

ED Fast Track Services at ENH

A Little bit of history

- Fast track concept initiated in 1998: Goal? Get patients in and out “fast”
- Stats after one year? Fast track was actually “slow track”, with less than 20% of patients in and out in 60 minutes
- In October 1997, 2 NPs replaced the resident, RN and tech that usually staffed the Fast Track

Staffing 2005

- We currently have 9 FT , 2 PT and 10 RT
- We cover all 3 hospitals (EV, GB and HP)
- At least 12 hours per day

What we typically see in Fast Track

- Lacerations
- HEENT
- URIs, UTIs, STDs,
- Rashes, burns, bites
- Needlesticks
- Extremity injuries (excluding those that require conscious sedation)

2005: our role expanded into the main treatment area at GB

- See all ED patients (emergent and urgent)
- * Huge staff satisfier
- Great learning opportunities
- Educational needs : MDs have mentored

Lessons learned along the way.....

keep track of what you do-always

Productivity --- Why Bother?

CALVIN AND HOBBS



I CAN'T IMAGINE
MASTERING THE SKILLS
INVOLVED HERE
WITHOUT A CLEARER
UNDERSTANDING OF
WHO'S GOING TO BE
IMPRESSED.



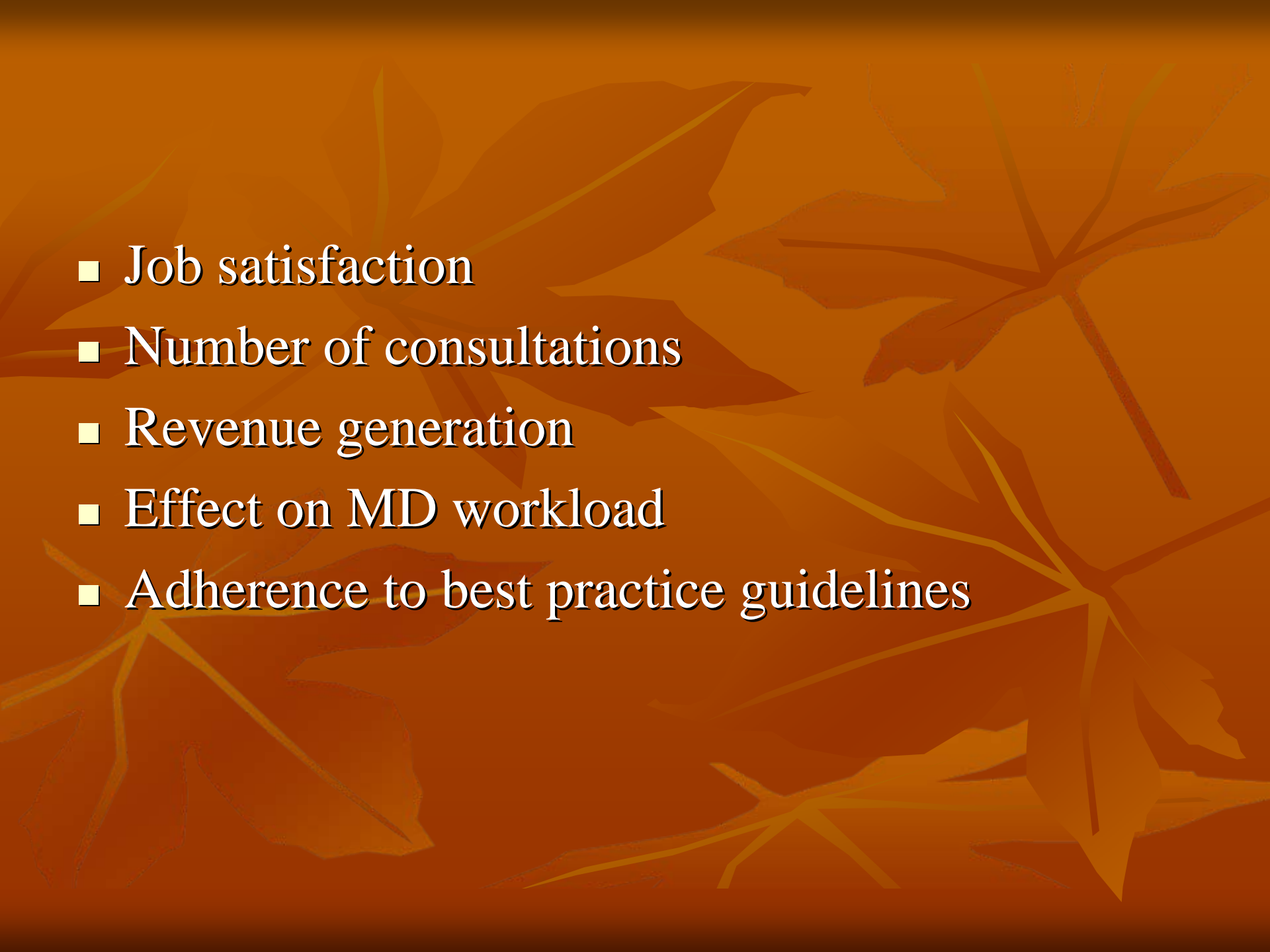
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WFS

Productivity: what to measure?

- Cost
- Length of stay
- re-admission rates
- Patient satisfaction
- Wait time

- 
- Job satisfaction
 - Number of consultations
 - Revenue generation
 - Effect on MD workload
 - Adherence to best practice guidelines

How to measure?

- *prospective-keep track on a daily basis
- *your own “small business”
- *Communicate your findings regularly
- *will help you trouble shoot challenges

For example...

- 1999..FT times were on the rise...why?
- Tracked time to room, time to radiology, etc
- Found that radiology TAT 50 minutes
- Presented that info to administration
- Additional help given to decrease Radiology TAT to approximately 15 minutes!!

Who should measure?

- *ALL OF US*
- EPIC and the clarity reports...will help us track what we do
- Administrators need information from us (productivity, outcome measures) in order to support what we do
- We are the best ones to tell our story

Patient Satisfaction Survey



Evanston Hospital

EMERGENCY DEPARTMENT SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS [write in answer or fill in circle (for example ●) as appropriate]

1. Time spent in the Emergency Department:

05
hours

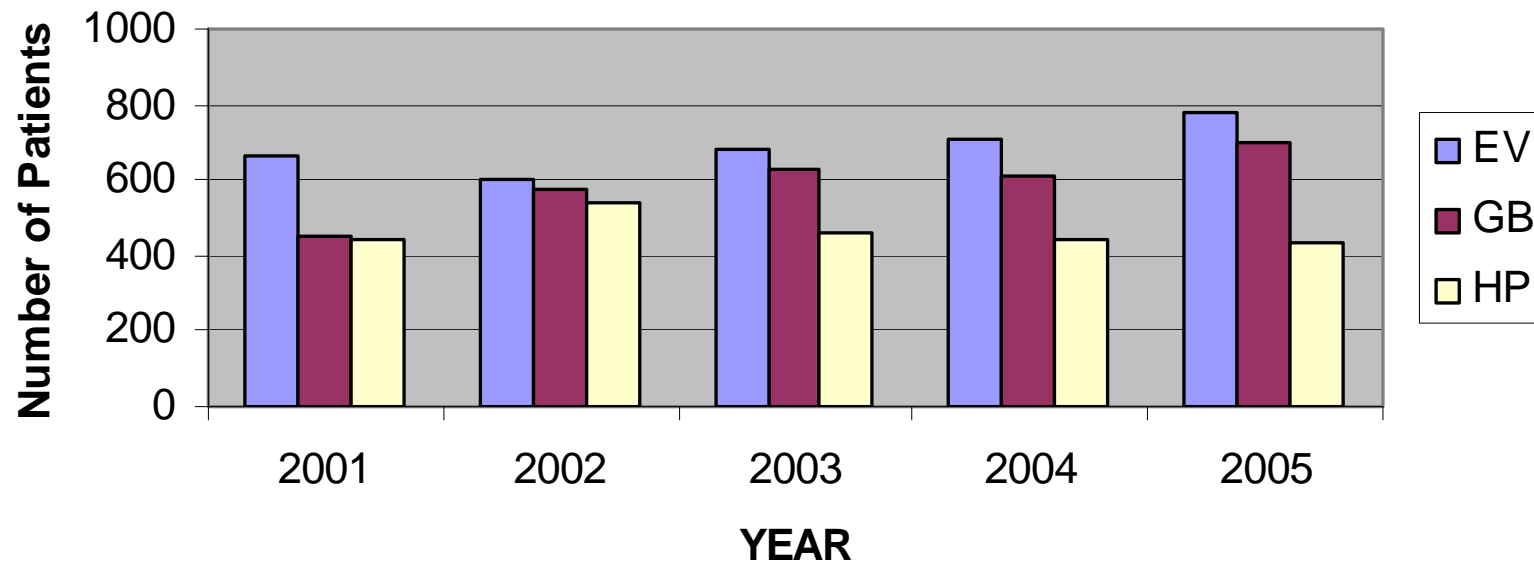
00
minutes

2. Were you seen in Fast Track?..... ● Yes ○ No

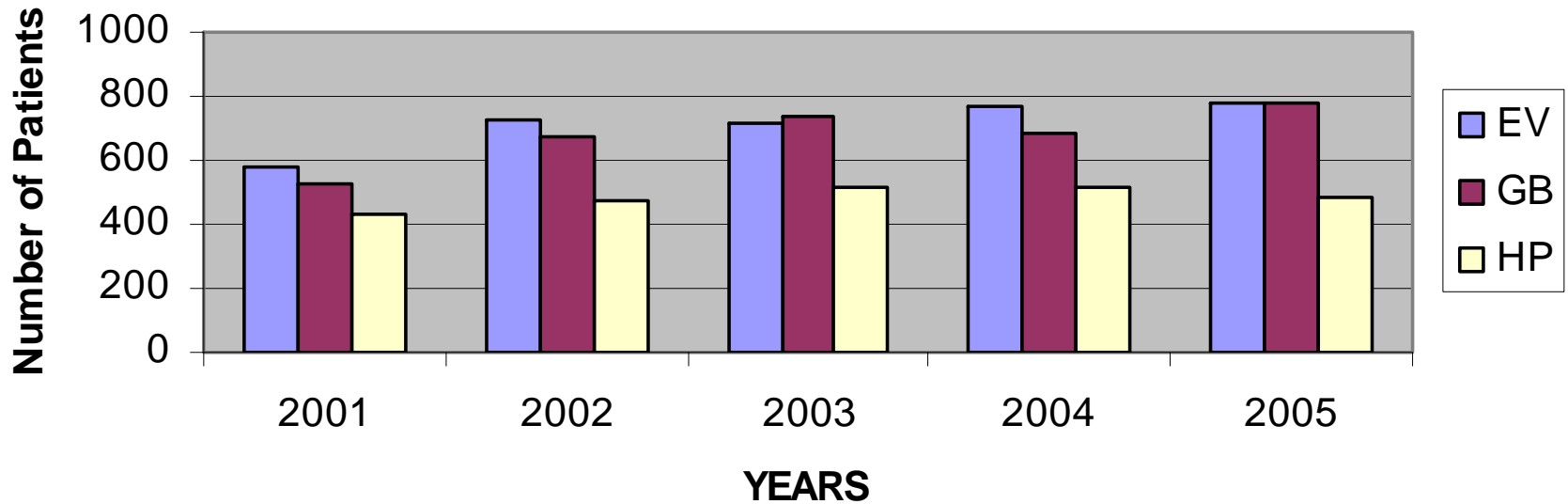
3. Who is filling out this survey?

- Patient
- Parent
- Family
- Friend
- Other

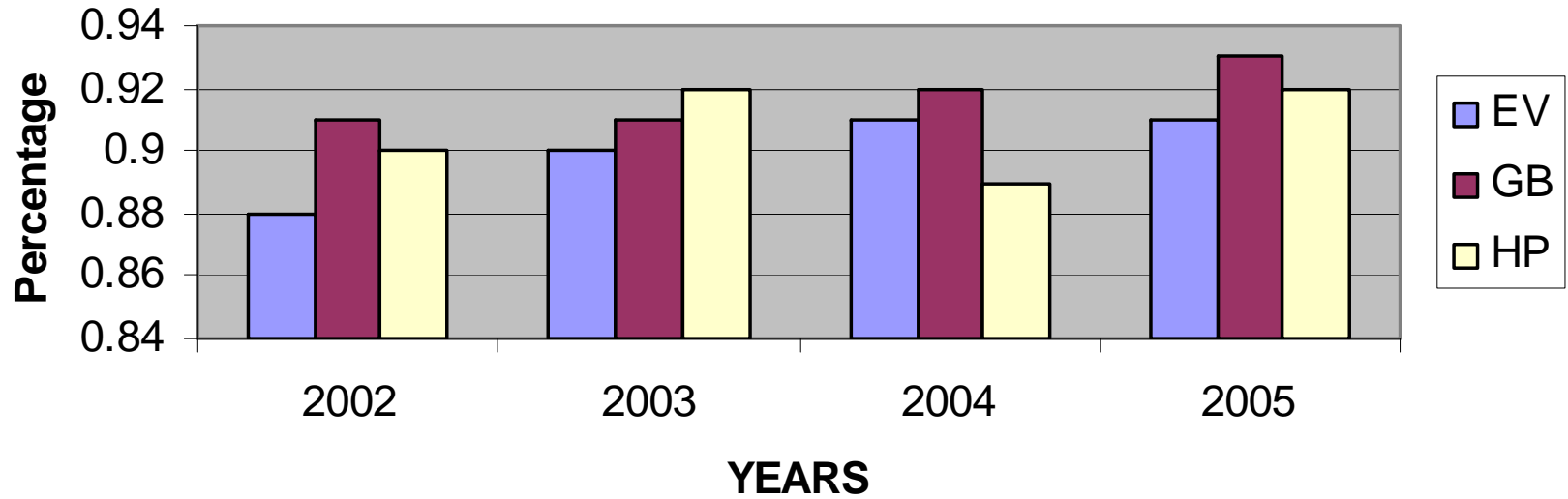
Monthly Average No. of Patients - Fast Track



Summer Monthly Average Number of Patients - FAST TRACK



Percentages of Patients Who Would Use Fast Track Services Again



Other ways to tell your story:

- Publish: professional journals

Toxicologic Emergencies

Susan Bednar and Jerrold Blair Leikin

Poisonings are responsible for more than 1 million emergency department (ED) visits annually in the United States, with more than two thirds of them involving children. The fact is, *all* chemicals have the potential to be poisonous, if given in large enough doses. For confirmation of this fact, one can open any clinical pharmacology textbook and note therapeutic agents that can lead to specific toxic syndromes. Despite the potential for the wide range of clinical presentations as a result of a virtually unlimited amount of toxins, <0.05% of all poison exposures called to a poison control center result in death. It is evident that if one follows a consistent treatment algorithm of the poisoned patient, the outcome will be favorable in the vast majority of cases.

The intent of this chapter is to review what questions the RN should consider when triaging the patient with a suspected ingestion/overdose, and practical advice (in the form of "commonly asked questions") on what to do with that information. We will also review "red flags" or symptoms/complaints that require immediate action. Finally we will provide some resources to help guide your care of the patient with a suspected or known overdose/ingestion.

1. What information is most important when triaging a patient with suspected overdose/ingestion?

It's important to get as much detailed information that you can about the incident. What they took, the amount they took, when they took it, and the route of exposure are all salient questions. If an overdose attempt is suspected, family and the patient's physician may be able to give more detailed information regarding the patients' motives. The old chart may be invaluable for this information as are any pharmacy records. If accidental ingestion/exposure, witnesses to the event or emergency medical technicians (EMTs) on the scene might be able to provide more information.

Although attempting to obtain the history of a suspected overdose/ingestion (accidental or intentional) is important, it is often unreliable and/or inaccurate. Take home message here—don't spend a lot of time at triage trying to figure out the specifics. A physical examination (including vital signs) is more helpful in that it allows the examiner to objectively identify any physical abnormalities present.

EVALUATING THE ROLE OF THE ADVANCED PRACTICE NURSE

Susan M. Bednar, RN, MSN, ANP

Performance evaluations are a vital tool for the advanced practice nurse (APN) and serve as a report card to administrators, delineating how well the APN has performed in the past and also giving direction for future goals. Evaluations can affect pay, job security, promotions, and even restructuring. Institutions that credential and privilege APNs to perform advanced practice procedures can use evaluations as a tool to evaluate and recommend continuation of these privileges in the future. The most effective evaluations reveal outcome data that have demonstrated the APN's worth in quantitative or qualitative measures and can even serve as road maps for the year ahead. The body of this chapter will present an overview of the who, what, when, and how of APN evaluation. It is intended to serve as a guide for the novice APN and an update for the experienced APN.

Who Evaluates the APN?

Because the APN is an autonomous, independent practitioner, determining who will evaluate the APN can be a challenge. It is important that the APN knows, up front, who will conduct the performance evaluation. Negotiating this point is essential prior to signing an employment contract. Usually, multiple people contribute to the APN evaluation including administrators, collaborating physicians, colleagues, staff nurses, and most importantly, patients. This multidisciplinary role of the APN can lead to difficult and often erroneous evaluations. Although some physicians may fail to recognize or value the teaching/counseling role of the APN, nursing supervisors may not appreciate the expanded medical management incorporated into the role,¹ and patient feedback may be limited to their level of satisfaction with the care they received while hospitalized. Therefore, it is important for the APN to know who will contribute to

the evaluation so the APN role can be structured accordingly. The APN may need to educate the evaluator about aspects of the role of which they are unaware and make a case for a multidisciplinary evaluation that would give the employer an appreciation for the role of the APN. Using a minimalist approach, the APN evaluation should include a self-evaluation, a peer evaluation, and an administrator evaluation.

What Will Be Evaluated?

Ideally, the APN should be evaluated on the components of the job description, including both process and outcomes evaluations. In other words, it is not enough to measure just how well the APN completed expectations of the role, but how well the process was implemented.²

The emergency department (ED) APN role includes the components of clinical expertise, leadership, educator, consultant, research, and outcomes management. APNs need to have a thorough understanding of the job description for the role into which they are hired. An example of a typical job description is provided in Table 23-1. Although the general components of the APN role include aspects of both traditional nurse practitioner (NP) and clinical nurse specialist (CNS) roles, there is much discussion in the literature today regarding merging the CNS and NP roles. Though there are variations in the role preparation (Table 23-2), the NP and the CNS do share similar scopes of practice.³ It is important for the APN to know each of the components of the role that are stressed in their current employment and how these roles are going to be measured. For example, although both CNS and NP programs emphasize physical assessment, NP programs focus more training in the development

Contributing Author to Books

Trismus and Acute Respiratory Distress in a 63-year-old Woman Ten Days After Stepping on a Firecracker

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A 63-year-old woman came to the emergency department with complaints of pain and stiffness in her neck and jaw, difficulty in opening her mouth (trismus), weakness in her left arm and leg, and solid food dysphagia that had begun earlier in the day. The patient had stepped on a firecracker 10 days prior to arrival at the emergency department. Two days after the accident, she received treatment in an urgent care center, where the staff cleansed her wound and gave her a tetanus booster. Two days later, she returned to the urgent care center, this time with a swollen, erythematous foot and yellowish drainage in the wound. The physician further debrided the wound and removed part of the firecracker that was imbedded in her foot. He obtained a wound culture, prescribed penicillin, and discharged the patient.

When the emergency physician examined the patient in the emergency department 10 days after her injury, he was concerned that she might have tetanus. She had never received any tetanus vaccinations in the past because she had emigrated from Eastern Europe as an adult. Her medical history was significant only for hypertension. Physical examination revealed tight jaw and masseter muscles, left upper arm weakness, and 3+ deep tendon reflexes in the lower extremities. Results of her complete blood cell count were within normal limits. Similarly, results of her EKG and chest radiograph were unremarkable.


The physician ordered 5000 units of human tetanus immunoglobulin (TIG) to be administered intramuscularly. However, because the hospital pharmacy did not have TIG available, the patient was transferred to another hospital for treatment.

Professional Journal

Don't overlook your local news

CLOSE TO HOME

CAROL MUELLER



NPs: Necessary people

In the beginning, medicine created doctors and nurses, and between them they cared for most of our health care needs. The latter were not made from the rib of the former, however, though they originally filled something of a "helpmeet" role.

But that was in the genesis of modern medicine. Gradually the medical family branched out. Specialization turned GPs into a variety of "ists," and nurses began specializing as well. Not that as many people noticed.

Which is exactly why Susan Bednar, NP, called me.

"NP?" I asked.

"Nurse practitioner," she replied.

I wasn't sure exactly what that meant. Turns out a lot of other people aren't, either.

Bednar is a nurse practitioner who specializes in emergency medicine, and she works in the emergency departments at Evanston, Glenbrook and Highland Park hospitals on a

"We see from 35 to 40 percent of the patients

Poster presentations:

- A few examples
- Easy to do
- Non threatening
- Contact your professional organization for opportunities

POSTER PRESENTATION – ACEP



EVANSTON
NORTHWESTERN
HEALTHCARE

Northwestern University Medical School
Emergency Medicine Residency



Northwestern Memorial
Hospital

A New Clinical Practice Model for Nurse Practitioners in the Emergency Department Susan Bednar, RN, MSN, ANP; Mary E. Hardesty, RN, MSN, FNP; John Flaherty MD, FACEP

Objectives: The role of Nurse Practitioner (NP) in the Emergency Department (ED) has not been well defined as to clinical practice parameters, and existing models of Emergency Medicine Practice for NP's in the emergency department have varied widely and have not been formally studied. Previous studies have demonstrated a comparative level of patient care between physicians and NP's in the fast track setting. We used a prospective, observational cohort study model to track the ED patients triaged directly to the fast track treatment area over an 18 month period from 7/99 until 12/00.

Methods:

The fast track treatment area was designed for rapid treatment of patients with specific complaint based criteria. The fast track was staffed by a single nurse practitioner, with direct physician supervision, for 10 hrs/day. A nurse's aide or EM technician was assigned to the treatment area when staffing allowed. This model was employed at three different suburban hospitals with a total annual volume of 85,000 patients. All NP's rotated between each hospital on a random basis. All patients meeting the complaint based criteria were admitted directly to the fast track area for diagnosis and treatment. The admissions to the fast track area logged and throughput times tabulated for all patients. Transfers out of the fast track area into the main ED were also logged. Percentages of total patients seen and average throughput times were compiled.

Results:

The total patient's seen on a monthly basis averaged 520 per month per hospital, ranging from 15 to 30 patients per day. Average throughput time was 58 minutes from the initial triage. The percentage of total ED patients seen during the hours of fast track operation was between 34 to 40%, and the percentage of total patients seen was between 25% to 40%. The NP facilitated chart documentation. The net effect was a significant reduction on ED physician workload and was universally praised by ED Staff and patients.

Conclusions:

Nurse Practitioner's can effectively practice in an Emergency Department Fast track area. The Nurse Practitioner can reduce ED physician patient load by an average of 30%. This results in greater ED efficiency, productivity, and is an effective an practical model for Emergency Medical Care.

Pearls gathered along the way

- Respect what others have to teach you (techs, RNs, MDs, Pharm-Ds, administrators and volunteers)