. A precourse assessment survey was not conducted because of the rapid, emergent need to implement this role to protect the health and well-being of ED staff.

Site Manager Roles and Responsibilities

Roles and responsibilities were indoctrinated throughout the program and were divided into 3 domains of support: for patients/families, for staff, and for public health systems ([Figure 1]). By design, site managers did not have a patient assignment so that they could focus on supporting safety. They assisted staff with patient care activities in the COVID-19 cohort area while monitoring for safety protocol compliance and serving as a resource when process-related issues arose.

Site managers' support for patients/families included family education, comfort rounds, assessment, and referral to meet social health needs such as access to nutrition and eviction protection. Our institution's family education materials can be found in the website listed in the corresponding reference.[7] Additional resources are listed in [Table 2]. Support for staff notably included safety protocol reinforcement, especially in triage, in the COVID-19 cohort areas and during patient resuscitations. Site managers reinforced patient screening at the point of triage to identify patients suspected of having COVID-19 and to facilitate prompt isolation of these patients. Additional responsibilities involved educating staff, including new residents, specialty consultants, and environmental service staff in safe practices, including PPE donning and doffing to support their safety as vulnerable members of the care team.

The site managers' role during resuscitation and emergency response was to serve as gatekeeper at the entrance to the patient's bedspace to limit the number of personnel in the room to decrease the staff's exposure to COVID-19. They ensured that all responders wore appropriate PPE and facilitated acquiring the needed equipment and supplies because bedspaces were minimally stocked to prevent contamination. Site managers supported staff during critical events by monitoring safety protocol adherence, promoting innovative communication technologies, ensuring availability of appropriate PPE donning and doffing stations, and facilitating team huddles to review team performance.

The site managers' role included fostering the adaptive capacity and resilience of all members of the multidisciplinary team, including environmental service staff, clinical assistants, nurses, physician assistants, nurse practitioners, and attending physicians. Assisting staff to adapt innovative electronic technologies to promote optimal communication with families and minimizing potential exposure proved to be essential during the pandemic.

Similarly, the site managers' role of monitoring and coaching safe PPE practices remained critical to promoting staff resiliency.

Opportunities were available for site managers to collaborate with our global health team to review and contribute to current pediatric COVID-19 research and public health initiatives. Multidisciplinary activities included literature and case reviews of all patients with COVID-19 evaluated in the department. Site managers reviewed publications to select literature that was timely and relevant to emergency staff and disseminated these to physicians, nurses, and clinical assistants. Case reviews contributed to studies on presentation and emergency care needs of children infected with COVID-19, as there were scant existing data for this patient population.

With the support of institutional leadership, site managers participated in voluntary community outreach activities. For example, site managers supported public health initiatives by educating local emergency medical service colleagues in safe transfer practices and families regarding the importance of participating in contact tracing, physical distancing, and quarantining initiatives. Site managers were also invited to collaborate with local public school nurses in safe practices as they prepared to return to school to care for over 50 000 students. While participating in these activities, site managers came forward with innovative ideas and connected with new mentors beyond the emergency department.

Throughout the initial surge in cases, the site manager team met weekly with COVID-19 leadership. With the transition from the acute response of the pandemic, the meeting frequency decreased to monthly. Meetings included a combination of policy updates and education (Figure 2), as well as unstructured time for open discussion. Site managers were encouraged to share all COVID-19-related problems so that departmental and infection control leadership could develop a clear procedure or policy. For example, certain challenges resulted in policy modifications for eyewear-cleaning protocols, reorganization of patient rooms to minimize supply contamination, and re-evaluation of patient transport practices.

Site Manager meetings were recorded and disseminated to the team to promote inclusivity of those working off-shift or unable to attend. During the meetings, nursing leadership addressed questions solicited from the team. Site managers could presubmit their questions in an optional forum if they wished to remain anonymous. These forums provided a clear, direct channel for site managers working at the bedside to escalate concerns up the chain of command and to propose practical solutions. Conversely, these forums served as a channel for the leadership to disseminate information to those on the frontlines, thus supporting a clear top-down/bottom-up communication model. Therefore, site managers actively participated in the multidisciplinary COVID-19 leadership team.

Although the early-hypothesized needs of the department dictated initial roles and responsibilities of the site manager, team members were encouraged to provide suggestions to adapt or edit the role as these demands evolved. For example, 7 months into the pandemic, during a lull when COVID-19 cases were not rising, site managers re-assessed skill competency in PPE donning and doffing for the multidisciplinary team to ensure safe PPE practices. This re-education was in prediction of a second surge in cases to reinforce procedures that promoted continued staff and patient safety.

The site manager role and responsibilities evolved monthly on the basis of the needs of staff as the pandemic progressed. Team members received suggestions from the staff they supported. Therefore, all staff nurses providing direct patient care contributed meaningfully to the evolution of the site managers' role by identifying vulnerabilities in current protocols that required additional support and adaptation. Changing paradigms, the site managers worked for their colleagues and peers. In this light, when nurses and multidisciplinary members of the team received adequate support, patient care appeared more effective, patient-centered, efficient, equitable, and safe.

Ongoing Evaluation and Change

During the COVID-19 pandemic, providing ED staff with extra psychological and physical support through the work of the site manager team has the potential to improve patient care. Staffing the emergency department with 1 volunteer site manager 24/7 helped our department facilitate COVID-19 processes to deliver safer patient care. Since the implementation of our site manager program in March 2020 through April 2021, our emergency department evaluated 10 082 patients for COVID-19. The site managers were a valuable resource to mitigate this additional workload burden while prioritizing safety. Within the first 2 months of implementation of the role, the percentage of patients placed in an ED bed within 30 minutes of arrival increased from 55% to 96%. This helped to decrease potential COVID-19 exposure between patients and families in the ED waiting area. In review of our internal data, we discovered that appropriate implementation of constantly evolving isolation/precautions protocols for COVID-19 patients in the emergency department increased by 91% immediately after the launch of the site manager program. This improvement sustained through the writing of this paper.

With a reduction in our patient census during the pandemic, reallocation of nursing resources allowed us to implement the site manager's role on a permanent basis without any significant budgetary impact. There was no additional stipend for nurses assuming this role. With the expectation that our patient census will increase after the pandemic, the cost to maintain this role has yet to be determined. As the pandemic resolves, expansion of the site manager's role to a permanent clinical nursing leader position is in development.

Our institution adopted process changes that supported the site manager position. For example, the environment of care was modified to create dedicated donning and doffing stations with defined hot, warm, and cold zones. Innovations in technology such as web conferencing platforms and portable tablets enhanced communication between the care team and the patients and families in isolation to minimize staff exposure. Hospital-wide protocols established PPE conservation and N-95 mask reuse. Dedicated storage areas served as departmental pick-up and drop-off zones for reusable masks and eyewear between shifts. Rapid point-of-care testing for COVID-19 in the emergency department expedited patient care and disposition.

Approximately 1 year after the implementation of the site manager role, a multidisciplinary survey assessed the perceived effectiveness of the role (e-Content). This survey had a 22% response rate. Of the 65 respondents, 97% of nurses, and 93% of physicians stated that the role was helpful during the COVID-19 pandemic. Open-ended responses from the survey are listed in Table 3.

Conclusion

With the contributions of every member of the site manager team, our program was a model of shared governance, collaborative decision making, and staff nurse autonomy. We learned that the shared governance framework of the team, as exemplified in the self-designed role and responsibilities, has helped maintain confidence and buy-in for the team's high professional standards. Site managers were able to address the complex, interrelated health needs of patients and families while prioritizing staff safety. They protected and championed safety for all, supporting rapidly evolving science and practice changes while maintaining quality patient care.

Implementation of the site manager's role as we described has assisted our department in the provision of safety for staff, patients, and families. We believe that this role could be adapted to meet the needs of other departments and institutions. In the event of a future pandemic, further study is necessary to determine how the site manager's role would be executed and expanded in multiple settings where both pediatric and adult patients receive care. However, the knowledge and skills gained from this program may serve as a foundation for other clinical nursing leadership roles. As frontline providers and emergency staff, site managers are change agents, brave professionals lighting the way for others, providing solace and safety, and supporting best practice patient care.

Acknowledgments

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Author Disclosures

Appendix Supplementary materials

Image, application 1

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.jen.2021.07.009.

Content	Time	Teaching method
COVID-19 introduction	10 min	Didactic lecture, clinical case study
Infection prevention and control basics	15 min	Didactic lecture, clinical case study
Personal protective equipment indications and use, troubleshooting problems	15 min	Didactic lecture, clinical case study
Personal protective equipment donning and doffing practice	15 min	Skills workshop
Drive-through swab protocols and family education	5 min	Didactic lecture
Special care practices for the emergency department, resource review	15 min	Didactic lecture, clinical case study
Psychological first aid practices	20 min	Didactic lecture
Applying psychological first aid	15 min	Clinical case studies
Orientation to the practice environment	10 min	In-situ orientation, narrative sharing

Patient resources	
FDA: COVID-19 Educational Resources	https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-educational-resources
FDA: Multi-lingual COVID-19 Resources	https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/multilingual-covid-19-resources
FDA: COVID-19 Vaccine Information	https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines
NIH: Supporting Mental Health During the COVID-19 Pandemic	https://www.nimh.nih.gov/news/science-news/2020/supporting-mental-health-during-the-covid-19-pandemic
Family resources	
CDC: Helping Children Cope	https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/for-parents.html
VA: Strategies for Families to Adapt to the COVID-19 Pandemic	https://www.ptsd.va.gov/covid/covid_family_strategies.asp
CDC: COVID-19 Parental Resources Kit–Childhood	https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/parental-resource-kit/childhood.html
NIH: Helping Children and Adolescents Cope with Disasters and Other Traumatic Events	https://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-disasters-and-other-traumatic-events/
USDA: COVID-19 Resources for Individuals and Families	https://www.fns.usda.gov/disaster/pandemic/covid-19/resources-individuals-families
Health care provider/nurses' resources	
ENA: COVID-19 Information	https://www.ena.org/practice-resources/covid-19
Aiken: Nurses: How to Help Your Patients Cope with COVID-19	https://online.usca.edu/articles/rnbsn/help-patients-cope-covid-19.aspx

AACN: Clinical Resources	https://www.aacn.org/clinical-resources/
ANA: COVID-19 Resource Center	https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/
HHS: COVID-19 Resources for Healthcare Professionals	https://combatcovid.hhs.gov/hcp/resources
WHO: COVID-19 Resources and Guidance	https://healthcluster.who.int/resources/covid-19-resources-and-guidance

	Staff Response
Registered Nurse	I find the role hugely helpful. With the inability to leave the room without doffing, the Site Manager is instrumental in obtaining supplies, relaying messages, providing an extra pair of hands. It is also helpful that this person is globally aware of everything happening on the team in order to lend support, offer rooms to triage, etc.
	Site Managers have the broader view of the flow and facilitate safe and efficient care.
	Better flow and resources and safety when a Site Manager is part of the team.
	Great resource, has global view of the team.
	Site managers are a great "go-to" for all COVID-related questions.
	Able to help the team RN feel supported during times of high volume and heavy COVID burden.
	It is useful in managing patient flow and having another set of RN hands. Alleviates some of the rooming from the charge nurse.
Physician	Maintaining COVID infection prevention and control practices has added new tasks that need to be covered during clinical shifts. The environment needs to be maintained and the extra hands to support patient care are so helpful.
	Helpful that they [site managers] know the latest rules.
	It is helpful to have someone knowledgeable about the COVID-related policies as they change.

	Provides expertise re: COVID placement, protocols, etc.
	Help with current policies. Help with in-room tasks. Help with training of new staff and trainees.
	Can help facilitate care for patients when nurses are busy with sick patients. Can help keep a finger on the pulse for sicker patients in the pod.
	Aware of the larger picture of what's going on with the team, very helpful in being the clean person and getting supplies for people gowned up.

DETAILS

Subject:	Severe acute respiratory syndrome; Personal protective equipment; Hospitalized; Workers; Leadership; Emergency services; Staff nurses; Teams; Infections; COVID-19; Health care; Distraction; Epidemics; Specialists; Occupations; Pandemics; Medical personnel; Mortality rates; Educational needs; Coronaviruses; Clinical nursing; Pediatrics; Disease control
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Emergency Nurses Association Position Statement: Medication Management and Reconciliation in the Emergency Setting: JEN

🔗 ProQuest document link

ABSTRACT (ENGLISH)

The three phases of the reconciliation process are imperative to ensure effective medication management and obtaining an as complete and accurate medication history is the first step.2 Medication management and reconciliation in the emergency setting is a collaborative effort between nurses, physicians, pharmacists, and patients to reduce risk for patients in health care settings and at home.1,2,4,8,9,13–15 This process requires that health care providers, including emergency nurses, communicate clearly with patients and their caregivers about the importance of maintaining an accurate medication list.4,13,16 An accurate medication list includes all medications including prescriptions, over-the-counter medications, supplements, herbals, medicinal marijuana, known allergies and last dose. Emergency nurses play an important role in empowering patients to understand the role they play in the medication management process as well as helping them to understanding the potential risks of drug/drug or drug/food interactions.3,13,16,20,36 Emergency nurses can educate patients and/or their caregivers on the importance of maintaining and keeping with them an accurate medication history including, dosage and frequency of all prescriptions, over-the-counter drugs, supplements, medicinal herbs, and other substances.16,20,36 Additionally, emergency nurses are in a position to advocate for best practices in the medication management process to ensure patient safety.ENA Position It is the position of the Emergency Nurses Association that: Triage is intended to rapidly identify life-threatening or high-risk situations. [...]collection of comprehensive medication history can be delayed and

performed after the patient is stable. When first announced, there was little direction as to the who, what, when, where, and how to complete the process, which led to, and continues to create, confusion among emergency nurses and other health care providers.18,37 As initially defined by TJC, the process of medication reconciliation was intended to reduce discrepancies and prevent medication errors but was complex, laborious, and did not necessarily result in accurate information.18,19 Because of difficulty in implementation the lack of proven strategies for success TJC, in 2011, suspended the original NPSG and incorporated medication reconciliation into NPSG number 3.1 This safety goal acknowledges the challenges of reconciliation yet still requires a "good faith effort" to obtain a medication history (the first step) on arrival and then comparing it with those medications that are prescribed (the reconciliation stage).

FULL TEXT

Description

Medication reconciliation remains a patient safety issue worldwide. In the United States, The Joint Commission (TJC) began pivoting focus from medication reconciliation toward overall medication management when introducing the seven foundations for safe quality transitions of care in 2013.[1] Medication management as one of the foundations broadly includes activities such as verification, prescribing, administration and monitoring used in conjunction with the current National Patient Safety Goals (NPSG) on medication reconciliation. Medication management is intended to safeguard patients from medication errors and adverse drug events (ADEs) during transitions between care settings, including emergency departments, urgent cares centers, other ambulatory emergency settings or other types of care settings.[1–12] Medication management is more than just an accurate medication history or reconciliation. The three phases of the reconciliation process are imperative to ensure effective medication management and obtaining an as complete and accurate medication history is the first step.[2] Medication management and reconciliation in the emergency setting is a collaborative effort between nurses, physicians, pharmacists, and patients to reduce risk for patients in health care settings and at home.[1,2,4,8,9,13–15] This process requires that health care providers, including emergency nurses, communicate clearly with patients and their caregivers about the importance of maintaining an accurate medication list.[4,13,16] An accurate medication list includes all medications including prescriptions, over-the-counter medications, supplements, herbals, medicinal marijuana, known allergies and last dose.

For patients who present to emergency care settings, an accurate medication history is imperative for patient safety and to enable appropriate evaluation and treatment. However, in the often busy and chaotic emergency setting where time is essential, obtaining accurate and complete medication history can be an arduous process. With medication information coming from multiple sources (patient, family, caregivers, multiple pharmacies, etc) and other conflicting or competing patient care issues, errors in the communication of significant information at key transition points are possible and can be problematic.[4,12,13,17–20]

Most patients who present to an emergency department enter through the hospital's triage area. Triage is a process to rapidly sort patients based on patient acuity and resources needed.[21,22] Triage is intended to identify life-threatening or high-risk situations that require immediate intervention to save lives. When triaging patients, the emergency nurse obtains a brief assessment along with any other relevant medical history and may obtain a focused medication history pertinent to the chief complaint. A more comprehensive medication history (the first phase of the reconciliation process) should be obtained after the initial triage process and stabilizing care prior to admission or other disposition.

Evidence demonstrates that collecting a medication history during triage is more likely to result in errors in the patient record than pharmacy-led acquisitions of medication information.[19,23–25] In two studies, omission of medications or doses were the most frequent errors attributed to nurses completing the medication history.[23,24] These findings are due in part to time constraints. Evidence shows that completing an accurate and complete medication history can take 20 to 79 minutes.[5,23,26,27] The time constraints lead to debate about whether the emergency care setting is the appropriate place to obtain a detailed medication history.[18]

Many studies and authoritative bodies in the United States as well as internationally indicate that pharmacists or pharmacy technicians are best suited to compile the medication history and subsequently complete the reconciliation process.[1,4–6,11,12,15,19,23,24,26–33] Position statements from multiple prominent health care associations are substantiated by research findings. When pharmacists or pharmacy technicians are available in the emergency setting, their participation in medication management not only improves the medication reconciliation process but effectively improves patient safety and reduces medication errors in the hospital setting.[15,28–31,34,35] Despite these findings, there are still significant challenges to establishing a dedicated pharmacy staff present in the emergency setting to participate in the medication management process.

In addition to time constraints, there are numerous barriers experienced by emergency nurses in collecting medication histories, including high patient volumes and patient care activities. Not only is the emergency care setting not the most opportune time to collect an accurate medication history, but emergency nurses should not perform the actual reconciliation phase as this is completed by the licensed independent provider (LIP). Emergency nurses can actively contribute to the medication management process through their performance of assessments, interventions, reevaluations, patient education, and discharge. Emergency nurses play an important role in empowering patients to understand the role they play in the medication management process as well as helping them to understanding the potential risks of drug/drug or drug/food interactions.[3,13,16,20,36] Emergency nurses can educate patients and/or their caregivers on the importance of maintaining and keeping with them an accurate medication history including, dosage and frequency of all prescriptions, over-the-counter drugs, supplements, medicinal herbs, and other substances.[16,20,36] Additionally, emergency nurses are in a position to advocate for best practices in the medication management process to ensure patient safety.

ENA Position

It is the position of the Emergency Nurses Association that:

1. Medication management is a collaborative partnership between multiple health care disciplines including nurses, physicians, and pharmacists.

2. Ideally, pharmacists or pharmacy technicians are the preferred clinicians to complete the medication history and medication reconciliation.

3. Emergency nurses can support medication management by collaborating with prescribers and facilitating two-way communication regarding any medication changes, additions, or deletions to the patient's current medication regime to patients, families, caregivers and/or transferring facilities especially elderly polypharmacy and other high-risk patients.

4. Emergency nurses can support medication management by collaborating with providers to ensure that daily medications are ordered and being administered to admission patient being held in the department.

5. Emergency nurses obtain an accurate and complete medication list if possible after the initial triage process.

6. Triage is intended to rapidly identify life-threatening or high-risk situations. Thus, collection of comprehensive medication history can be delayed and performed after the patient is stable.

7. Emergency nurses educate patients, their families, and caregivers on the importance of keeping an accurate medication list with them at all times.

8. Emergency nurses participate in policy and guideline development to assure optimal medication management processes are developed.

9. Emergency nurses collaborate with pharmacists and facility leadership to advocate for pharmacy-led medication management as best practice.

Background

Medication reconciliation is a complex multi-pronged process. TJC NPSG number 8 to "accurately and completely reconcile medications across the continuum of care," [7] has evolved since first introduced in 2005. When first announced, there was little direction as to the who, what, when, where, and how to complete the process, which led to, and continues to create, confusion among emergency nurses and other health care providers.[18,37] As initially defined by TJC, the process of medication reconciliation was intended to reduce discrepancies and prevent medication errors but was complex, laborious, and did not necessarily result in accurate information.[18,19] Because of difficulty in implementation the lack of proven strategies for success TJC, in 2011, suspended the original NPSG and incorporated medication reconciliation into NPSG number 3.[1] This safety goal acknowledges the challenges of reconciliation yet still requires a "good faith effort" to obtain a medication history (the first step) on arrival and then comparing it with those medications that are prescribed (the reconciliation stage). This is done to identify and resolve discrepancies and to improve the safe use of medications across the continuum of care.[1–3,14]

Factors such as unreliable patient provided information, inaccurate information from outside sources, and ineffective communication among health care providers have been identified as barriers to collecting accurate medication histories.[20,22,37,38] According to the Institute for Healthcare Improvement[39,40] and the Institute for Safe Medication Practices[41] inaccurate medication histories may cause up to 50% of all medication errors and as much as 20% of the ADEs seen in the hospital setting. Furthermore, numerous studies have found that medication histories collected by nurses or health care personnel other than pharmacy staff were less accurate,[24,38] had higher rates of discrepancies,[23,32] and higher rates of omissions[27] compared to pharmacy staff-led history collection. Preventing medication errors, ADEs, or other harm to patients resulting from an inaccurate medication history should always be the primary goal of medication management regardless of what specialty completes the task.

Emergency department medication reconciliation and management in the United States and internationally is complex. Policies aimed at both are impacted by various factors including the country of origin, the accrediting body used by each hospital, and the various regulatory agencies definitions of what medication reconciliation or medication management entails, all have influence over policies and protocols in the emergency department. International Pharmaceutical Federation[31] lists 6 different definitions of medication reconciliation. Regardless of these factors accurate medication history, management, and reconciliation depends on emergency nurses around the world to understand their individual facility, country, and regulatory agency guidelines, policies, and procedures. Overall, medication management is a collaborative, cooperative partnership between multiple health care disciplines, including nurses, physicians, and pharmacists, to ensure medication safety through effective communication. It is essential that information given to a patient, family, caregiver, transferring, or receiving facility include changes, additions, or deletions to the patient's current medication regime. Emergency nurses need to continue advocating for patient safety measures that protect the patient and enable the nurse to be actively engaged in processes without unnecessary barriers.

Resources

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The Joint Commission. National patient safety goals effective January 2020. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/npsg_chapter_ahc_jan2020.pdf?db=web&hash=32FE3AF116E76BC4AAF21C831155C1E7

World Health Organization. Medication safety in transitions of care. https://www.who.int/patientsafety/medication-safety/TransitionOfCare.pdf?ua=1

DETAILS

Subject:	Risk reduction; Emergency medical care; Home health care; Collaboration; Life threatening; Healthy food; Communication; Physicians; Drug stores; Nurses; Emergency services; Caregivers; Reconciliation; Best practice; Prescription drugs; Medical errors; Herbs; Patient safety; Delayed; Marijuana; Health care; Personal safety; Triage; High risk; Discrepancies; Critical incidents; Medical personnel; Patient education; Pharmacists; Confusion; Dosage; Nurse patient relationships

Commentary on "Remote Advance Care Planning in the Emergency Department During COVID-19 Disaster: Program Development and Initial Evaluation": JEN

🔗 ProQuest document link

ABSTRACT (ENGLISH)

Novel applications of telehealth exploded during the pandemic.1 From virtual acute care visits to virtual triage and home visits and telehealth via ambulances, synchronous and asynchronous telehealth etched a permanent place in the emergency care specialty.2 In this edition of the Journal of Emergency Nursing (JEN), Liberman et al3 explore a pragmatic telehealth program developed to take the heavy, bedside end-of-life discussion away from the front-line staff and offload it to a trained group of nurses via telehealth. The program developed a system by which the bedside team could alert the remote palliative care providers to engage the family in end-of-life decisions.4 These included DNR/DNI, MOLST, health care proxy discussions, and disposition. Considerations on supporting the entire health care workforce included providing work during quarantine, providing offsite work to those health care workers at higher risk of contracting severe COVID-19, and providing a channel to support both the emotional needs of the emergency health care workers at the bedside and the need to work for those sidelined; this program was ideal.

FULL TEXT

Novel applications of telehealth exploded during the pandemic.[1] From virtual acute care visits to virtual triage and home visits and telehealth via ambulances, synchronous and asynchronous telehealth etched a permanent place in the emergency care specialty.[2] In this edition of the *Journal of Emergency Nursing (JEN)*, Liberman et al[3] explore a pragmatic telehealth program developed to take the heavy, bedside end-of-life discussion away from the front-line staff and offload it to a trained group of nurses via telehealth. A logic model describing the use of Remote Goals of Care Program (GOC) was developed and implemented.

The emergency department can be loud and crowded and lack the quiet privacy needed to have end-of-life discussions with patients and families. During the COVID-19 pandemic, when visitation policies were restricted, many end-of-life discussions took place via remote platforms.[4] Patients were often scared, alone, and dying of COVID-19 without their closest loved ones to hold their hands at the bedside. Many hospitals had transitioned to a virtual platform to deliver bad news and work through these decisions; however, the authors' GOC program[3] used a bidirectional platform. This was unique in that both the patient and the bedside clinician were remote. Telehealth programs in the emergency department such as remote stroke care and tele-psychiatry are examples of established one-directional programs—the patient is in person in the bricks-and-mortar emergency department, but the provider is remote. These programs spared the provider the exposure risks from being physically present during the visit during the pandemic. The programs that were bidirectional—both the patient/family and the provider were remote—included acute unscheduled visits and platforms that connected families to remote providers.

Pairing both the need for virtual conversations and job continuity for nurses sidelined during the pandemic, this Remote GOC Program[3] offered a sustainable solution to a major gap in care. The program developed a system by which the bedside team could alert the remote palliative care providers to engage the family in end-of-life decisions.[4] These included DNR/DNI, MOLST, health care proxy discussions, and disposition. The Remote GOC Program[3] was created as a joint endeavor between the division of geriatrics and palliative medicine and emergency medicine. "In

decanting the responsibility of goals of care discussions from the emergency department to a calmer, remote setting," the authors seized a unique moment in time, a time where the most precious conversations regarding end-of-life care could were transitioned to a group of nurses working remotely. While this was a nurse-driven initiative, it spanned disciplines including social work and the division of palliative care and emergency medicine, fueling the success of this program.

The advantages of such a program include offloading the clinical team from having difficult, often prolonged discussions at the bedside. The nurses conducting the interviews were not on site, allowing protection from COVID-19 exposure and conservation of precious personal protective equipment (PPE).[5] The pandemic created extraordinary emotional and physical stress on bedside care teams. Health care workers struggled to communicate with the patients in full PPE, screaming above the whirl of the PAPR hood and N95 masks. Face shields prevented not only droplets from spreading but words from traveling, and conversations were strained at best.[6] Caregivers of patients who were not capable of making end-of-life decisions for themselves attempted to connect to next of kin via iPad. The telehealth platform for end-of-life care was born. Considerations on supporting the entire health care workforce included providing work during quarantine, providing offsite work to those health care workers at higher risk of contracting severe COVID-19, and providing a channel to support both the emotional needs of the emergency health care workers at the bedside and the need to work for those sidelined; this program was ideal.

The authors created a logic model for Remote GOC Program,[3] for other institutions to replicate their implementation. The inputs included the key partnership between emergency medicine and palliative care, nurses who were not onsite, the technology to perform the telehealth visits. Outputs include number of referrals into the program, GOC discussions with families, and any changes in code status. Evidence of the anticipated impact of this program after the pandemic will be continued offloading of the cognitive burden of the bedside clinician and providing meaningful work for nurses sidelined from clinical practice.

The pitfalls of this type of program are typical of many telehealth programs, with a few unique challenges. Families may not have access to the technology needed to conduct the telehealth interview. This lack of access is more prevalent in lower socioeconomic and rural areas.[7] These types of technology barriers may be more profound during a very intense end-of-life discussion compared with a virtual visit for an uncomplicated self-limited medical condition. Glitches in Wi-Fi or software may be extremely intrusive in these sensitive moments. There may also be conflicting advice given to the patient's family by a telehealth nurse who is not the patient's primary in-person bedside nurse. Would the weight given to the information provided to make such difficult decisions be watered down by the nurse being remote? There is something profound about the bedside clinician giving advice regarding advanced directives with the patient in front of them. Would a virtual approach convey the same meaning?

Health care providers, including nurses, are often sidelined from clinical care secondary to injury, illness, exposure, or, recently, COVID-19 quarantine.[8] This unique GOC program[3] paired the nurses who were not able to work clinically to participate in a valuable program. The use of nursing in telehealth has expanded rapidly over the past 5 years. A gap still exists around telenursing and disaster care. This application of telehealth as an avenue for emergency nurses to use their specialized skillsets begins to fill this gap. The telehealth platform for nursing seemed counterintuitive at first, with the goals of bedside nursing to be truly a hands on specialty. There was a delayed launch of the specific telehealth nursing applications.[8] The potential for delivering nursing care such as patient history, triage, individualized patient education, postdischarge counseling, and care coordination is enormous. Nurse-led telehealth initiatives during the pandemic provided a platform for virtual care that limited infection exposures and physical demands and allowed flexibility to work from home. The pandemic disproportionately affected working parents, who had to manage their jobs, their own psychological stressors, and children who were learning at home during lockdown. The use of telehealth to mitigate the occupational psycho-social stressors during the pandemic can be stretched to postpandemic times.[9] Health care is not only complicated, it has now become draining, leading to high rates of burnout and dissatisfaction. Allowing nurses to intermittently perform their duties from home is one possible solution, for some nurses, some of the time.[10] The Remote GOC Program[3] manuscript provides important feasibility evidence that remotely working nurses can engage patients in end-of-life discussions.

During staff shortages, remote nurses can potentially help perform the admission intake for patients boarding the emergency department; they may be able to provide more continuous visual monitoring or patient surveillance care when staffing levels cannot be maintained. Remote nurses might be engaged to have more comprehensive discharge planning meetings with patients and their families. The pandemic taught us that you can be an emergency nurse but do not need to be in an emergency department to deliver specialty care. It is about the skill set and not the location. The paper by Liberman et al[3] illustrates that very nicely. Through their discussion about end of life, they have breathed new life into how we care for patients.

DETAILS

Document 9 of 19

Prevalence of Prolonged Length of Stay in an Emergency Department in Urban Denmark: A Retrospective Health Records Repository Review: JEN

ABSTRACT (ENGLISH)

Introduction

Prolonged length of stay in emergency departments is associated with increased hospitalization, hospital-acquired pressure ulcers, medication errors, and mortality. In acute admissions in Denmark in 2018, 67% of patients experienced waiting time from arrival to examination. This study aimed to estimate the prevalence of prolonged length of stay (≥6 hours) and identify risk factors related to input, throughput, and output components.

Methods

A retrospective health records repository review included 4743 patients admitted to a single urban emergency department in Denmark in January 2019. Data collected from the electronic health record system repository included demographic and organizational characteristics and were analyzed using descriptive statistics and logistic regression.

Results

Among patients admitted in the study period, 31% had a prolonged length of stay of ≥6 hours. Prolonged length of emergency department stay was associated with being female (male odds ratio [OR], 0.86; 95% confidence interval [CI], 0.75-0.98), treatment by medical service (OR, 4.25, 95% CI, 3.63-4.98) vs surgical or injury, triage acuity of 2-Orange (OR, 1.45; 95% CI, 1.18-1.78) or 3-Yellow (OR, 1.47; 95% CI, 1.23-1.75) on a 5-level scale, evening (OR, 1.44; 95% CI, 1.24-1.66) or night (OR, 2.36; 95% CI, 1.91-2.91) arrival, ages 56 to 80 (OR, 1.79; 95% CI, 1.52-2.11) and >81 (OR, 2.40; 95% CI, 1.99-2.88) years, and hospital admission (OR, 1.19; 95% CI, 1.04-1.38) vs discharge from the emergency department to home.

Discussion

Female, elderly, and medical patients were each identified as at-risk characteristics for ≥6-hour length of stay in the emergency department. Acute care patient pathways in the emergency department, particularly for evening and night, with guideline-based care and system level improvements in patient flow are warranted. Further research with larger populations is needed to identify and support interventions to decrease prolonged length of stay.

FULL TEXT

DETAILS

Subject:	Emergency medical care; Patient safety; Drugs; Risk factors; Patients; Mortality; Ulcers; Triage; Older people; Emergency services; Critical incidents; Length of stay; Acute services; Health records; Hospitalization; Injuries; Medical errors; Demography; Pressure ulcers
Location:	Denmark
Identifier / keyword:	Clinical pathway; Emergency department; Emergency nursing; Length of stay; Crowding
Publication title:	Journal of Emergency Nursing:; JEN; Philadelphia
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Section:	International Nursing
Publisher:	Elsevier Limited
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Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2021.08.005
ProQuest document ID:	2616586639

Document 10 of 19

Experience of Violence and Factors Influencing Response to Violence Among Emergency Nurses in South Korea: Perspectives on Stress-Coping Theory: JEN

🔗 ProQuest document link

ABSTRACT (ENGLISH)

Introduction

This cross-sectional study aimed to explore the experiences of workplace violence involving emergency nurses and to identify the factors influencing the response to violence on the basis of the stress-coping theory formulated by Lazarus and Folkman.

Methods

Using a cross-sectional design, a structured questionnaire was administered to measure the experience of violence, perceived stress, coping actions after violence, resilience (Connor-Davidson Resilience Scale), and responses to violence. The participants were 131 nurses who were working in the emergency departments in 9 of 11 general hospitals in 2 cities in South Korea. The collected data were analyzed using descriptive statistics, t tests, analyses of variance, Pearson correlations, and hierarchical multiple regression analyses.

Results

The most frequent type of violence was verbal violence, and the main offender involved in all types of violence was the patient. The methods for coping with violence were mainly passive, and emotional responses were the most frequently reported response to violence. In the final model (explanatory power = 41.5%), with response to violence as the dependent variable, the effects of the experience of violence disappeared, and only the effects of perceived stress and resilience remained.

Discussion

The results of this study suggest that internal factors such as perceived stress and resilience have a more meaningful effect on the response to violence than the experience of violence itself. The findings are expected to serve as assessment data for preparing interventions and policies around prevention of, and effective coping regarding, workplace violence toward emergency nurses.

FULL TEXT

DETAILS

Subject:	Occupational stress; Emergency medical care; Hospitals; Job satisfaction; Prevention programs; Perceptions; Workplace violence; Coping; Emotional responses; Stress response; Adjustment; Workplaces; Nurses; Emergency services; Nursing; Stress; Resilience; Post traumatic stress disorder
Business indexing term:	Subject: Occupational stress Job satisfaction Workplace violence
Location:	South Korea
Identifier / keyword:	Violence; Emergency department; Stress; Coping; Resilience
Publication title:	Journal of Emergency Nursing:; JEN; Philadelphia
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Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
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Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2021.07.008
ProQuest document ID:	2616586598
Document URL:	https://www.proquest.com/scholarly-journals/experience-violence-factors-influencing-response/docview/2616586598/se-2?accountid=211160

A Framework for Standardizing Emergency Nursing Education and Training Across a Regional Health Care System: Programming, Planning, and Development via International Collaboration: JEN

🔗 ProQuest document link

ABSTRACT (ENGLISH)

Introduction

The challenges related to providing continuing education and competence management for emergency nurses are not unique to any one organization, health system, or geographic location. These shared challenges, along with a desire to ensure high-quality practice of emergency nursing, were the catalyst for an international collaboration between emergency nurse leaders in Region Zealand, Denmark, and nurse leaders and educators from a large academic medical center in Boston, Massachusetts. The goal of the collaboration was to design a competency-based education framework to support high-quality emergency nursing care in Region Zealand. The core objectives of the collaboration included the following: (1) elevation of nursing practice, (2) development of a sustainable continuing education framework, and (3) standardization of training and nursing practice across the 4 emergency departments in Region Zealand.

Methods

To accomplish the core objectives, a multi-phased strategic approach was implemented. The initial phase, the needs assessment, included semi-structured interviews, a self-evaluation of skills of all regional emergency nurses, and a survey regarding nursing competency completed by emergency nurse leadership. Two hundred ninety emergency nurses completed the self-evaluation. The survey results were utilized to inform the strategic planning and design of a regional competency-based education framework.

Results

In 18 months, and through an international collaboration, emergency nursing education, training, and evaluation tools were developed and integrated into the 4 regional emergency departments. Initial feedback indicates that the education has had a positive impact. The annual competency day program has continued through 2021 and is now fully institutionalized within the regional emergency nursing continuing education program. Furthermore, use of this innovative education framework has expanded beyond the emergency department to other regional nursing specialties.

Discussion and Conclusion

Through this unique collaboration with regional and international participants, a sustainable, regional emergency nursing education program was developed that has elevated and standardized the practice of emergency nurses in Region Zealand, Denmark. This program development can serve as a model for region-wide or health care system–wide collaborations in other countries.

FULL TEXT

Introduction

The complexity of care and demand placed on emergency care practitioners continues to increase globally. Emergency nurses, like other health care providers, face many challenges to remain current and competent in the skills and knowledge required to manage increasingly complex patient populations.[1] A qualified emergency nurse is expected to be competent in the management of emergent, urgent, and nonurgent patients across the health and age continuum.[2] Maintenance of competence in an evolving practice requires the astute emergency nurse to engage in lifelong learning, knowledge acquisition, and skills refinement.[2] In 2011, the Institute of Medicine released a report, *Future of Nursing: Leading Change, Advancing Health*, recommending that all nurses adopt a framework of continuous lifelong learning and ongoing competence evaluation.[3] The Institute of Medicine report also highlighted an urgency for health care organizations and administrators to foster an environment and a culture that is supportive of the nursing professional's lifelong learning needs.[3]

Despite growing evidence supporting the need for continuing education and competence evaluation, nurse education is often cited as being inadequate relative to the evolving complexity of patient care.[4] Globally, in both rural and community settings, these effects are frequently compounded by restricted finances and limited resources.[5] The challenges related to continuing education and competence management in nursing are not unique to any one organization, health system, or geographic location. These shared challenges, in addition to concerns related to its impact on the quality and practice of emergency nursing, were the catalyst for an international collaboration between emergency nurse leaders in Region Zealand, Denmark, and nurse leaders and educators from Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center in Boston, Massachusetts.

Setting

Denmark is located in northern Europe and has a population of approximately 5.8 million. Located in the southeast of Denmark is Region Sjaelland (Region Zealand), a region with 821 000 inhabitants and an area of 7273 km.[26] Region Zealand has 7 hospitals, 4 of which have emergency departments: Zealand University Hospital in Køge, Nykøbing Falster Hospital, Holbæk Hospital, and Slagelse Hospital ([Figure 1]).[7] The emergency departments are distributed throughout the region and form the center of emergency care delivery in Zealand. Because it is a publicly funded system, health care services are available to all residents.

Zealand Nursing Education: Background

In Region Zealand, emergency nurse education, training, and scope of practice are primarily determined by local leaders. In addition to local programs, education of regional emergency nurses has historically consisted primarily of the completion of a theory-based national education program designed to address the training and competence needs. However, over time, leaders found that the program length, cost, and associated staffing logistics created significant barriers to individual completion, rendering it impractical as the primary source of training and competence assessment for emergency nurses (the national program continues in parallel to this project).

In addition, in 2015, Zealand emergency nursing leaders and regional health care administrators identified several internal inconsistencies in regional training and education leading to significant variability in practice and quality of care. Nurse leaders also reported that general staff satisfaction and retention were negatively impacted by these practice and education inconsistencies.

The Project

To address these identified issues, regional leadership engaged in a unique international collaboration, leveraging an existing relationship with the Department of Emergency Medicine at Beth Israel Deaconess Medical Center. The primary goal of the collaboration was to elevate and standardize emergency nursing practice across Region Zealand. Central to achieving the goal was the development of a sustainable regional education framework, which focused on strategies to align and standardize educational priorities, delivery methods, and tools through the use of existing regional staff and resources. A logic model describing the project is found in [Table 1].[8]

Project Funding

The regional health care system of Region Zealand provided strategic funding for the initial development of the program. This funding covered, among other things, the costs of the international collaboration, including consultancy services from the United States partner, the first train-the-trainer course, and travel expenses for Danish and US participants to attend the various program planning initiatives. The majority of the program costs, however, including staff time for initial and ongoing program development, ongoing train-the-trainer courses, and the skills stations themselves, were incurred by the individual emergency departments. While it is logical that this project provided an overall regional cost savings through leveraging system resources, such as equipment, program development, and educator training, this saving has not been quantified.

Methodology

A comprehensive plan was designed to achieve the goals of the collaboration and included 5 distinct phases: (1) needs assessment, (2) regional strategic planning, (3) curriculum/tools development, (4) staff development (train-the-trainers course), and (5) project launch/implementation. These phases resulted in the initial project milestones depicted in Figure 2. The collaboration was coordinated and overseen by a designated regional steering committee consisting of nurse leaders and educators from the 4 emergency departments, an administrative program director from the regional health system, and US nurse educators. Throughout the project planning and implementation phase, the steering committee met monthly to review progress and make key project decisions. The 5 project phases are described in the sections below.

PHASE I: NEEDS ASSESSMENT

Needs assessments, specifically in the context of international emergency specialty collaborations, provide clarity on the development of specific achievable education objectives and have been determined to be essential to program success.[9,10] To inform educational planning, a needs assessment of regional emergency nursing education was conducted by the US nursing team. The assessment included the use of an electronic self-assessment tool designed to capture both emergency nurses' and leaders' perceptions of practice and competence. In addition, semistructured interviews with nurse leaders at each hospital were conducted via telephone.

The data collected were originally in the interest of the project and program development and were not collected specifically for this paper or study. In addition, none of the authors or individuals who contributed to the project had access to any subject identifiers linked to our surveys. Therefore, our paper does not fall within the category of human subjects research.[11]

The electronic self-assessment tool distributed to regional nurses was a multi-part, self-reported questionnaire. A 5-point scale (0-4) was used to measure nurses' perceived competency experience levels, with proficient being a score of 3 or greater. The 202 skills and assessments represented on the questionnaire were informed by the Emergency Nurse Core Curriculum[12] and modified to reflect the Danish emergency nurses' scope of practice. The questionnaire was distributed electronically to 290 nurses from the 4 regional emergency departments, with an 82.8% response rate (see Supplementary Appendix 1).

The electronic assessment distributed to nurse leadership was a similar multipart questionnaire intended to capture leaders' perceptions of staff competence. Nursing leadership teams from the 4 emergency departments completed the assessment by hospital group. Leaders were instructed to respond on the basis of their knowledge of incident reports, patient feedback, and direct observation experience. Participants were given 5 weeks to complete the survey. The electronic questionnaires were tested, and content validity established, by educators and leaders from each hospital before implementation.

The results of the needs assessment informed the educational program goals and learning objectives, which were developed in subsequent project phases. The nurse self-assessment questionnaire offered the majority of insight, and its results underscored the need for improved education. Relevant supporting results are displayed in Figures 3 and 4. A 42-page needs assessment report was generated to serve as a basis for the subsequent strategic planning phase.

Of note, in the survey, it was not our intention to make direct comparisons between the skills-based training of the newly developed program with the largely theory-based training of the national emergency nurse training program,

but simply to understand what type of education was being received by the emergency nursing staff. The newly developed program includes both theory and skills-based learning.

PHASE II: STRATEGIC PLANNING

After the needs assessment, the second phase of the collaboration began. In this phase, 12 Danish nurse leaders and educators attended a weeklong strategic planning session in Boston, Massachusetts. During this week, leaders utilized the needs assessment report and leveraged new knowledge obtained from on-site education and observations in Boston in order to design a framework and roadmap for the implementation of a regional emergency nurse competency-based education, training, and assessment program.

The strategic planning program was designed and led by US nurse leaders and educators and included didactics, clinical observations, and expert-led discussion related to the following topics: emergency nursing scope and standards of practice, curriculum development, competency assessment, competency validation, and trainer development strategies. In addition, the US project team facilitated strategic discussions regarding program decision-making. These outcomes are described below.

The decision to host the planning session in Boston versus Denmark was twofold: (1) to provide a supportive environment with dedicated time for emergency nurse leaders to build relationships with one another, parallel to the collaborative development of the regional strategic plan, and (2) to provide inspiration and share best practices through direct observation of emergency nursing practice and delivery of competency-based education.

During strategic planning sessions, expert consensus was used to drive decision making, and this was informed by (1) the assessment results, (2) leadership knowledge of critical areas, and (3) the US partner's shared experience. Arriving at consensus among all 4 hospital leadership teams was a priority. Disagreements were analyzed and discussed until consensus was achieved. Decisions, once made, were written on a whiteboard throughout the sessions and finalized with a report at the end of the week for distribution. Strategic discussion led to the development of outcomes detailed in [Figure 5] and [Table 2].

In addition to the key strategic decisions described above, the group, facilitated by US nurse collaborators and project managers, developed a detailed project plan that includes a project timeline, tasks, roles, and responsibilities. The project plan guided project implementation as the group moved through the subsequent phases of curriculum development, trainer development, and project launch.

PHASE III: CURRICULUM DEVELOPMENT

In September 2015, shortly after the strategic planning workshop in Boston, 15 nurse educators from Region Zealand and 2 US nurse leaders convened for 5 days in Denmark. The goal of was twofold: first, to identify a transferable method for the development and delivery of competency-based emergency nursing education and, second, to apply this new knowledge and process in the development of the 2016 competency-based education program. The deliverable of the weeklong process was a comprehensive evidence-based education toolkit for each of the 5 identified skills stations, in addition to standardized documents to support nurse trainers and leaders in program delivery. See [Supplementary Appendix 2] for a toolkit sample and [Figure 6] for a brief description of the toolkit contents. Before the curriculum development session, applicable pre-existing training and educational materials were collated from the 4 hospitals and reviewed for transferability to the 2016 skills stations. US nurse leaders provided educational and academic input to the work process, as well as an updated project plan for competency development in Region Zealand. The curriculum was grounded in internationally recognized standards and theories identified during strategic planning.[13-16] Published research suggests that implementing emergency medicine education programs that adhere to internationally recognized standards will lead to successful education programs.[9, 17-21]

PHASE IV: TRAINER DEVELOPMENT AND TRAIN-THE-TRAINER

After curriculum development and translation of materials, 32 Zealand nurses were selected to be trainers for the 2016 regional "competency day." Trainers were selected on the basis of their adherence to emergency nursing standards of practice, in addition to their ability to evaluate competence and provide peer feedback. In addition, trainers were generally viewed as professional role models or ambassadors of excellence in emergency nursing. A

regional train-the-trainers workshop was then scheduled for November 2015. The workshop was designed to prepare these trainers for program launch through a series of didactic and hands-on training delivered by the US nurse educator team.

The project task force had determined that the train-the-trainers model would be the most efficient and effective model for rapid program implementation. The use of the train-the-trainers model for international emergency medicine projects has been discussed in the literature as being a scalable and instrumental component to program success and long-term sustainability.[22] In fact, train-the-trainers programs have been used to develop physician, nurse, and prehospital emergency medicine education throughout the world in many countries,[23] including China,[24,25] Turkey,[22] India,[22] Italy,[22,26-28] Poland,[29] Armenia,[30] Ethiopia,[31] Costa Rica,[32,33] Rwanda,[34] Ghana,[35] Estonia, Armenia, Kazakhstan, Russia, Moldova, Georgia, Ukraine, Turkmenistan, Uzbekistan, Belarus, Tajikistan, and Albania.[36] Backed by strong evidence, a train-the-trainers session was scheduled, in which each trainer received 22 hours of training (see [Figure 7]) as follows: first, a 7-hour training workshop, facilitated by the US nurse educators, was held for the entire regional trainer group. The workshop included a series of lectures and breakout sessions for application and return demonstration, incorporating adult learning theory and best practices for teaching in a flipped classroom setting. Upon completion of this workshop, trainers were presented with individual binders filled with the above described curriculum materials, and regional leadership set expectations on their roles and responsibilities during the upcoming annual training. Printing materials and collating them into binders, which are consistently updated throughout the year, is invaluable to the trainers. During a competency day the curriculum binders enable the trainers to have all of the materials and resources at their fingertips. They are able to use the detailed scripts, scenarios, and detailed clinical rationales to more easily respond to trainee questions. In the event of a trainer's absence, a substitute trainer can more easily step into the role with minimal preparation, using the curriculum binder resource.

After completion of the workshop, each trainer participated in 7.5 hours of skills station practice at their own hospitals and 7.5 hours at a partner hospital. Trainers had the opportunity to trial their skills station by presenting it to 2 US nurse educators for feedback. Present at these practice sessions were colleague trainers from the same hospital and a selected regional partner hospital. The colleagues served in the role of mock trainee during the station practice sessions or served as observers contributing to the poststation feedback sessions.

The trainers also had the opportunity to discuss their roles and responsibilities with the US team and the Zealand hospital leadership during these practice sessions. Leaders highlighted the importance of the trainer role as ambassadors for excellence in emergency nursing practice and as essential leaders in the journey of emergency nursing from "good to great," a previously articulated goal of the educational program. After completion of the train-the-trainer program, leaders and trainers at each hospital focused on a logistical preparation of the annual competency day program, determining schedules and internal education policies.

Outcomes

In January 2016, the Region Zealand emergency nurse education program was launched, and the first competency days were held in each of the 4 emergency departments. During the first month of project launch, each department had 10 to 15 nurses participate in 5 competency-based skill stations, each containing critical concepts and skills related to emergency nursing. Regional emergency nurse competency days launched in January 2016, and by December over 270 regional nurses had successfully completed the training program.

To evaluate the program and measure the impact of education on emergency nurse education, the project group identified 2 tools: (1) postprogram evaluation, and (2) a self-assessment tool (see [Supplementary Appendices 3] and [4]). The postprogram evaluation tool was distributed to participants at the completion of the competency day to solicit participant feedback on individual trainer performance, individual skills station educational value, and logistical aspects of the day. Relevant improvements were made after each competency session, based on learner feedback, and were agreed upon region-wide, communicated by change management form (see [Supplementary Appendix 5]). In general, feedback was positive in all 4 hospitals, and educators reported that their staff nurses were working enthusiastically and inquisitively with the material.

Second, participants were asked to complete a modified version of the original needs assessment survey. As discussed above, the original needs assessment survey was designed to measure nurses' perceived competency experience levels for 202 identified emergency nurse skills and competencies. The modified survey was designed to measure nurses' perceived competency specifically related to the skills and competencies validated during the 2016 competency days. This survey was administered at 3 separate intervals: before receiving their prework material, on the day of competency skill training, and 1 week after training.

Results of the first 4 competency days showed a significant increase in nurses' perceived competency with those skills practiced during the 2016 competency day. Averaged across all practiced skills, regional emergency nurses' perceived competency levels showed a percentage increase of 5.29% and 22.85%, respectively ([Figure 8]), and 29.34 overall. A total of 27 of 34 skills showed an increase between the first and second survey, whereas 34 of 34 skills showed an increase in comfort level between the second and third survey. Whereas only the first 4 competency days were evaluated, results indicated an increase in perceived competence due to skills station training.

Competency Day Rollout

One month before each competency day, staff nurses received an email with the prework materials for all 5 stations and were asked to review these materials before competency day. Time was provided within the staff's schedule to study the materials. Leadership regularly communicated with staff regarding the importance of preparing for competency day.

Those staff nurses who were unable to perform the skills on competency day were assisted with station completion by the trainers. Trainers were not involved in any improvement or learning plan discussions with staff nurses. Station trainers made note of staff performance and, at the end of the competency day, leadership met with the trainers to receive feedback and a develop a list of staff members who needed additional follow up. Nurse leaders addressed these issues directly with staff and nurse educators after competency day.

Project Institutionalization and Expansion

The first regional competency days began in January 2016, and annual competency day programs have been launched each year from 2017 to 2021, with plans to continue; the program has been institutionalized within the regional emergency nursing education system. (We define institutionalization as the stage in the organizational change process at which an educational program has taken hold in the host culture's medical system and is described by local organizational members as a fully ingrained part of their medical/nursing education system).[23] In addition, the Zealand nurse educators have recently been consulted by other hospital departments and have served as a reference for the creation of standardized nurse education programs in other specialty areas. The 5 regional internal medicine departments created a similar annual competency day program, therein standardizing internal medicine nurse education, using the ED project as a point of reference. Regional nursing education programs have also been replicated in internal medicine (2017), abdominal surgery (2018), orthopedic surgery (2019), and pediatric departments (2020).

Discussion

The rapidly evolving landscape and required skill set for emergency nurses requires organizations to identify unique and innovative solutions for lifelong learning. The Region Zealand emergency nursing education collaboration demonstrates a unique approach to a common challenge faced by nurses globally. Utilizing a strategic approach, which incorporated regional stakeholders and international partners into a collaborative project leadership structure, Zealand was able to develop a sustainable competency-based education framework designed and implemented to support emergency nurses, trainers, and leaders in the delivery of high-quality evidence-based care.

The education collaboration had 3 core objectives: (1) to elevate nursing practice, (2) to develop a sustainable continuing education framework, and (3) to standardize training and nursing practice across the 4 Zealand emergency departments. It achieved these goals via an international collaboration and a multi-phased strategic approach to project implementation.

The international collaborative strategic approach that guided the program development used best practices to achieve these goals. A literature search of international emergency medicine project literature identified 3

recommended best practices for program success and institutionalization.[23] These 3 best practices are the following: the use of the train-the-trainers model in program design,[22] use of standardized educational content as a basis for curriculum planning,[21] and use of preprogram needs assessments as a basis for program design and implementation.[10] As demonstrated in the sections above, this collaboration incorporated all 3 of these best practices, and the result was project success and institutionalization. It is reasonable to conclude that international collaborations that use the aforementioned best practices may be a beneficial model to facilitate and expedite the development of emergency nursing education programs.

Also critical to achieving the above-noted outcomes was the use of a multi-phased strategic approach to project implementation, which included a needs assessment, curriculum development, train-the-trainer, and supported project launch. In addition, regional alignment and early stakeholder engagement were critical to gaining overall momentum and support for the project.

In terms of benefits of a standardized regional program, through this collaboration, project leadership saw that an initial investment offered by a regional health care system subsequently yielded efficiency and economy. The collaboration between the 4 hospitals allowed them to share resources, thereby reducing the workload of any 1 hospital bearing the burden of developing independent education. Sharing equipment, curriculum, trainers, and educational materials can reduce combined spending and workload; it can also result in high-quality nursing education and lead to program success.

The identification and dissemination of best practices to address nurses' continuing education and competency needs are critical to the advancement of the profession and the patients and communities that the emergency nurses serve. The outcome of this collaboration was the design and implementation of a sustainable competency-based education framework that included key education, training, and evaluation tools to support both emergency nurses and leaders in the pursuit of high-quality care across Zealand. Given the adoption and success of this program, the authors strongly believe in the transferability of this regional project to similar projects in other countries, regions, or health care systems. As already demonstrated with the replication of this model leading to the creation of 4 other regional nursing education programs in Zealand (internal medicine [2017], abdominal surgery [2018], the orthopedic surgery [2019] and the pediatric departments [2020]), the transferability of the described program is high.

The 5-phase approach outlined above provides emergency nursing colleagues, working within a health care system with a generalizable strategic approach to collaborative educational program development, from assessment to implementation. The framework was designed and outlined in detail for easy replication. The authors believe that the process, collaborative and consensus-based in nature, which takes advantage of existing system resources, would function in other environments that share similar challenges related to continuing education and competence management.

Implications for Emergency Clinical Practice

Recommendations for translating the findings of this paper into emergency clinical practice include the following:

••Innovative and collaborative approaches to standardizing emergency nursing education across a health care system or region can result in high-quality nursing education and can lead to program success.

••Investment in training and education for emergency nurses across a region or system ensures that consistent high-quality nursing care is available to all patients.

••Leveraging system or regional resources, such as equipment and trainers, may reduce the overall burden and challenges both fiscally and operationally associated with independent education programs.

••International collaborations that use best practices such as use of standardized, internationally recognized educational content, use of a train-the-trainers model throughout program implementation, and use of a comprehensive preprogram needs assessment may be a beneficial model to facilitate and expedite the

development of emergency nursing education programs.

••The transferability of the described program is high and has been found to be easily replicable. The program model can be used for future regional or system-wide collaborations.

Conclusion

The challenges related to providing continuing education and competence management for emergency nurses are not unique to any 1 organization, health system, or geographic location. These shared challenges, in addition to a desire to ensure high-quality practice of emergency nursing, were the catalyst for an international collaboration to design a competency-based education framework to support high-quality emergency care in Region Zealand. In 18 months and through an international collaboration, emergency nurse education, training, and evaluation tools were developed and integrated into 4 regional emergency departments. The annual competency day program has continued through 2021 and, now fully institutionalized within regional emergency nursing education, has expanded to include education in other regional nursing specialties. Through this unique collaboration with regional and international participants, a sustainable education program was developed that has elevated and standardized the practice of emergency nurses in Region Zealand. This collaboration and project can also be used as a model for future nurse education development projects across multiple departments.

Author Disclosures

Conflicts of interest: none to report.

Appendix Supplementary materials

SUPPLEMENTARY APPENDIX 1 Nurse self assessmentImage, application 1SUPPLEMENTARY APPENDIX 2 Tool-kit sampleImage, application 2SUPPLEMENTARY APPENDIX 3 Post program (modified) self-assessment toolImage, application 3SUPPLEMENTARY APPENDIX 4 Change management formImage, application 4SUPPLEMENTARY APPENDIX 5 Post-program (skills stations) evaluationSubmissions to this column are encouraged and may be submitted at jenonline.org where submission instructions can be found in the Author Instructions.Image, application 5

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jen.2021.08.006.

Image, table 1

Image, table 2

DETAILS

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Considerations for Collaborations: International Nursing Continuing Professional Development: JEN

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ABSTRACT (ENGLISH)

Efforts to standardize continuing professional development (CPD) activities will assist in achieving baseline competency in a rapidly changing health care environment, no matter the geographical location. [...]the Nursing Council of Hong Kong defines CPD as "...any post-registration/post-enrollment educational skill or experience updating which is nursing-specific or health care related with an aim to enrich the nurses' contribution to quality health care and help them in their pursuit of professional goals,"4 whereas nursing CPD is defined by the American Nurses Credential Center (ANCC) as an educational activity that builds upon the educational or experiential knowledge of a professional registered nurse.5 The administrative bodies, generally referred to as regulators, of nursing and midwifery professional practice have a strong voice in the regulation of practice and have used this influence to motivate and inspire specific CPD requirements.6 Some studies have called for specific CPD requirements for advanced practice nurses and midwives, especially in pharmacology.7 Regardless of the regulatory body over nursing practice in a particular region, flexibility toward professional development, especially during this pandemic, is necessary.8 Knowing and understanding nurses' professional practice needs and development requires awareness and perspective of the particular health care landscape.Perspective Outside the United States Nursing CPD can mean several different things throughout the world. Under this regulatory body, the Professional Development Committee advises the Nursing Council on many things, including the authorization of CPD providers, their educational activities, and their performance.12 To maintain nursing licensure, nurses must accumulate a minimum of 45 CPD points every 3 years.4 These different regulatory models, of which there are many more, do have some elements in common. Just as significant is the desire for collaboration among nurses, midwives, or other health care providers to develop high-quality nursing education within their country or region.Lessons Learned Through Successful International Collaboration Sigma Theta Tau International Honor Society of Nursing (Sigma), founded in 1922 by 6 nurses at the then Indiana University Training School for Nurses in Indianapolis, IN, is an international nursing organization.

FULL TEXT

In the January 2022 issue of the *Journal of Emergency Nursing*, Calder et al[1] discuss the development of emergency nursing educational activities within Denmark. Efforts to standardize continuing professional development (CPD) activities will assist in achieving baseline competency in a rapidly changing health care environment, no matter the geographical location. The World Health Organization recently called for an increased

expansion of CPD processes.[2] Many countries link CPD to academic progressions and nurse credentialing[3]; however, there are varying definitions. For example, the Nursing Council of Hong Kong defines CPD as "...any post-registration/post-enrollment educational skill or experience updating which is nursing-specific or health care related with an aim to enrich the nurses' contribution to quality health care and help them in their pursuit of professional goals,"[4] whereas nursing CPD is defined by the American Nurses Credential Center (ANCC) as an educational activity that builds upon the educational or experiential knowledge of a professional registered nurse.[5]

The administrative bodies, generally referred to as regulators, of nursing and midwifery professional practice have a strong voice in the regulation of practice and have used this influence to motivate and inspire specific CPD requirements.[6] Some studies have called for specific CPD requirements for advanced practice nurses and midwives, especially in pharmacology.[7] Regardless of the regulatory body over nursing practice in a particular region, flexibility toward professional development, especially during this pandemic, is necessary.[8] Knowing and understanding nurses' professional practice needs and development requires awareness and perspective of the particular health care landscape.

Perspective Outside the United States

Nursing CPD can mean several different things throughout the world. This often depends on the regulatory body for the country, territory, or providence. Some ministries of health, nursing organizations, and nursing and midwifery councils have developed and provided their own regulation around continuing education of health care professionals. Still others rely on other governmental agencies to develop, monitor, and enforce nursing care models.

In the Republic of Ireland, CPD is regulated by the Nursing and Midwifery Board of Ireland (NMBI).[9] Multiple types of organizations can develop CPD activities. The activities require review and approval through the NMBI to be valid and accepted for nursing professional development.[10] The evaluation process is less formal in the Republic of Ireland. Evaluating educational activities is at the discretion of the developer who provides the educational content. Some activities that provide educational content and support for nurses and midwives are not considered professional development and are not approved through the NMBI. These activities may include mentorship, journal clubs, and case reviews. At present, the NMBI does not require nurses and midwives to provide evidence of participation in CPD to maintain their annual registration.[10]

Canadian nurses are not regulated by a national nursing licensure body. They are accountable to the province or territory in which they practice.[11] Canadian nurses and midwives are self-regulated in their professional responsibility, meaning they are not required to obtain a specific number of CPD hours for re-licensure. Each provincial and territorial regulatory body has continuing competency programs that nurses use to demonstrate their competence,[11] such as a portfolio, instead of CPD activities or a specific number of required hours.

In Hong Kong, nursing practice is regulated by the Nursing Council of Hong Kong. Under this regulatory body, the Professional Development Committee advises the Nursing Council on many things, including the authorization of CPD providers, their educational activities, and their performance.[12] To maintain nursing licensure, nurses must accumulate a minimum of 45 CPD points every 3 years.[4]

These different regulatory models, of which there are many more, do have some elements in common. Most notable is management and influence over the educational content that counts toward nursing re-licensure. Just as significant is the desire for collaboration among nurses, midwives, or other health care providers to develop high-quality nursing education within their country or region.

Lessons Learned Through Successful International Collaboration

Sigma Theta Tau International Honor Society of Nursing (Sigma), founded in 1922 by 6 nurses at the then Indiana University Training School for Nurses in Indianapolis, IN, is an international nursing organization. Sigma's mission is to develop nurse leaders anywhere, in order to improve health care everywhere.[13] With more than 135 000 members in more than 110 countries, Sigma has a unique vantage point and much experience collaborating with nurses from around the world.

Sigma has gained valuable insights into international collaboration by developing and delivering educational

programming such as online CPD courses, leadership development programs, webinars, and in-person and virtual conferences. Sigma's history of international collaboration also involves the publications of books and peer-reviewed journals. The in-person and virtual conferences feature multiple educational topics, including research, evidence-informed practices, creating healthy work environments, and many more with the presence of international partners. Sigma has a presence at and works with the United Nations and collaborates with its many international chapters, committees, and task forces.

Collaborative projects result in higher quality and satisfaction when expectations by and for all involved parties are clear. When setting expectations, it is important to establish a timeline that includes cultural considerations for holidays and vacations. In the US, "taking a vacation" does not mean the same thing as in Europe or Australia when someone is "going on holiday." Both are used to describe taking time off from work with a high probability of traveling during that time. However, in the US, the word "holiday" generally refers to a short period of time away from work, 1 or 2 days perhaps, and is generally tied to a national or religious event, frequently involving celebrations and feasts. These days are often bank holidays, originally designated by the government and when banks were closed. If someone is "going on holiday" for a month, they may not be checking their work email or phone. These differences in terminology and expectations should be considered in project timelines.

There are other considerations regarding religious holidays to take into consideration as well. While asking about religious preferences may not be a routine part of leading a project or committee, asking about holidays or observances should be considered. For example, the Muslim faith observes prayer 5 times a day. When scheduling an all-day meeting or orientation, consider asking about ideal times to take a break from working. In 2014, Sigma hosted its annual International Nursing Research Congress in Hong Kong. During this event, Sigma held its onsite Career Center, an opportunity for participants to meet with career advisors to discuss various topics. As privacy was an issue in this particular culture, partitioned screens were needed in between the participants to protect their privacy.

Considerations for general working days and schedules may also need to be considered. For example, in many countries in the Middle East, typical workdays are Sunday through Thursday. Differences in time zones and dates need to be clarified if you are working with countries such as Australia that may be 12 to 16 hours ahead of US time zones. Projects that involve nursing schools with faculty in academia should consider the academic calendar. The traditional academic calendar in the US is August or September through May or June. In New Zealand and Brazil, the academic calendar is generally from March through November or December.

In addition to planning when you will collaborate, it is also important to consider how you will communicate. Discuss the platform that works best for all individuals involved. Although video streaming meetings have become very common, the Wi-Fi capabilities in some areas may not be able to support the speed necessary to have seamless communication. A broken connection combined with English not being someone's first language or accents could contribute to members of a group feeling disengaged. Consider using closed captioning during meetings, setting expectations to utilize a microphone, reducing background noise by utilizing mute functionality when not speaking, and sending documents well in advance, in case translation is needed.

When beginning an international collaboration, it is important to understand even some of the most basic terms and come to an agreement on what terminology should be used. The titles, qualifications, and preparation to become a nurse and the scope of practice can look very different in many cases. In Nigeria, a chief nursing officer may be a clinically practicing nurse with extensive experience, and the term clinical is used rather than bedside. It is also helpful to understand the preparation for working with nurses in various countries. In the US, nurses are prepared as generalists and can then begin caring for individuals wherever they choose to work. This is not the case in other countries. In Finland, nurses specialize in pediatric nursing, acute care nursing, or mental health nursing. Once their training as pediatric nurses has been completed, nurses are only credentialed to care for that population and require additional training for other areas. This is the same for nurses in the United Kingdom, Saudi Arabia, Italy, Indonesia, Chile, and many more.

Scope of practice can vary between countries. Unlike the US, in Australia, nurses are legally able to independently

prescribe and administer vaccinations in most (but not all) jurisdictions. The same is true for childhood immunizations in the United Kingdom. Many other countries, including Denmark, Sweden, Iceland, Kenya, and Columbia, have some level of prescribing authority for nurses. The Advanced Practice Nurse prescribing authority model in the US may be most similar to the models in Singapore, South Korea, and Taiwan.[14]

Conclusion

As our health care environment rapidly changes, so do the continuing educational needs of nurses and midwives. Interdisciplinary and international collaboration is essential during the current pandemic. We recognize and applaud the authors for their work and program development. We see where their efforts could serve as a model for future emergency nursing collaboration among countries. We also hope that our lessons can be passed along to others to make their international partnerships even more successful.

DETAILS

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National Estimates of Workplace Telehealth Use Among Emergency Nurses and All Registered Nurses in the United States: JEN

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ABSTRACT (ENGLISH)

Introduction

The goal of this research was to quantify the baseline status of prepandemic workplace emergency nursing telehealth as a key consideration for ongoing telehealth growth and sustainable emergency nursing care model planning. The purpose of this research was to: (1) generate national estimates of prepandemic workplace telehealth use among emergency and other inpatient hospital nurses and (2) map the geographic distribution of prepandemic workplace emergency nurse telehealth use by state of nurse residence.

Methods

We generated national estimates using data from the 2018 National Sample Survey of Registered Nurses. Data were analyzed using jack-knife estimation procedures coherent with the complex sampling design selected as representative of the population and requiring analysis with survey weights.

Results

Weighted estimates of the 161 865 emergency nurses, compared with 1 191 287 other inpatient nurses revealed more reported telehealth in the workplace setting (49% vs 34%) and individual clinical practice telehealth use (36% vs 15%) among emergency nurses. The geographic distribution of individual clinical practice emergency nurse telehealth use indicates greatest adoption per 10 000 state residents in Maine, Alaska, and Missouri with more states in the Midwest demonstrating emergency nurse adoption of telehealth into clinical practice per population than other regions in the United States.

Discussion

By quantifying prepandemic national telehealth use, the results provide corroborating evidence to the potential long-term adoptability and sustainability of telenursing in the emergency nursing specialty. The results also implicate the need to proactively define emergency nursing telehealth care model standards of practice, nurse competencies, and reimbursement.

FULL TEXT

DETAILS

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Is Your Trauma Center Peds Ready?: JEN

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ABSTRACT (ENGLISH)

Injury remains the leading cause of death for children age 1 to 18 years, yet the initial care of most injured children also takes place in emergency departments primarily designed and equipped to treat adults.5 The results of recent studies have shown that even trauma centers are inconsistent in their level of readiness to care for children.6,7 For example, while the majority of trauma centers have a tool to use for precalculated pediatric drug dosing, many lack other important parameters such as recording pediatric weights in kilograms only and the presence of a quality improvement process that includes pediatric-specific metrics.6 A recently published study of injured children brought to 832 emergency departments in US trauma centers was the first to dig deeper and evaluate the association between pediatric readiness of emergency departments verified as trauma centers (as per the 2013 NPRP nationwide assessment), in-hospital mortality, and in-hospital complications.7 In the study of over 372 000 injured children, receiving initial care in an emergency department that had a pediatric readiness score within the highest quartile of readiness was associated with 42% lower odds of death. The authors concluded that if all the children included in the study had been treated in emergency departments in the highest quartile of readiness, an additional 126 lives (95% confidence interval 97-154 lives) might have been saved in each of the 6 years for which data were collected.7 That is over 700 children's lives that might have been saved if the trauma centers had all invested the time and resources required to better prepare for stabilizing pediatric emergency care! The presence of a PECC has been identified as the single most important factor that influences the readiness of any emergency department that cares for pediatric patients.10 The 2018 American Academy of Pediatrics Committee on Pediatric Emergency

Medicine and Section on Surgery, American College of Emergency Physicians Pediatric Emergency Medicine Committee, and Emergency Nurses Association Pediatric Committee Joint Policy Statement, "Pediatric Readiness in the Emergency Department,"9 identified the presence of 2 PECCs, one a physician and one a nurse, as central to the readiness of any emergency department that cares for children. "Implementing a Novel Nursing Site Manager Role in the Pediatric Emergency Department for Patient and Staff Safety during the COVID-19 Pandemic,"12 published in this current issue of the Journal of Emergency Nursing (JEN) described the way the Boston Children's Hospital emergency department pivoted quickly at the onset of the pandemic to meet the specialized needs of their multidisciplinary staff during this time, while ultimately also benefiting their pediatric patients.

FULL TEXT

DETAILS

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Remote Advance Care Planning in the Emergency Department During COVID-19 Disaster: Program Development and Initial Evaluation: JEN

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ABSTRACT (ENGLISH)

Background

The coronavirus disease 2019 pandemic caused an unprecedented surge of patients presenting to emergency departments and forced hospitals to adapt to provide care to patients safely and effectively. The purpose here was to disseminate a novel program developed under disaster conditions to address advance care planning communications.

Methods

A program development and initial evaluation was conducted for the Remote Goals of Care program, which was created for families to communicate patient goals of care and reduce responsibilities of those in the emergency department.

Results

This program facilitated 64 remote goals of care conversation, with 72% of conversations taking place remotely with families of patients who were unable to participate. These conversations included discussions of patient preferences for care, including code status, presence of caregivers or surrogates, understanding of diagnosis and prognosis, and hospice care. Initially, this program was available 24 hours per day, 7 days per week, with gradual reduction in hours as needs shifted. Seven nurses who were unable to work in corona-positive environments but were able to continue

working remotely were utilized. Lessons learned include the need for speed and agility of response and the benefit of established relationships between traditionally siloed specialties. Additional considerations include available technology for patients and families and expanding the documentation abilities for remote nurses. A logic model was developed to support potential program replication at other sites.

Discussion

Upon initial evaluation, Remote Goals of Care Program was well received and demonstrated promise in decanting the responsibility of goals of care discussions from the emergency department to a calmer, remote setting. In future iterations, additional services and technology adjustments can be made to make this program more accessible to more patients and families. Other facilities may wish to replicate our Remote Goals of Care Program described here.

FULL TEXT

Contribution to Emergency Nursing Practice

•• The current literature on innovative delivery of health care indicates a growing need for remote and telehealth options, particularly in the context of the novel coronavirus disease.

•• This article contributes an innovative method for utilization of telehealth and remote nursing to engage in goals of care conversations for patients presenting to the emergency department.

•• Key implications for emergency nursing practice found in this article are the utilization of remote nurses to engage in goals of care conversations with families of patients presenting to the emergency department. Due to infection-control restrictions, these families were prevented from accompanying patients to the hospital. Further implications include the reassignment of nurses who could not provide in-person patient care due to coronavirus health restrictions.

Introduction Problem Description

In late 2019, first reports of human transmission and circulation of the severe acute respiratory syndrome coronavirus 2 coronavirus disease 2019 (COVID-19) in Wuhan, China, began to make global headlines.[1] By March 1, 2020, New York City reported its first confirmed case of COVID-19 and quickly became an international hot spot.[2] Throughout the spring of 2020, health care systems across New York were forced to adapt usual operations to accommodate a surge of patients with COVID-19 who required hospitalization and, often, critical care services. These adaptations, including reassignment of clinical providers to areas outside their expertise, resulted in the use of traditionally nonclinical spaces for clinical care and, with limitations on supplies, often placed additional stress on providers in addition to the surge.

Those with pre-existing comorbidities, particularly hypertension, cardiovascular disease, diabetes, and chronic obstructive pulmonary disease, are at increased risk for morbidity and mortality from COVID-19.[3,4] In addition to presence of comorbidities, older age has been identified as a significant risk factor for severe disease and mortality.[5] During the COVID-19 surge in New York, many of the patients presenting to the emergency department were older adults and those with chronic comorbidities. It became imperative during the peak of the pandemic to speak with patients and families and clarify goals of care (GOC) as an early intervention to help avoid unwanted use of scarce resources.

Before the onset of the COVID-19 pandemic, GOC and Advance Care Planning (ACP) discussions, often including family and loved ones, were standard of care for patients presenting to the hospital with multiple comorbidities, advanced illness, or advanced age.[6,7] The addition of the COVID-19 pandemic magnified the need for GOC and ACP discussions as ensuring goal-concordant care and avoiding unwanted intervention became a pressing concern for most health care systems.[8] Traditionally, GOC and ACP discussions can be an iterative process involving

multiple discussions and a significant time investment for clinicians, patients, and families. The COVID-19 pandemic placed additional time and resource pressure on the health care providers who would usually be involved in these conversations because of the increasing volume of high acuity patients presenting to the emergency department. This led to some clinicians being utilized in roles where they did not have specialty training, including GOC conversations. In addition to the limited providers available, most patients in the emergency department were not able to have family accompany them to admission because of a no visitation rule that was put in place to protect patients, families, and staff.

Aims

The implications of this new clinical reality required attempts to find alternative routes to conduct these conversations in an innovative manner. Building upon previous strong relationships between the Division of Geriatrics and Palliative Medicine and the Emergency Medicine Service Line, a Remote GOC Program was established to have these vital conversations and facilitate communication with families during the height of the COVID-19 pandemic.[9,10] The goal of this program was to provide a resource for ACP and GOC conversations for patients who may have been unable to have these conversations and who could not have loved ones present to identify their wishes.

Methods Design

A program development and retrospective evaluation design were used. The health system Institutional Review Board approved this study and waived the need for informed consent. Informed consent waiver was approved by the Institutional Review Board because collection and review of patient data was performed via retrospective chart review.

Setting

This work was conducted in the emergency departments across a large health system in the New York metropolitan area. Because of the remote nature of the program, 12 emergency departments were able to participate simultaneously. Typically, these emergency departments serve approximately 650 000 patients per year combined.

Participants

Participants were included by consult referral at the clinical judgment and discretion of the clinician team providing care in the emergency department between April and June of 2020. Of the patients hospitalized with COVID-19 in this health system, at least half were age 63 years or older, 57% had history of hypertension, and 34% had history of diabetes.[11]

Remote GOC Program

In response to this potential communication barrier introduced by the increasingly busy ED environment, redeployed clinicians, and limited family accompaniment, the Remote GOC Program was developed to continue communication with families of patients in the emergency department to understand the goals and needs of the patients. As a pragmatic choice, this program utilized nurses who were unable to work in COVID-positive environments but could continue working remotely via telehealth to supplement the clinical resources within the emergency departments ([Table 1]). Initially, the program included 7 remote nurses from various specialties, including pain management, medical/surgical, emergency, and operating room nursing. As staffing needs changed in the hospitals, the size of the Remote GOC Program was reduced to accommodate the same. The program began in April 2020 and provided remote GOC support 24 hours per day, 7 days per week, using 7 nurses covering 4.5 full-time equivalent positions. As the first wave of the pandemic began to lessen by June, the remote GOC support was reduced to 16 hours per day, 7 days per week. This phase of the Remote GOC Program utilized 4 nurses to cover 3 full-time equivalents. To support the providers, the registered nurses were given laptops and communication software to remotely guide

conversations with patients' families. The majority of the nurses were not previously trained in end-of-life or GOC conversations, so they were provided training via a prerecorded online course created by the system Geriatrics and Palliative Medicine team. These courses focused on how to have GOC conversations, how to have discussions on end-of-life care and bereavement support, and the importance of advanced directives and health care proxies, particularly in the midst of the COVID-19 pandemic. The materials provided to the remote nurses included context for the workflow within the emergency department, instructions on how to use the secure technology and how to educate families on its use, on-site contact information, and additional resources for ACP support. Owing to the nature of the pandemic surge, the educational materials and workflow were streamlined to allow for quick initiation of the program.

Upon referral for a patient requiring a GOC discussion, the ED team would enter a "Goals of Care" order in the patient's electronic medical record (EMR), including the reason for the conversation ([Figure 1]). As previously described, patients were identified on the basis of the medical judgment of the ED team and their anticipated ACP need. The remote GOC nurses would receive notification of the GOC order and contact the ordering provider to further discuss the purpose of the GOC conversation. Where possible, patients would be involved in the GOC conversations, but there was often limited ability to speak to patients directly, owing to the acuity of their illness and the technology available to patients in the emergency department. If patient communication was limited, nurses contacted family or surrogate decision makers remotely using a Health Insurance Portability and Accountability Act (HIPAA) secure platform or traditional landline phone calls, depending on the preferences and technology available to the families. During these conversations, the nurses discussed the patient's current health and living situation with families, including whether the patient already had some form of advance directive or health care proxy and whether the patient had a caregiver or surrogate. Conversations also included discussion of the patient's current treatment needs, prognosis, diagnosis, whether the family believe the patient would want to complete a Do-Not-Resuscitate (DNR), Do-Not-Intubate (DNI), or Medical Orders for Life Sustaining Treatment (MOLST) form, and whether the patient would be open to hospice services, if medically indicated. After the GOC conversation with patients' families, the remote nurse would contact the ED treating provider to relay the details of the conversations. The remote nurse would also complete the GOC note in the EMR and enter any follow-up needs for the patient, including additional consults, such as social work, case management, palliative care, and hospice services.

Data Collection

Patient information was collected from Allscripts Sunrise Emergency Care, the EMR, in July 2020. Study data were collected and managed using REDCap electronic data capture tools.[12,13] REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources.

Deidentified demographic data were collected from the medical record. Primary outcomes included details of early GOC discussion in emergency departments and disposition after GOC discussions. GOC were defined as Code Status, with options being DNR and/or DNI, and Full Code (cardiopulmonary resuscitation and intubation desired). Other potential topics of discussion during these conversations included appointment of a health care proxy, diagnosis, treatment, prognosis, chaplaincy, and hospice.

Analysis and Evaluation

Owing to the disaster context in which this program was initiated and the retrospective nature of data collection, the study was not designed to provide analysis on statistically significant changes for patient outcomes. To provide

context for the patients who were included in the program, demographic details and descriptive statistics are reported. As changes in health outcomes cannot be reported, this program was evaluated on the basis of the logic model provided in [Table 1].

Results

We included 64 patients for whom a health care professional was consulted to have a remote GOC conversation between April and June 2020. Across the health system, all 64 patient records were reviewed and included for analysis. [Table 2] presents the demographic characteristics and patient information upon presentation to the emergency department. Sixty-three percent of patients who received remote GOC conversations were female, and almost 70% were aged 75 years or older. Just under half of patients (42%) presented from a communal living residence, including skilled-nursing or assisted-living facilities. About half of patients were confirmed or suspected COVID-19 positive, and although there were instances of patient involvement in the remote GOC conversations (8%), most conversations were with family (72%). Before presentation in the emergency department, 48% of patients already had some form of advance directive documentation. Of the patients residing in a skilled-nursing or assisted-living facility, 51% presented to the emergency department with advance directive documentation.

[Table 3] outlines the course and outcomes of the GOC conversations and the topics covered with patient families. Most GOC conversations involved discussion of DNR, DNI, and/or MOLST; fewer conversations involved discussion of the patient's diagnosis, treatment, and prognosis. After discussion of DNR/DNI and MOLST, 34% of patients completed a health care proxy, although a majority of these patients had a previous form of advance directive, and 48% of patients remained Full Code. Only 6% of discussions involved the offering of chaplaincy services, and 20% involved discussion of hospice.

[Table 4] presents the disposition outcomes for the patients who received remote GOC conversations upon presenting to the emergency department. Eighty percent of patients were admitted to the hospital, 8% died while in the emergency department, and 10% were discharged from the emergency department directly to inpatient or home hospice. Of the patients admitted to the hospital from the emergency department, 28% expired before discharge, 28% were discharged to a skilled-nursing or assisted-living facility, and 19% were discharged to inpatient or home hospice ([Figure 2]). Of the patients who died during hospitalization, 55% remained Full Code after the GOC conversation with the remote nurse. Of all patients who had remote GOC conversations, 28% were discharged to hospice either from the hospital or directly from the emergency department.

Discussion

The COVID-19 pandemic forced hospitals and health systems to create innovative solutions to provide high quality patient care while in the midst of an unprecedented crisis. The Remote GOC Program was created to continue vital GOC discussions for patients and families while restrictions on family visitation and provider time and resources were mounting. As the majority of patients were not able to participate in the GOC conversations owing to the acuity of their illness, fast and open communication with families was vitally important. This program relied heavily on the relationship between the Division of Geriatrics and Palliative Medicine and the Emergency Medicine Service Line that was created before the pandemic. This relationship was vital to creating and running the Remote GOC Program quickly, as there was well-established communication and trust between these traditionally siloed groups. Although this was a nursing-driven initiative, this program provided interdisciplinary benefit across nursing, social work, and ED providers. Although small, this initial, disaster-related program highlighted the strengths and opportunities involved in remote GOC conversations.

A major strength of the Remote GOC Program was the collaborative relationship that allowed for quick setup and decision making. This program required innovative use of personnel and technology that was easily accommodated

through collaboration among health care teams. This program was effective in maximizing staffing ability by using nurses who were not able to safely remain in a patient-facing setting in a new capacity. As an estimated 104.2 per 100 000 nurses experience a work-related injury, this style of telenursing may also serve as a potential option for nurses requiring light-duty assignments.[14] This utilization made the redeployed nurses feel valued, and the staff in the emergency department appreciated the additional help during a busy time. This freed providers in the emergency department to perform procedures and attend to the immediate stabilization needs of the patients while the patient's further GOC were established. In addition, the Remote GOC Program was able to decant the time-intensive and delicate aspects of the GOC conversations from the busy ED environment. By allowing these conversations to occur in the nontraditional but much calmer environment of remote telehealth, they could be deeper and more meaningful toward providing goal-concordant care, as evidenced by the noteworthy proportion of discharges to hospice for these patients. Establishing and documentation of health care proxies were also vitally important for patients who were later admitted to the hospital, as this documentation clarified appropriate contacts at a time when families were unable to visit patients in the hospital.

As hospitals and emergency departments begin to transition back to prepandemic operations, this Remote GOC Program can continue to be useful for patients presenting to the emergency department who would benefit by GOC conversations before inpatient admission. Although these conversations can be lengthy, they are important for directing decision making and connection to appropriate resources directly from the emergency department. This style of remote care provision is also transferable to additional specialties and health care needs. Although telenursing has been utilized in rural communities for some years, the global pandemic has sparked innovations in telenursing and patient care in a way that is more universal.[15-18] This shift toward increased access to telehealth services is in line with previous programs that are able to provide robust patient care at home, including programs for dialysis and palliative medicine.[19,20] This Remote GOC Program and other telehealth-based programs will continue to grow as a viable option for emergency departments as reimbursement for telemedicine evolves and expands.[21,22]

This article provides an outline of a Remote GOC Program implemented in New York during the height of the first COVID-19 surge. This program was able to gather ACP information and provide GOC conversations with detail and nuance. This program was especially valuable during the time that families could not accompany patients to the ED setting to provide context for patient wishes. Although this program was pragmatically implemented and was not designed to show statistically significant changes, future studies should examine whether these conversations improved adherence to goal-concordant care. This program is valuable in that it is easily modifiable and transferable to many settings and specialties and utilizes the telehealth format that will likely continue to grow out of the COVID-19 pandemic.

Limitations

Although the Remote GOC Program was a valuable use of resources during the first surge of the COVID-19 pandemic, there were areas of the program that could be improved upon. First, the technology used was sometimes a significant barrier for patients and families. The communication software utilized by the remote nurses was sometimes difficult to navigate for families outside of the hospital, especially for those who did not have a stable internet connection or familiarity with remote communication software. Within the emergency department, having the remote nurse contact the patient was equally difficult. The hectic ED environment was not conducive to video conferencing, and the patients included in this program were mostly older, with less experience with the needed technology and no family to support them. In addition, patients who had sensory difficulties, including hearing loss, vision loss, or cognitive decline, in addition to their reason for presenting to the emergency department, were less

able to participate in conversations. Even when the remote nurses were able to have GOC discussions with families, the staff within the emergency department was still required to contact the families to give status updates regarding the patient during a particularly tense time. ED staff was also required to complete MOLST documentation within the emergency department, as these forms are still completed on paper and require the presence of the patient or family to complete. Although an electronic MOLST process is available in New York State, it is not currently utilized by the health system. Finally, this program description does not include a comparison group. In addition, chaplaincy services were limited because most of the chaplaincy personnel were not on-site during the initial COVID-19 surge. Only a small portion of patients requested chaplaincy services, and their needs were met through the reduced staffing model available. Future studies should assess the benefit and practicality of remote chaplaincy services for patients who are agreeable.

Although the intention of this program was not to determine the efficacy of an intervention, the lack of a comparison group limits the strength for the current work and the ability to utilize inferential statistics. Similarly, owing to the disaster context in which the program was utilized, we were not able to collect the number of patients and families approached who refused or could not participate. Further studies on program implementation can be structured to include comparison groups and population approached for statistical analysis but hopefully not within the context of a global pandemic.

Conclusion

Overall, the Remote GOC Program was well-received and will be utilized again, should the need arise. In future iterations, preparation of the program should be started as early as possible and can be expanded to other services, including Hospital Medicine and select consult services. The earlier start time and expansion of services will allow for an improvement in training on the technology used and documentation needs. Additional time and comfort with the technology will allow the remote nurses to assist patient families in troubleshooting common connection problems before the GOC conversation and be familiar with alternatives if the primary communication method is unavailable. Additional training on documentation and expansion of documentation access for remote nursing staff would also be helpful. GOC conversations can be very delicate and nuanced discussions that are heightened in the midst of an unexpected public health crisis. Detailed documentation of the GOC conversation will allow providers in the hospital to build on these conversations with patients and families as the patient moves through their disease course. Through this program, remote nurse staff were able to identify additional resources through GOC conversations that may not have been easily accessible without this program, such as hospice care and specialized consults.

Author Disclosures

Conflicts of interest: none to report.

Planned work		Intended results		
Inputs	Activities	Outputs	Outcomes	Impact

•ED and geriatric and palliative medicine partnership•Registered nurses who could not work onsite•Laptops, HIPAA compliant communication platform•Patient baseline code status[*]	•Online training in GOC and end-of-life conversations for remote nurses•Introductory discussions with referring ED providers•Discussions surrounding existing resources (surrogates, caregivers, health care proxies)•Discussions surrounding patient wishes (DNR/DNI, MOLST, chaplaincy, hospice)•Discussions surrounding patient care (diagnosis, prognosis, treatment)	•GOC and end-of-life conversations with patient families•Completed GOC notes in EMR•Number of referrals into the program•Changes in code status[*]	•Increased recognition of the need for GOC conversations•Increased referrals to remote nurses•Discharge to appropriate level of care from the emergency department (hospice, home)•Discharge to appropriate level of care after admission (hospice, SNF, home)	•Long term increase in GOC and end-of-life conversations•Increase in goal-concordant care

Demographic category	N	%
Sex		
Female	40	63
Male	24	38
Age category (y)		
<65	10	16
65-74	10	16
75-84	11	17
85-94	23	36
≥95	10	16
Race		

Caucasian/White	39	62
African American/Black	11	17
Asian	4	6
Other/Multiracial/Unknown	9	14
Participants in conversation		
Family	46	72
Other	11	17
Patient	4	6
Patient and family	1	2
COVID-19 status at time of ED encounter		
Confirmed COVID-19 negative	31	48
Confirmed COVID-19 positive	26	41
Suspected COVID-19 positive	1	2
Unknown	5	8
Patient residence prior to ED present		
Community home	37	58
Skilled-nursing facility/Rehab	23	36
Assisted-living facility/Group home	4	6
Prior advance directive		
Yes	31	48
No	28	44

Activity	N	%
Completed health care proxy	22	34
Have a surrogate	16	25
Have a caregiver	9	14
Discussion of:		
DNR	45	70
DNI	45	70
MOLST	42	66
Treatment	21	33
Diagnosis	20	31
Prognosis	15	23
Hospice	13	20
Chaplaincy	4	6
Remained full code	31	48

Disposition	N	%
ED disposition		
Admission to hospital	51	80
Expired	5	8
Inpatient hospice	5	8
Home	2	3
Home with hospice	1	2

Hospital disposition		
Expired	18	28
Assisted-living facility	4	6
Skilled-nursing facility/Rehab	14	22
Home	7	11
Inpatient hospice	7	11
Home with hospice	5	8

DETAILS

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Over-the-Counter Medication Prescribing in a Pediatric Emergency Department: Health Records Review: JEN

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ABSTRACT (ENGLISH)

Objective

The purpose of this project was to describe patterns in over-the-counter medication prescribing for nonacute patients with Medicaid in a pediatric emergency department. Differences were also tested in visit time and charges between patients with and without over-the-counter medication prescriptions.

Methods

Retrospective chart review of children with Missouri Medicaid presenting to a single site between January 1, 2018 and December 31, 2018 was conducted. Low-acuity patients with common diagnoses were included. Over-the-counter medications prescribed, the cost of prescriptions, the time spent in the emergency department, provider care time, patient age, and the month of visit were extracted. Data were analyzed with descriptive statistics and t tests.

Results

Approximately 37% of children were prescribed over-the-counter medications, most commonly antipyretics. When comparing visits in which an over-the-counter medication was prescribed to visits without an over-the-counter medication prescription, we found no significant difference in the associated charges, total time in the department,

and provider care time.

Conclusion

Over-the-counter medications were prescribed for more than one-third of children cared for in the pediatric emergency department for low-acuity presentations. These visits may represent a substantial area for Medicaid access barriers, system redesign, and cost savings.

FULL TEXT

Introduction

In most states, patients with Medicaid are required to obtain a prescription written by a health care provider to receive Medicaid-paid over-the-counter (OTC) medications from pharmacies.[1] Missouri, the state where we (the authors) practice, is one such a state. Nonurgent visits to the pediatric emergency department (PED) have long served as a safety net for the uninsured and patients with Medicaid to obtain medical care. Patients have relied on the PED for a multitude of reasons, including limited family resources and limited or minimal access to primary care. OTC and prescription drugs often serve as first-line tools for treating many acute and chronic illnesses, making drug coverage an important part of the recipient's care. Requiring a prescription for patients covered by Medicaid to receive common OTC medications free of charge may represent one part of a parent's motivation to go to the PED. Historically, Medicaid was originally enacted through Title 19 of the Federal Social Security Act in 1965[2] to provide public health insurance coverage to millions of low-income Americans. Medicaid eligibility was expanded to include children in the late 1980s and again in the early 1990s.[3] As part of the law, the federal government covers medication costs by offering matching funds to states to support the financing of medications (both prescription and OTC) for Medicaid programs. State participation is voluntary, and currently all states participate in this federal matching funds program for prescription drugs.[4] States who choose to cover OTC medications in their Medicaid programs are eligible to receive federal Medicaid dollars with the requirement that OTC medications must be *prescribed* by an authorized medical provider to access payment.[1] Children enrolled in Missouri Medicaid currently have no co-payment for OTC medication prescriptions but are limited to a preferred list of covered OTC medications that they can receive free of patient charge.[5]

In Missouri, children represent the largest demographic group served by Missouri Medicaid with one-third of all children in the state enrolled.[6] From March 2020 to March 2021 during the coronavirus disease (COVID-19) pandemic, the state of Missouri experienced a 35.5% rise in Medicaid enrollment, the second highest increased enrollment rate in the country.[7] This number may have been affected in part by unprecedented unemployment rates during the pandemic disaster.

According to the Centers for Disease Control and Prevention (CDC), there were 138 million ED visits in the United States in 2017, 20.4% of which were for children younger than 15 years.[8] One-third of visits for patients aged 15 years or younger were triaged as low-acuity Emergency Severity Index (ESI) 4 and 5, with the most frequent reasons for the visit being fever, cough, abdominal pain, skin rash, and nasal congestion.[8] Much of the nonurgent care provided in the emergency department can result in crowding, increased cost, poor health outcomes, lack of continuity of care, and inadequate access to primary care.[9] Rasooly et al[10] evaluated a national sample of ED visits along with the US Census data between 2001 and 2010 and found an increase of 14.4% of ED visits by children over this period.

Children enrolled in Medicaid use the emergency department more commonly than other insured populations. According to the CDC's 2012 National Center for Health Statistics Report, 25% of children covered by Medicaid used the emergency department, whereas uninsured children used the emergency department at 16% and children covered by private insurance at 13%.[11] In 2012, children with Medicaid coverage were more likely to have visited the emergency department by one more visit over a 12-month period compared with the uninsured and those with private coverage for less serious medical complaints.[11] A study by Samuels-Kalow et al[12] found that among Medicaid-insured children, previous use of the emergency department for lower acuity complaints led to an increased frequency of return ED visits for low-acuity reasons. The growing use of emergency departments for

nonurgent child visits contributes to the overall cost of care.[12]

Identifying and overcoming obstacles for patients covered by Medicaid to obtain common OTC medications without the need for a medical prescription may represent one method to reduce the use of PED use for nonurgent visits. Eliminating the need for an OTC medication prescription may reduce the barriers parents experience when trying to provide timely care for their children. We focused on OTC medication prescribing for patients enrolled in Medicaid in a regional children's hospital PED in Missouri. Our goal was to help identify and quantify OTC prescribing among low-acuity Medicaid-insured patients presenting to PED. We compared PED visits in which an OTC medication was prescribed with those in which they were not prescribed; we examined if there were differences in associated charges, total time in PED, and provider care time.

Methods Setting

The study was conducted at an urban, free-standing, Midwestern academic children's hospital with a tertiary care 39-bed PED with an annual volume of more than 70000 patients per year. Patients are triaged according to ESI criteria.[13] The area of the PED reserved for lower acuity (ESI 4-5) patients is staffed primarily by advanced practice registered nurses. Over the course of 2018, 18% of patients seen in the PED were considered nonurgent (ESI 5), whereas 23% were semiurgent (ESI 4). Of the low-acuity patients presenting to the PED during the study period payor type for patients presenting to the PED, 59% had Medicaid/Medicare, 34% had commercial insurance, 6% were self-pay, and 1% of the patients were on hospital financial assistance.

Study Design and Participants

We conducted a retrospective chart review of PED visits for children insured by Missouri Medicaid, aged 2-17 years, who presented between January 1, 2018 and December 31, 2018 and were assigned an acuity level of 4 (semiurgent) or 5 (nonurgent). We included one or more of the following common discharge diagnoses: fever, upper respiratory infection, nasal congestion, constipation, insect bites, seasonal allergies/allergic rhinitis, and diaper rash (see [Supplementary content]). These diagnoses were chosen by author consensus as they are historically some of the most frequent reasons patients are seen in PED lower acuity setting (patients with ESI 4 and 5). Constipation was chosen as it tends to be a lower severity cause of abdominal pain versus abdominal pain in general, which can include bowel obstruction or appendicitis. Children with complex chronic conditions, such as cystic fibrosis, malignancy, sickle cell disease, Hirschsprung's disease, as well as patients with surgery in the past 30 days, were excluded. In addition, patients who left the PED against medical advice were excluded because their data were incomplete. The initial data report showed that 5053 participants met initial parameters. A power analysis was not conducted.[14] A sample size of approximately 500 (10% sampling) was deemed too large to provide sufficient precision for any effects that would be clinically and practically meaningful. Because manual review of the data was also necessary, we determined that 500 was a feasible sample size.

A second data report was generated on the randomly selected sample and the following information was obtained from the electronic medical record: if and which OTC medications were prescribed, patient's time in department in total minutes (calculated from time of check-in to discharge); provider care time (noted from the time the provider assigned themselves to the patient until the patient was electronically discharged); and the demographic variables of age, month of visit, and diagnosis (see [Supplementary content]). Researchers also reviewed the patient's chart to investigate and correct any discrepancies or unclear data. The hospital's financial department provided charge estimates for the visit cost, and pharmacy provided estimated prescription cost.

The Children's Research Institute Children's Mercy Kansas City Institutional Review Board at the hospital approved the study protocol (STUDY00000758).

Statistics

Descriptive statistics were used to describe categorical variables. An independent t test was used to compare groups (OTC medication prescribed vs OTC medication not prescribed) for time spent in the PED, provider care time, and charges associated with the visit.

Results Population

Of the 505 randomly selected visit records, 43 were excluded because of electronic medical record screening errors

(8.5%). The remaining 462 (91%) medical records were included in the study group. The most common discharge diagnosis was fever (44.2% of visits), upper respiratory infections (19.3% of visits), and insect bites (10.4% of visits) ([Figure 1]). Included records were for patients who were aged from 2 to 17 years, with a mean age of 6 years (SD = 3.86). The number of prescriptions for OTC medications was highest during the month of February and lowest during the month of June ([Figure 2]).

OTC Medication Prescriptions

More than one-third (37.2%) of the study group were prescribed an OTC medication. The 3 most common classes of OTC medications prescribed were antipyretics (54.7%), antihistamines (26.7%), and stool softeners (16.3%) ([Figure 3]). In addition, we reviewed charges generated for the visits. The mean charge for a PED visit for ESI 4 or 5 was $365.23. When comparing visits in which an OTC medication was prescribed with visits without an OTC medication prescription, we found no significant difference in the associated charges (t = 0.65, P = .52, 95% CI [-23.14, 45.73]).

Visit Time

The mean time spent in the department was 130.84 minutes if an OTC prescription was provided versus 134.19 minutes if no prescription was given (t = 0.50, P = .62, 95% CI [-9.80, 16.51]). Direct provider care time spent when a prescription was given was 58.97 minutes compared with 55.47 minutes when no prescription was provided (t = −0.75, P = .46, 95% CI [-12.75, 5.73]) ([Table]).

Discussion

More than one-third (37.2%) of our study participants were prescribed an OTC medication. The top 3 OTC medications prescribed were antipyretics, antihistamines, and stool softeners, which is consistent with the most frequent reasons children are seen in the emergency department as described by Rui and Kang.[8] The high frequency of the diagnosis of fever coincides with the approximately 12838493 total claims for generic ibuprofen prescriptions written for patients with Medicaid coverage in 2018.[15] Even though visits in which an OTC medication was prescribed versus visits without an OTC medication prescription did not show a significant difference in associated charges, it is important to consider whether the PED visit could have been avoided entirely if prescriptions for OTC medications were not required. Future studies could help clarify whether a parent's primary reason for bringing their child to the PED was to obtain an OTC medication prescription. Additional (publicly funded) costs relate to the large disparity in charges for OTC medications when filled by a hospital-based pharmacy versus purchased in a retail outlet. For a standard 118-mL bottle of ibuprofen when dispensed from our hospital's pharmacy the Medicaid reimbursement was $22.17 to the pharmacy. Comparatively, the out-of-pocket expense for the same medication at any commercial stores was estimated to be $4.00. For a 188-mL bottle of acetaminophen, the Medicaid reimbursement was $21.18 if dispensed by the hospital pharmacy, and the pay out-of-pocket cost was between $2.88 and $4.00. This has significant implications for the Medicaid program.

There has been increasing interest in ways to reduce avoidable ED use in Medicaid-insured individuals who historically have higher numbers of ED visits.[12] According to Nelson et al,[16] limiting and restricting access to payments for basic medical care (such as OTC medications) may in part explain why many publicly insured patients must seek out nonurgent care centers and emergency departments for their care as opposed to primary care providers. The current requirement necessitating a prescription for the payment for OTC medications can be burdensome, especially for families with no or limited access to transportation and who rely on public transit. Parents may be additionally affected financially owing to missed work, and their Medicaid-insured children would most likely also be absent from day care or school owing to a common virus causing a fever. During this illness, their caregivers must take them to their primary care provider or an urgent care, have a telehealth visit, or be seen in the emergency department to get an antipyretic when they may not have funds to purchase it on their own. This Medicaid requirement for OTC medications places additional burdens on health care systems by increasing the number of patients needing to be served, hence delaying provider accessibility. The state government can play an important role in creating better access to and distribution of OTC medications for children with Medicaid coverage. By reducing patient reliance on prescribing providers to obtain OTC medications, Medicaid may help reduce the potentially avoidable use of the emergency department and primary care visits for such purposes and reduce costs

to the Medicaid program. A few other states have already attempted to find better ways to improve OTC medication access for publicly insured individuals. Recently, during the COVID-19 pandemic, the Ohio Department of Medicaid advised that they will reimburse pharmacies dispensing OTC medications without a prescription to help by "reducing provider burden and opening up access to medications to Medicaid beneficiaries."[17] ArchCare Advantage Health Maintenance Organization Special Needs Plan, a current New York program for Medicare patients provides members with a prepaid OTC card to buy eligible OTC medications and health-related items redeemable at local stores.[18] PeachCare for Kids, the Georgia State Children's Health Insurance Program, allows $12 each month for OTC items with more than 100 items to choose from.[19] Rice Memorial Hospital in Willmar, Minnesota has a dedicated pharmacy-provided vending machine in its emergency department where patients receive a magnetic swipe card from the prescribing provider to access most commonly used drugs.[20] Similar programs could be modeled or modified to help improve access to common OTC medications for pediatric patients enrolled in Medicaid.

Implications for Emergency Clinical Practice

As nursing professionals, we should take an active role in improving health and patient care on a local or national level. As those in the discipline with the most direct patient care contact, nurses provide highly valued ideas, practical and innovative solutions, and especially realistic perspectives to policymakers. Nurses can consider contacting state and federal legislatures and find their local state and federal Medicaid agencies at the corresponding website listed in the reference list.[21]

We encourage emergency nurses to inform their patients enrolled in Medicaid that OTC medications can be obtained by requesting a prescription by their primary care prescribing provider. Nurses can also advocate for medical providers to provide standardized weight-based prescriptions for OTC medications covered by Medicaid for enrolled patients at their well-child or, potentially, specialist visits and to update these prescriptions at each in-person or telehealth visit. Families and caregivers should be encouraged to safely store OTC medications at home for common, non–life-threatening symptoms and educated on how to safely store them. Patients and families would benefit from having these OTC medications easily available at home, especially during busy respiratory seasons or the COVID-19 pandemic.

Future Research

The second phase of our project will focus on surveying parents and guardians with Medicaid coverage who visit the PED regarding their needs and access preferences for obtaining OTC medications. These data, along with what is reported here, will be used as a baseline problem identification and needs assessment for interdisciplinary intervention development and feasibility testing. These interdisciplinary interventions may include pharmacist-led medication supply chains and distribution options. We will also be enlisting our informational technology/medical informatics group to help develop automatic prescription templates that could help provide OTC medication prescriptions at childcare well-visits. Despite our efforts, much more research needs to be done on a larger scale to better evaluate the scope of Medicaid's ability to provide effective and fiscally responsible care to their enrollees.

Limitations

We acknowledge that this study had several limitations. The study was performed at only 1 site and may not have been representative of smaller populations. We were limited in our financial analysis to charges only. Future studies could be devised to calculate true actual costs. The inclusion/exclusion criteria did not represent all Medicaid-covered children who received care at the study site and may have excluded relevant visits with an OTC medication prescription. The visit was the unity of analysis, and it is possible that the same patient may have been to the emergency department on more than 1 occasion. We were unable to test the assumption to whether nonacute patient visits were to obtain an OTC medication prescription owing to the retrospective design.

Conclusion

The article represents a retrospective, descriptive review of patients seen in the emergency department at the study hospital. One-third of the patients enrolled in Medicaid with an ESI of 4 or 5 received a prescription for an OTC medication at the emergency department. Current Medicaid policy requires that a prescription be obtained for an OTC medication for enrolled patients, although these costs appear to be higher than the actual true cost of the

medication. Current OTC medication allocation systems within Medicaid need to be redesigned, thus reducing patient barriers to basic medical care.

Acknowledgments

Author Disclosures

Supplementary Data

Supplemental

Supplementary Appendix

The diagnosis was pull, by code and then by description. We did not pull by HPI or Discharge Instructions, only if it was active at the time of visit.

Query Summary:

(Diagnosis Code Between J00 AND J06.9) (Acute upper respiratory infections)

OR Diagnosis Description Matches pattern Upper Respiratory%

OR Diagnosis Description Matches pattern %Diaper dermatitis%

OR Diagnosis Description Matches pattern %diaper dermatitis%

OR Diagnosis Description Matches pattern Fever%

OR Diagnosis Description Matches pattern fever%

OR Diagnosis Description Matches pattern Constipation%

OR Diagnosis Description Matches pattern constipation%

OR Diagnosis Description Matches pattern Diaper Rash%

OR Diagnosis Description Matches pattern Nasal congestion%

OR Diagnosis Description Matches pattern Seasonal%

OR Diagnosis Description Matches pattern seasonal%

OR Diagnosis Description Matches pattern allergic rhinitis%

OR Diagnosis Description Matches pattern Insect bite%

OR Diagnosis Description Matches pattern Insect%)

Supplementary Data

Time	Prescription not given (n = 290)	Prescription given (n = 172)	Total sample mean (range)	SD	t value	P value
ED provider care time, min	55.47	58.97	56.77 (0-378)	48.77	−0.75	.46
Total time family in PED, min	134.19	130.84	132.94 (0-493)	69.49	0.50	.62

DETAILS

Subject:	Prescriptions; Health care access; Enrollments; Medical records; Medicaid; Patients; Uninsured people; Visits; Chronic illnesses; Hospitals; Health status; Prescribing; Chart reviews; Emergency services; Fever; Abdomen; Constipation; Pediatrics; Prescription drugs; Insurance coverage; COVID-19; Electronic health records; Insect bites; Cost control; Pandemics; Primary care; Pain; Health records; Coronaviruses; Children
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Bibliography

Risk assessment of self-injurious behavior and suicide presentation in the emergency department: An integrative review: JEN. (2022). Journal of Emergency Nursing, 48(1), 57-73. doi:https://doi.org/10.1016/j.jen.2021.10.002

IntroductionGlobally, there is a lack of clarity regarding the best practice to distinguish patients at the highest risk of suicide. This review explores the use of risk assessment tools in emergency departments to identify patients at high risk of repeat self-harm, suicide attempts, or death by suicide.MethodsThe review question ("Does the use of risk assessment tools in emergency departments identify patients at high risk of repeat self-harm, suicide attempts, or death by suicide?") focused on exposure and outcome. Studies of any design were included. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines were used. Study characteristics and concepts were extracted, compared, and verified. An integrative approach was used for reporting through narrative synthesis.ResultsNine studies were identified for inclusion. Two risk assessment tools were found to have good predictive ability for suicide ideation and self-harm. Three had modest prediction of patient disposition, but in one study, the clinical impression of nurses had higher predictive ability. One tool showed modest predictive ability for patients requiring admission.DiscussionThis review found no strong evidence to indicate that any particular risk tool has a superior predictive ability to identify repeat self-harm, suicide attempts, or death by suicide. Best practice lacks clarity to determine patients at highest risk of suicide, but the use of risk assessment tools has been recommended. Nevertheless, such tools should not be used in isolation from clinical judgment and experience to evaluate patients at risk. Education and training to augment risk assessment within the emergency department are recommended.

The effect of music-moving toys to reduce fear and anxiety in preschool children undergoing intravenous insertion in a pediatric emergency department: A randomized clinical trial: JEN. (2022). Journal of Emergency Nursing, 48(1), 32-44. doi:https://doi.org/10.1016/j.jen.2021.10.004

IntroductionIntravenous catheter insertion is a highly invasive medical procedure that causes fear and anxiety in children. This study aimed to analyze the effect of a toy (with music and movement) distraction method on fear and anxiety in children aged 4 to 6 years.MethodsThis experimental, randomized clinical trial used parallel trial design guided by the Consolidated Standards of Reporting Trials checklist. Using simple randomization, eligible children (age 4-6; N = 60) were assigned to the intervention group (n = 30), who received the toy distraction method, or to the control group (n = 30), who received standard care. The Children's Fear Scale was used to evaluate the fear levels, and Children's State Anxiety Scale was used to evaluate anxiety levels. Physiological parameters (pulse, oxygen saturation) and crying time were monitored by the researcher as indicators of fear and anxiety. The chi-square test, repeated measures analysis of variance, Friedman test, t test, the Mann-Whitney U test, Wilcoxon test, and the intraclass correlation test were used for data analysis.ResultsThere was no statistically significant difference in terms of fear and anxiety scores, physiological parameters, and crying time during the procedure between the children in the intervention and control group.DiscussionWe found that this method of toy distraction was not effective in reducing fear or anxiety during the intravenous catheter insertion procedure. Accordingly, we recommend that this distraction method be performed in different age groups and with larger samples in various painful and stressful practices in the future and that comparison be made with various distraction methods.

Board of directors: JEN. (2022). Journal of Emergency Nursing, 48(1) doi:https://doi.org/10.1016/S0099-1767(21)00314-7

NCPD earn up to 11.5 contact hours: JEN. (2022). Journal of Emergency Nursing, 48(1), 117. doi:https://doi.org/10.1016/S0099-1767(21)00328-7

The path ahead and the promise of the future: JEN. (2022). Journal of Emergency Nursing, 48(1), 1. doi:https://doi.org/10.1016/j.jen.2021.09.007

Today, I'm the Chief Nursing Officer at the same hospital and about to embark on my year as the ENA President. ENA continues to be here to support you in many ways: advocating for a healthy nursing work environment, creating

ENA University for your continuing education and skill development, and offering volunteer opportunities to help you grow within the organization. With that goal in mind, if we each push forward down the path toward our highest hopes and aspirations, the momentum of the emergency nursing community will build toward positive change.

Implementing a novel nursing site manager role in the pediatric emergency department for patient and staff safety during the COVID-19 pandemic: JEN. (2022). Journal of Emergency Nursing, 48(1), 13-21. doi:https://doi.org/10.1016/j.jen.2021.07.009

1 Much of the worldwide severe acute respiratory syndrome outbreak was hospital based, and health care workers were a significant portion (37%-63%) of suspected cases in affected countries.2 There are limited data on infection and mortality rate from coronavirus disease 2019 (COVID-19) among health care workers in the United States and around the world. Among 6760 adults hospitalized from March 1 to May 21, 2020, 5.9% were health care providers, with nursing-related occupations (36.3%) representing the largest portion of hospitalized providers.3 In the US and Mexico, health care workers represent 1 in every 7 COVID-19 cases.4 Notably, "these two countries account for nearly 85% of all the COVID-19 deaths among health care workers in the Pan American Health Organization] region.4 This reality, along with the idea that "there can be no patient safety without health worker safety,"5 made it immediately apparent that programs supporting the emergent and unprecedented educational needs of emergency nurses had to be implemented in a rapid, sustainable manner. Key stakeholders involved during the initial development and implementation of the site manager program included hospital-wide biocontainment team leaders, infection control experts, emergency department physician and nursing leadership, and staff nurses, clinical assistants, environmental services, and administrative staff. Because strict isolation was necessary for these patients, site managers enlisted the assistance of child life specialists to help with distraction techniques to decrease the patient's fears and anxiety.

Emergency nurses association position statement: Medication management and reconciliation in the emergency setting: JEN. (2022). Journal of Emergency Nursing, 48(1), 88-93. doi:https://doi.org/10.1016/j.jen.2021.10.003

The three phases of the reconciliation process are imperative to ensure effective medication management and obtaining an as complete and accurate medication history is the first step.2 Medication management and reconciliation in the emergency setting is a collaborative effort between nurses, physicians, pharmacists, and patients to reduce risk for patients in health care settings and at home.1,2,4,8,9,13–15 This process requires that health care providers, including emergency nurses, communicate clearly with patients and their caregivers about the importance of maintaining an accurate medication list.4,13,16 An accurate medication list includes all medications including prescriptions, over-the-counter medications, supplements, herbals, medicinal marijuana, known allergies and last dose. Emergency nurses play an important role in empowering patients to understand the role they play in the medication management process as well as helping them to understanding the potential risks of drug/drug or drug/food interactions.3,13,16,20,36 Emergency nurses can educate patients and/or their caregivers on the importance of maintaining and keeping with them an accurate medication history including, dosage and frequency of all prescriptions, over-the-counter drugs, supplements, medicinal herbs, and other substances.16,20,36 Additionally, emergency nurses are in a position to advocate for best practices in the medication management process to ensure patient safety.ENA Position It is the position of the Emergency Nurses Association that: Triage is intended to rapidly identify life-threatening or high-risk situations. ...]collection of comprehensive medication history can be delayed and performed after the patient is stable. When first announced, there was little direction as to the who, what, when, where, and how to complete the process, which led to, and continues to create, confusion among emergency nurses and other health care providers.18,37 As initially defined by TJC, the process of medication reconciliation was intended to reduce discrepancies and prevent medication errors but was complex, laborious, and did not necessarily result in accurate information.18,19 Because of difficulty in implementation the lack of proven strategies for success TJC, in 2011, suspended the original NPSG and incorporated medication reconciliation into NPSG number 3.1 This safety goal acknowledges the challenges of reconciliation yet still requires a "good faith effort" to obtain a medication history (the first step) on arrival and then comparing it with those medications that are prescribed (the reconciliation stage).

Commentary on "Remote advance care planning in the emergency department during COVID-19 disaster: Program development and initial evaluation": JEN. (2022). Journal of Emergency Nursing, 48(1), 7-9. doi:https://doi.org/10.1016/j.jen.2021.10.007

Novel applications of telehealth exploded during the pandemic.1 From virtual acute care visits to virtual triage and home visits and telehealth via ambulances, synchronous and asynchronous telehealth etched a permanent place in the emergency care specialty.2 In this edition of the Journal of Emergency Nursing (JEN), Liberman et al3 explore a pragmatic telehealth program developed to take the heavy, bedside end-of-life discussion away from the front-line staff and offload it to a trained group of nurses via telehealth. The program developed a system by which the bedside team could alert the remote palliative care providers to engage the family in end-of-life decisions.4 These included DNR/DNI, MOLST, health care proxy discussions, and disposition. Considerations on supporting the entire health care workforce included providing work during quarantine, providing offsite work to those health care workers at higher risk of contracting severe COVID-19, and providing a channel to support both the emotional needs of the emergency health care workers at the bedside and the need to work for those sidelined; this program was ideal.

Prevalence of prolonged length of stay in an emergency department in urban denmark: A retrospective health records repository review: JEN. (2022). Journal of Emergency Nursing, 48(1), 102.e1-102.e12. doi:https://doi.org/10.1016/j.jen.2021.08.005

IntroductionProlonged length of stay in emergency departments is associated with increased hospitalization, hospital-acquired pressure ulcers, medication errors, and mortality. In acute admissions in Denmark in 2018, 67% of patients experienced waiting time from arrival to examination. This study aimed to estimate the prevalence of prolonged length of stay (≥6 hours) and identify risk factors related to input, throughput, and output components.MethodsA retrospective health records repository review included 4743 patients admitted to a single urban emergency department in Denmark in January 2019. Data collected from the electronic health record system repository included demographic and organizational characteristics and were analyzed using descriptive statistics and logistic regression.ResultsAmong patients admitted in the study period, 31% had a prolonged length of stay of ≥6 hours. Prolonged length of emergency department stay was associated with being female (male odds ratio OR], 0.86; 95% confidence interval CI], 0.75-0.98), treatment by medical service (OR, 4.25, 95% CI, 3.63-4.98) vs surgical or injury, triage acuity of 2-Orange (OR, 1.45; 95% CI, 1.18-1.78) or 3-Yellow (OR, 1.47; 95% CI, 1.23-1.75) on a 5-level scale, evening (OR, 1.44; 95% CI, 1.24-1.66) or night (OR, 2.36; 95% CI, 1.91-2.91) arrival, ages 56 to 80 (OR, 1.79; 95% CI, 1.52-2.11) and >81 (OR, 2.40; 95% CI, 1.99-2.88) years, and hospital admission (OR, 1.19; 95% CI, 1.04-1.38) vs discharge from the emergency department to home.DiscussionFemale, elderly, and medical patients were each identified as at-risk characteristics for ≥6-hour length of stay in the emergency department. Acute care patient pathways in the emergency department, particularly for evening and night, with guideline-based care and system level improvements in patient flow are warranted. Further research with larger populations is needed to identify and support interventions to decrease prolonged length of stay.

Experience of violence and factors influencing response to violence among emergency nurses in south korea: Perspectives on stress-coping theory: JEN. (2022). Journal of Emergency Nursing, 48(1), 74-87. doi:https://doi.org/10.1016/j.jen.2021.07.008

IntroductionThis cross-sectional study aimed to explore the experiences of workplace violence involving emergency nurses and to identify the factors influencing the response to violence on the basis of the stress-coping theory formulated by Lazarus and Folkman.MethodsUsing a cross-sectional design, a structured questionnaire was administered to measure the experience of violence, perceived stress, coping actions after violence, resilience (Connor-Davidson Resilience Scale), and responses to violence. The participants were 131 nurses who were working in the emergency departments in 9 of 11 general hospitals in 2 cities in South Korea. The collected data were analyzed using descriptive statistics, t tests, analyses of variance, Pearson correlations, and hierarchical multiple regression analyses.ResultsThe most frequent type of violence was verbal violence, and the main offender involved in all types of violence was the patient. The methods for coping with violence were mainly passive, and emotional responses were the most frequently reported response to violence. In the final model (explanatory

power = 41.5%), with response to violence as the dependent variable, the effects of the experience of violence disappeared, and only the effects of perceived stress and resilience remained.DiscussionThe results of this study suggest that internal factors such as perceived stress and resilience have a more meaningful effect on the response to violence than the experience of violence itself. The findings are expected to serve as assessment data for preparing interventions and policies around prevention of, and effective coping regarding, workplace violence toward emergency nurses.

A framework for standardizing emergency nursing education and training across a regional health care system: Programming, planning, and development via international collaboration: JEN. (2022). Journal of Emergency Nursing, 48(1), 104-116. doi:https://doi.org/10.1016/j.jen.2021.08.006