The Handbook of

EMERGENCY NURSING MANAGEMENT

Linda Buschiazzo

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EMERGENCY NURSING MANAGEMENT

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With love to Horacio
and our children
Michele, Alex, and Michael

In memory of my father
Morris Bush

Preface

Changes in health care, largely due to stricter regulatory mechanisms governing reimbursement, the growth and recognition of emergency services, improved technology, and the increasingly competitive atmosphere of health care systems, have created new challenges for emergency nursing managers. The special nature of the emergency department's organization, function, and relationships requires that you, as a nurse manager, possess specific management knowledge, experience, and skills to be able to meet the goals of the hospital and emergency department (ED), while meeting the expectations and needs of the public.

I wrote this book to share specific, practical information that I learned, adapted, and found useful during 15 years as an ED nurse manager so that others can benefit from my experiences. The contributors to this book also have a good deal of experience in emergency nursing and management, which enhances their contributions.

Acknowledgments

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Introduction

In past years, the emergency department (ED) was viewed by hospital administrators as a nonprofit patient care area. As a result, hospitals were unwilling to invest money into the ED, which led to an unintentional or intentional neglect of updating or improving emergency services. With this lack of financial and personnel support, resources were at a minimum, thereby preventing or delaying growth in ED management, planning, and development. There was little understanding of the need for the patient's experience in the ED to be seen as a positive one, even though it formed the patient's first contact and image of the hospital.

In addition, the nursing administration often did not recognize emergency nursing as a specialty requiring special knowledge, training, and skills. EDs were (and in many cases, still are) understaffed, and nurses were provided little to no continuing education specific to emergency nursing. Down time, which is inevitable in all EDs, resulted in a misinterpretation of staffing needs. Although intensive care and cardiac care units received recognition for their special needs, emergency nursing did not. Yet, no other nursing care area provides nursing care for both inpatients and outpatients and for medical, surgical, pediatric, gynecologic, psychiatric, critical care, and multiple trauma patients all in the same unit by the same nursing staff.

In recent years, the ED has been viewed more as an integral part of the hospital. With proper management and sufficient resources, it can be a positive force in the marketing and financial activities of the hospital. Effective and efficient management of the ED, which includes emergency nursing management, is essential to foster the understanding and acceptance of the ED's contribution to the hospital and community. The ED is now gaining deserved recognition and organizational status.

The growth of Emergency Medical Services Systems (EMSS), the increased number of emergency trained physicians, the development of the Emergency Nurses Association (ENA), and certification for emergency nurses have resulted

in an expanded awareness of emergency nursing as a specialty. Knowledge and skills required by the emergency nurse have been improved and standardized.

EDs have undergone accelerated organizational and operational changes during more recent years because of current health care trends. These include the rising incidence of chronic illness, an aging population, an increase in the birth rate, more sophisticated technology, stricter federal and state regulations, decreasing resources, third party reimbursement cost-containment measures, increasing competition, and growing consumerism.

Health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which are organized by private companies and physician groups, require preadmission approval for hospital services. They offer financial incentives to physicians to keep their patients out of hospitals. When the patient finally requires admission, the acuity state is high, and emergency admission is usually required. If a patient seeks services in the ED without prior approval from the HMO or PPO, the hospital is not paid for services rendered. Emergency patients sometimes have to be transferred to another hospital that has a contract with their HMO or PPO.

Prospective payment systems and DRGs are resulting in the premature discharge of inpatients, causing "repeaters." Recently discharged patients return to the ED because their acuity level is unmanageable for them or their family in the home setting.

Patients also arrive in the ED because they do not have approved admission diagnoses and are afraid or too ill to remain at home. The ED staff often winds up in the middle between the third party payer who will not pay the hospital for unapproved diagnoses and the patient who wants to be admitted.

The ED is no longer the back door to the hospital; it is now the front door. Health care consumers are actively choosing and challenging health care services to meet their standards.

All these factors have led to increased competition and marketing efforts in the health care field. All hospital managers must accept and must adapt to the importance of these factors. As a manager in the ED, you must be aware of changes and trends in the health care field so that you can meet hospital and department goals through effective, efficient, and creative management. To perform effectively, the ED nurse manager of today must possess both general and specific management knowledge and skills and be responsible and accountable as well.

Although EDs vary in size, number of patient visits, acuity levels of patients, personnel and financial resources, and organizational structure, the purpose and goals of all emergency departments are similar. This book addresses both these differences and similarities so that the nurse manager from the rural hospital ED that may see 15,000 patients per year and the nurse manager from the urban teaching hospital ED that may see 150,000 patients per year may both benefit from reading this book.

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Part I

The Emergency Nursing Management Environment

Chapter 1

Organization of the Emergency Department

TYPES AND CATEGORIZATION OF EMERGENCY SERVICES

Emergency services are the care rendered by qualified staff to the patient requiring emergent or urgent care. This care is given in a variety of places in addition to hospital EDs. Emergent care may be initiated in the community by prehospital care providers, in schools, in freestanding emergicenters, and in specialized facilities for burns, trauma, spinal cord injury, and the like.

The degree of hospital control and involvement with the ED varies, ranging from a high degree of control with corporate ownership and provision of finances and management to no control in which space is rented to an independent group of physicians who operate and manage the ED. Or, there may be a contract between the hospital and a private physician group under which expenses and revenues are shared.

The purpose of categorization of emergency services is to identify the readiness and capabilities of the hospital to receive and treat emergency patients. Several professional organizations have developed systems of categorization. The American Medical Association classifies hospitals according to their capability to provide care in specific critical care areas, which include:

- acute medical
- behavioral
- burns
- cardiac
- neonatal/perinatal
- poisoning and drug
- spinal cord
- trauma

Each of these special care areas is categorized by levels from 1 (highest capability) to 3 (least capability), with established standards for each level. Regionalization of centers for the provision of specialized care is gaining greater acceptance. These centers provide comprehensive care by trained and experienced staff, with wider distribution of facilities to render that care. Table 1–1 shows the American College of Surgeons standards for trauma categorization.

The Joint Commission on the Accreditation of Hospitals (JCAH) categorizes emergency services into four levels, with standards for each. In Emergency Services Standard 3.1 of the *Accreditation Manual for Hospitals*:*

3.1.3 A hospital's emergency department/service is classified according to the levels of the services provided.

Regardless of the nomenclature assigned, the levels of emergency services range from a comprehensive to a first aid/referral level of care.

3.1.4 Specific and general requirements are established for four levels of emergency services. Other comparable classifications, such as state or regional, are acceptable, and the hospital is evaluated for compliance at the appropriate level.

A. Level I emergency department/service offers comprehensive emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area. There is in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetrical/gynecological, pediatric, and anesthesiology services. When such coverage can be demonstrated to be met suitably through another mechanism, an equivalency is considered to exist for purposes of compliance with the requirement. Other specialty consultation is available within approximately 30 minutes; initial consultation through a two-way voice communication is acceptable.

The hospital's scope of services includes in-house capabilities for managing physical and related emotional problems on a definitive basis.

A. Level II emergency department/service offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Initial consultation through two-way voice communication is acceptable. The hospital's scope of services includes in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another facility when needed.

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*Reprinted from *Accreditation Manual for Hospitals*, pp. 23–25, with permission of the Joint Commission on Accreditation of Hospitals, © 1986.

Table 1–1 Standards for Trauma Categorization

	LEVELS		
	I	*II*	*III*
A. HOSPITAL ORGANIZATION			
1. Trauma service	E*	E	D*
2. Surgery departments/divisions/services/sections (each staffed by qualified specialists)			
Cardiothoracic surgery	E	D	
General surgery	E	E	E
Neurologic surgery	E	E	
Obstetric-gynecologic surgery	D	D	
Ophthalmic surgery	E	D	
Oral surgery—dental	D	D	
Orthopedic surgery	E	E	
Otorhinolaryngologic surgery	E	D	
Pediatric surgery	E	D	
Plastic and maxillofacial surgery	E	D	
Urologic surgery	E	D	
3. Emergency department/division/service/section (staffed by qualified specialists)	E	E	E
4. Surgical specialties availability			
In-house 24 hours a day:			
General surgery	E	E	
Neurologic surgery	E	E	
On-call and promptly available from inside hospital:			
Cardiac surgery	E	D	
General surgery			E
Neurologic surgery			D
Microsurgery capabilities	E	D	
Gynecologic surgery	E	D	
Hand surgery	E	D	
Ophthalmic surgery	E	E	D
Oral surgery—dental	E	D	
Orthopedic surgery	E	E	D
Otorhinolaryngologic surgery	E	E	D
Pediatric surgery	E	D	
Plastic and maxillofacial surgery	E	E	D
Thoracic surgery	E	E	D
Urologic surgery	E	E	D
5. Nonsurgical specialties availability			
In-hospital 24 hours a day:			
Emergency medicine	E	E	E
Anesthesiology	E	E	E
On-call and promptly available from inside or outside hospital:			
Cardiology	E	E	D
Gastroenterology	E	D	
Hematology	E	E	D