Volume 30
Number 2
Summer 2019

THE JOURNAL OF Legal Nurse Consulting

ISSUES IN THE ED

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AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

American Association of Legal Nurse Consultants
330 North Wabash Ave., Suite 2000
Chicago, IL 60611
877/402-2562
312/321-5177
Fax: 312/673-6655
E-mail: info@aalnc.org
Web site: www.aalnc.org

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PURPOSE

The purpose of The Journal is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

MANUSCRIPT SUBMISSION

The Journal accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org. Please see the next page for Information for Authors before submitting.

MANUSCRIPT REVIEW PROCESS

We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

The *Journal of Legal Nurse Consulting* is the official publication of the American Association of Legal Nurse Consultants (AALNC) and is a peer reviewed journal. Journal articles express the authors' views only and are not necessarily the official policy of AALNC or the editors of the journal. The association reserves the right to accept, reject or alter all editorial and advertising material submitted for publication.

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ARTICLE SUBMISSION

The *Journal of Legal Nurse Consulting* (JLNC), a peer reviewed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The JLNC follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: http://publicationethics.org/resources/code-conduct.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

INSTRUCTIONS FOR TEXT

- Manuscript length: 1500 – 4000 words
- Use Word© format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 6th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
- Note current retrieval date for all online references.
- Include a 100-word abstract and keywords on the first page
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

INSTRUCTIONS FOR ART, FIGURES, TABLES, LINKS

- All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art should be submitted as a separate file attachment, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

INSTRUCTIONS FOR PERMISSIONS

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- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned

GENERAL INFORMATION

Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed. All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

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Elizabeth Murray,
BSN RN LNCC

President, AALNC

President's Update

Dear AALNC Members,

Our organization celebrated another successful Annual Forum, this year in Louisville, Kentucky. Speaking on behalf of the Board, we are so grateful for the hard work of the Forum Planning Committee, under the able leadership of Susan Point. Evaluation feedback, letters, and emails to our headquarters praised the Annual Forum for excellent programming and speakers, great food and facilities, and a wonderful networking event at the Muhammad Ali Center.

This year, we also celebrated AALNC's 30th anniversary! AALNC officially formed as a not-for-profit association in 1989. Ten years later, in 1999, AALNCB received its initial accreditation from the American Board of Nursing Specialties (ABNS) for our board certification LNCC©. We are a relatively young organization, but packed with experience and nursing skill and knowledge. Looking at our accomplishments from the past thirty years, I am impressed with how far we have come, and how well we have leveraged technological changes to provide our members with the most excellent educational products at the most economical value.

The AALNC Board has set new strategic goals already guiding our budget decisions and projects.

1. AALNC will build upon its existing communal foundation to create a professional home for legal nurse consultants by creating new opportunities for community engagement to recruit and retain members.
2. AALNC will ensure its education and products continue to meet the evolving needs of the marketplace and its members.
3. AALNC will raise awareness of our organization, legal nurse consultants, and board certification to prospective members and employers of LNCs to grow membership and recognition of the value of legal nurse consultants and the LNCC© board certification.

I am honored to serve as AALNC President this year and look forward to continuing our momentum in raising awareness of our profession and professional association. One goal is to promote individual legal nurse consultant growth through AALNC education and mentorship available in an organization abounding with experienced, excellent teachers. I urge all the LNCs who joined us in Louisville to keep in touch with someone from the conference throughout the year. If you weren't able to join us, spend a few minutes contacting a new LNC on social media. There is no lack of work in this field: think hospital risk management, law firms, forensics, life care planning, and dozens of other areas where health and law intersect. We are all so much better together and our whole organization benefits from all of us succeeding, new and seasoned.

Finally, I am also committed to promoting awareness of AALNC as the non-profit professional organization for *every* legal nurse consultant, and I invite you to join me. No matter how you received your initial education, no matter what your specialty, AALNC is your home. The more awareness we can spread to legal nurse consultants who do not yet belong to AALNC, the more resources we can provide to all. Tell other nurses about AALNC. Explain to your attorney clients why belonging to a professional organization matters. Spread the word.

Elizabeth Murray, BSN RN LNCC

Editor's Note

Wendie Howland
MN, RN-BC, CRRN, CNLCP, LNCC

Editor, JLNC

I try to choose my words carefully, so I don't think it's hyperbole to say we are thrilled to have this issue on topics in ER care. Since most LNCs use an evidence-based practice model, you will be pleased to know that each of the articles herein received some of the highest ratings from our peer reviewers I've ever had the pleasure to read. Effusive thanks to those authors and reviewers who made editing easier this quarter!

We've just had a wonderful conference in Louisville (pronounced "LOO-v'l") I'm not much of a drinker, but I figured I owed it to myself to try some local bourbon and, while I was at it, some real southern fried chicken; they did not disappoint. The conference speakers offered a different kind of tasting menu of fresh ideas, research, perspectives, and enthusiasms that also whetted the appetite for more. Fortunately, I can keep using those when I return to work in a way that ongoing bourbon and chicken wouldn't be prudent.

Most of the time, though, I spent talking with LNCs: aspiring, new, experienced, and very seasoned legal nurse consultants. The energy was palpable. First time attendees got distinctive ribbons to stick on their name badges, and there were many of them, all with a bit of trepidation but also eager to learn why the rest of us were having so much fun. Those of us who manned tables in the exhibit area never had a down moment.

One of my goals for the Journal was to expand its reach to more LNC specialties by incorporating more articles about the variety of ways a nurse can be a consultant to those who need our specialized background and (usually hard-won) knowledge. I hoped this would translate into more interest in these roles, especially to attracting more people in active clinical practice to consider being testifying experts. You too may often hear that aspiring LNCs are pretty fixated on the idea of doing case reviews for attorneys to use in trials, and they pretty much all want to get their feet wet with that because it sounds less scary than ::gulp:: testifying.

However, and now I'm talking to you aspirants and new colleagues, remember that you are already experts in your nursing clinical areas. You've dealt with myriad opportunities to teach complex subjects to lay people; you've been doing that, with increasing proficiency, since your first week in nursing school. Don't forget all those papers you had to write in your programs. You'll be writing more of them. Sure, as LNCs you'll be acquiring a new vocabulary, using it in new ways, and finding yourself doing it in a new milieu. Do not let that scare you. You have many reasons to feel successful about this move.

Remember that anxiety releases those helpful endogenous catecholamines that increase your blood flow to your muscles and brain so you can move quickly, open your pupils so you can see things more clearly, and have your liver release glucagon for extra energy. You understand that already, and you know how to use it. You've acquired a whole new tribe of colleagues who want to help you. Bonus: you'll be wearing better clothes as befits your professional status.

You got this. Welcome, new legal nurse consultants. We're glad you're here.

Warm regards,

Wendie A. Howland

Wendie A. Howland MN RN-BC CRRN CCM CNLCP LNCC

Emergency Nurses Association Resources

Lynn Sayre Visser, MSN BS RN CEN CPEN CLN

Clinical Practice Guidelines

The Emergency Nurses Association provides clinical practice guidelines which are practice recommendations based on a systematic review and analysis of available literature.

These documents can be found at https://www.ena.org/practice-resources/resource-library/clinical-practice-guidelines

As of this printing, available clinical practice guidelines include:

Capnography During Procedural Sedation/Analgesia Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/capnographycpg.pdf?sfvrsn=2acee418_22

Capnography During Procedural Sedation/Analgesia CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/capnographysynopsise889c8857cb14698976b63853919baa1.pdf?sfvrsn=4a236ca6_24

Difficult Intravenous Access Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/difficultivaccesscpg.pdf?sfvrsn=9944da58_12

Difficult Intravenous Access CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/difficultivaccesssynopsis.pdf?sfvrsn=978ac6ae_18

Family Presence During Invasive Procedures and Resuscitation Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/familypresencecpg3eaabb7cf0414584ac2291feba3be481.pdf?sfvrsn=9c167fc6_16

Family Presence During Invasive Procedures and Resuscitation CPG Synopsis
https://www.ena.org/docs/default-source/resource-library practice-resources/cpg/familypresencesynopsis3bdad0aaaeeb4370856e849f26e553a3.pdf?sfvrsn=21ca66b_20

Gastric Tube Placement Verification Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/gastrictubecpg7b5530b71c1e49e8b155b6cca1870adc.pdf?sfvrsn=a8e9dd7a_14

Gastric Tube Placement Verification CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/gastrictubesynopsis.pdf?sfvrsn=ae56756d_18

Intimate Partner Violence Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/ipvcpg.pdf?sfvrsn=7ce56a4f_4

Intimate Partner Violence CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/ipvsnyopsis.pdf?sfvrsn=c777966f_6

Intranasal Medication Administration Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/intranasalmedcpg.pdf?sfvrsn=c9522db_12

Intranasal Medication Administration CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/intranasalmedsynopsis.pdf?sfvrsn=b971fc7f_18

Massive Transfusion Scoring Systems Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/masstransfusioncpg.pdf?sfvrsn=404db1b7_14

Massive Transfusion Scoring Systems CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/masstransfusionsynopsis.pdf?sfvrsn=38f44f8b_20

Needle-Related or Minor Procedural Pain in Pediatric Patients Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/pedpainmanagementcpg.pdf?sfvrsn=c650e1d6_16

Needle-Related or Minor Procedural Pain in Pediatric Patients CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/pedpainmanagementsynopsis.pdf?sfvrsn=eea9c79c_28

Non-Invasive Blood Pressure Measurement with Automated Devices Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/nibpmcpg.pdf?sfvrsn=8fe4af94_16

Non-Invasive Blood Pressure Measurement with Automated Devices CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/nibpmsynopsis.pdf?sfvrsn=a542dda1_22

Non-Invasive Temperature Measurement Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/temperaturemeasurementcpg.pdf?sfvrsn=8853209f_14

Non-Invasive Temperature Measurement CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/temperaturemeasurementsynopsis.pdf?sfvrsn=a65007e6_22

Orthostatic Vital Signs Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/orthostaticvitalsignscpg.pdf?sfvrsn=c73c24a6_12

Orthostatic Vital Signs CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/orthostaticvitalsignssynopsis.pdf?sfvrsn=82896f3a_18

Prevention of Blood Culture Contamination Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/bcccpg2c37f1815b664d2fa8d7e9fd0f475a41.pdf?sfvrsn=6d1899fb_12

Prevention of Blood Culture Contamination CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/bccsynopsis.pdf?sfvrsn=c46c438a_20

Prevention of Blood Specimen Hemolysis in Peripherally-Collected Venous Specimens Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/hemolysiscpg.pdf?sfvrsn=37ca9769_20

Prevention of Blood Specimen Hemolysis in Peripherally-Collected Venous Specimens CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/hemolysissynopsis67a4a7f96560416c81f94b45eac1a07d.pdf?sfvrsn=d86d12d6_22

Suicide Risk Assessment Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/cpgsuicide.pdf?sfvrsn=409a64fe_14

Suicide Risk Assessment Clinical Practice Guideline Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/cpgsuicidesynopsis.pdf?sfvrsn=522e6ed5_18

Wound Preparation Clinical Practice Guideline
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/woundpreparationcpg.pdf?sfvrsn=ae51bb1f_14

Wound Preparation CPG Synopsis
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/woundpreparationsynopsis.pdf?sfvrsn=4da0a990_22

Emergency Nurses Association. (2019). Clinical practice guidelines. Retrieved from https://www.ena.org/practice-resources/resource-library/clinical-practice-guidelines

Position Statements

These are the current position statements from the Emergency Nurses Association and are available at https://www.ena.org/practice-resources/resource-library/position-statements

Access to Quality Healthcare Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/accessqualityhealthcare.pdf?sfvrsn=c26b8f33_14

Adult and Adolescent Sexual Assault Patients in the Emergency Setting ENA/IAFN Joint Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/adultandadolescentsexualassaultpatientser.pdf?sfvrsn=234258f1_6

Advanced Practice in Emergency Nursing Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/advpracticeernursing.pdf?sfvrsn=e4186f66_18

Appropriate Credential Use/Title Protection for Nurses with Advanced Degrees Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/appropriatecredentialuse.pdf?sfvrsn=b464e4ca_14

Care of Prepubescent Pediatric Sexual Abuse Patients in the Emergency Care Setting ENA/IAFN Joint Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/careofpedsexualabusepatientser.pdf?sfvrsn=8d3e6e17_8

Care of the Patient with Chronic/Persistent Pain in the Emergency Care Setting Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/carepatientschronicpain.pdf?sfvrsn=8b1c97ca_16

Child Passenger Safety in the United States
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/childpassengersafetyus.pdf?sfvrsn=a5c2365c_8

Crowding, Boarding, And Patient Throughput
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/crowdingboardingandpatientthroughput.pdf?sfvrsn=5fb4e79f_4

Cultural Diversity and Gender Inclusivity in the Emergency Care Setting
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/culturaldiversity.pdf?sfvrsn=e85dc130_22

Death of a Child in the ED ENA/AAP/ACEP Joint Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/deathofachildined.pdf?sfvrsn=a4d34e7a_6

Disaster and Emergency Preparedness for All Hazards Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/allhazardspreparedness.pdf?sfvrsn=ea0879a4_10

Emergency Nurse Orientation Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/emergencynurseorientation.pdf?sfvrsn=e3ee2b66_14

Emergency Nursing Certification Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/encertification.pdf?sfvrsn=b3563eb6_14

Emergency Nursing Interface with MIH and CP Programs Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/interfacemihandcp.pdf?sfvrsn=16bec1ae_12

Emerging Infectious Diseases in the Emergency Care Setting Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/emerginginfectiousdiseasesemergencycaresetting.pdf?sfvrsn=7ec44f4f_14

Download (867 KB pdf)
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/emerginginfectiousdiseasesemergencycaresetting.pdf?sfvrsn=7ec44f4f_14

Expanded Roles and Responsibilities for Nurses in SBIRT for Alcohol Use ENA/IntNSA Joint Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/expandedrolesresponsibilitiesfornursesinsbirt.pdf?sfvrsn=594e67b0_6

Facilitating the Interfacility Transfer of Emergency Care Patients Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/facilitatingtheinterfacilitytransfer.pdf?sfvrsn=d3d9c8f4_14

Firearm Injury Prevention Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/firearm-safety-and-injury-prevention

Forensic Evidence Collection in the Emergency Care Setting Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/forensic-evidence-collection-in-the-emergency-care-setting.pdf?sfvrsn=a1f89eba_4

Guidelines for Care of Children in the ED ENA/AAP/ACEP Joint Policy Statement
https://els-jbs-prod-cdn.literatumonline.com/pb/assets/raw/Health%20Advance/journals/ymen/YMEN3392_proof-1540908484920.pdf

Handoffs: Transitions of Care for Children in the ED ENA/AAP/ACEP Policy Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/handoffs-transitionsofcareforchildrened.pdf?sfvrsn=ce8de40e_6

Healthy Work Environment Position Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/healthyworkenvironment.pdf?sfvrsn=a4170683_12

Human Trafficking Awareness in the Emergency Care Setting ENA/IAFN Joint Statement
https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/humantraffickingpatientawareness.pdf?sfvrsn=cd0ad835_28

Immunizations Position Statement
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https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/intimatepartnerviolence.pdf?sfvrsn=4cdd3d4d_10

Medication Safety in the Emergency Department ENA/AAP/ACEP Policy Statement
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https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/patienthandofftransfer.pdf?sfvrsn=e2c42cb6_18

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Plain Language Emergency Alerts Position Statement
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Emergency Department Triage: Not for the Faint of Heart

Deb Jeffries RN, MSN-Ed, CEN, CPEN, TCRN

Keywords: Emergency department, triage, EMTALA, emergency medical condition, medical screening examination

According to the Emergency Nurses Association, the process of triage is best carried out by registered nurses and nurse practitioners with emergency nursing expertise who have completed a triage-specific educational program.

Emergency Department (ED) triage is one of the most dangerous places in health care and unfortunately, also the one involved in the most litigation. The role of the triage nurse is complex and demands the highest level of clinical expertise. Emergency departments are frequently overwhelmed by the volume of patients presenting for care. For decades, EDs have been closing with some regularity: in 1994 there were 4,960 EDs with 90.5 million ED visits and in 2014 there were 4,408 EDs with 136.3 million ED visits (American Hospital Association, 2016).

That means that over those twenty years, visits increased by 50.6% while the number of EDs decreased by 11.7%. Studies show there is likely a correlation between EDs closing and negative patient outcomes (Shen, 2016). The ED has long been considered the safety net for those with little or no health care insurance coverage and has thus become the place of last resort for many in need.

Triage was originally used in French battlefields to allocate care and is defined by Webster's Dictionary as: "a.) the sorting of and allocation of treatment to patients and especially battle and disaster victims according to a system or priorities designed to maximize survivors and b.) the sorting of patients (as in an emergency room) according to the urgency of their need for care" (Merriam-Webster, n.d.). Many professionals incorrectly equate triage with a place of assignment rather than sorting and prioritizing. Triage is not confined to the ED but occurs in urgent care centers, clinics, schools, and field environments (Emergency Nurses Association, 2012).

TRIAGE CHALLENGES

Besides prioritizing and facilitating ED patient care, many triage nurses are also responsible for managing waiting patients who have been triaged but have not yet been placed in the treatment area. Adding to this challenge are other variables:

- Crowding
- Lack of staff or beds
- Lack of communication with treatment team
- Lack of support
- Patients/visitors under the influence of legal or illegal substances
- Behavioral health issues
- Violent individuals
- Individuals under stress and who may be in crisis mode resulting in loss of objectivity

KEY PLAYERS AT TRIAGE

Depending on an ED's size and staffing, multiple individuals may be involved in triage:

- Triage Registered Nurse
- ED Physician, Physician Assistant, or Nurse Practitioner
- Paramedic or Emergency Medical Technician

Triage comes from the French verb "trier" which means "to sort."

- ED Technician
- Registration
- Ancillary staff such as respiratory therapy or laboratory staff
- Volunteers

FEDERAL MANDATE: EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 was enacted as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

Gatewood v. Washington Healthcare Corp. 290 U.S. App. D.CF. 31, 933fF.2d 1037 (D.C, Cir. 1991), describes its rationale:

> *The Emergency Act was passed in 1986 amid growing concern over the availability of emergency health care services to the poor and uninsured. The statute was designed principally to address the problem of "patient dumping" whereby hospital emergency rooms deny uninsured patients the same treatment provided paying patients, either by refusing care outright or by transferring uninsured patients to other facilities.*

Patient dumping resulted in poor patient outcomes, including death, as people with acute conditions (including labor) were turned away or sent somewhere else without being stabilized.

EMTALA applies to Medicare-participating hospitals with a dedicated emergency department and requires that the hospital provide (not an all-inclusive list):

- An appropriate medical screening examination (MSE)
- Necessary stabilizing treatment for emergency medical conditions and labor within the hospital's capability and capacity
- Appropriate transfer of an unstable individual to another medical facility while meeting certain criteria (benefits outweigh the risks)

Other EMTALA requirements include:

- The MSE and/or stabilizing treatment cannot be delayed by inquiry about payment status
- The hospital must accept the appropriate transfer of individuals with an emergency medical condition if the hospital has specialized capabilities or facilities and can treat those individuals
- The hospital cannot penalize or take adverse action against a phy-

Many professionals incorrectly equate triage with a place of assignment rather than sorting and prioritizing.

CMS requires that patients with psychiatric symptoms receive a screen for suicidal or homicidal attempt or risk, orientation, or assaultive behavior that indicates danger to self or others.

sician or qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an unstable emergency medical condition, or against any hospital employee who reports a violation of these requirements.

(CMS: State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases.)

To meet the Centers for Medicare & Medicaid Services (CMS) requirements an MSE must be provided when a patient or someone on behalf of a patient requests emergency care or treatment for labor OR according the *prudent layperson standard:* A layperson who could conclude from the individual's appearance or behavior a need for examination or treatment of a medical condition.

THE MEDICAL SCREENING EXAMINATION

A MSE is defined as "the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an emergency medical condition (EMC) or not. An MSE is not an isolated event. It is an ongoing process that begins but typically does not end with triage" (CMS, n.d., p.36). The MSE includes all necessary testing and on-call services within the capability of the hospital. Therefore, while the MSE may begin during *the triage process, the triage process is not the MSE.*

CMS does not specifically say who can perform the MSE other than a qualified medical person (QMP) (Centers for Medicare & Medicaid Services, 2010):

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e. qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval.

DEFINING AN EMERGENCY MEDICAL CONDITION

An EMC is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in

- Placing the health of the individual (or, regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of bodily function or serious dysfunction of any bodily organ or part
- Regarding a pregnant woman having contractions – there is inadequate time to effect a safe transfer to another hospital before delivery dot that the transfer may threaten the

health or safety of the woman or her unborn child"

(Foster, 2019)

CMS also requires that patients with psychiatric symptoms receive a screen for suicidal or homicidal attempt or risk, orientation, or assaultive behavior that indicates danger to self or others.

COMMON EMTALA VIOLATIONS

EMATALA violations may be obvious and glaring (telling a patient presenting to the emergency department to go somewhere else) or subtle (suggesting or even hinting that a patient should go somewhere else.)

Examples include but are not limited to:

- Ambulance arrives on hospital property and the hospital tells the ambulance crew to take the patient to the hospital down the street
- Directing a patient to a local physician without receiving an MSE
- Transferring a patient without prior acceptance by the receiving hospital
- Inadequate transfer documentation
- Delaying the MSE to obtain financial information
- Turning away a patient due to insurance or financial status
- Improperly discharging a patient with an EMC

(Zuabi, 2016)

"But they've been discharged – how is that EMTALA-related?"

A recent EMTALA case found against a hospital when a patient, after receiving treatment, was discharged with a self-reported pain of 8 out of 10 on a 1 to 10 scale. The patient was experiencing an "internal hernia" and later that day suffered a cardiac arrest and ultimately died the following day from peritonitis and septic shock. (Munoz v Watsonville Community, Case No. 15-cv-00932-BLF, United States District Court - Northern District of California San Jose Division, Jan 25, 2017.) "(The court) held that discharging KH with a pain level of 8 out of 10 violated the hospital's duty to stabilize KH and it also failed to transfer her to a facility for her high level of pain, which was the identified emergency medical condition" (Brent, 2017).

COBRA and EMTALA have been explored extensively in the literature and there is a plethora of additional information provided by CMS at their website (CMS, 2012). The LNC can explore this site to gain more in-depth knowledge regarding these landmark statutes.

TRIAGE ACUITY DESIGNATION

Each person presenting to the emergency department for care is assigned a triage acuity on arrival *regardless of the method of arrival.* The purpose of a triage acuity is to rapidly and accurately identify those who are most seriously ill or injured and initiate life-saving interventions followed by those who are less so."The purpose of triage in the emergency department (ED) is to prioritize incoming patients and to identify those who cannot wait to be seen. The triage nurse performs a brief, focused assessment and assigns the patient a triage acuity level, which is a proxy of how long the patient can wait to be seen (Gilboy, 2011, p1). Although there are number of 5-level-acuity systems used world-wide, the two primarily used in the United States are the Emergency Severity Index (ESI) and the Canadian Triage and Acuity Scale (CTAS). Both these scales have been extensively researched and consistently determined to be valid and reliable (Mirhaghi, 2015, Mirhaghi, Green, 2012). Using a standardized scale (such as ESI) has been supported by both the Emergency Nurses Associations (ENA) and the American College of Emergency Physicians (American College of Emergency Physicians, 2010).

> The **process of triage** is to sort the patients who are "sick" from the "not sick."

Both ESI and CTAS are scales in which Level 1 is the most severely ill or injured and Level 5 is the least severe.

It is critical that the clinician performing triage receives education specific to the acuity scale used as part of the **overall triage education program** (McNair, 2012, Gilboy, 2011). Inadequate education may contribute to mistriage – the assigning of an incorrect acuity. Although assigning a triage acuity too high is still mistriage and may cause valuable resources being taken by a patient unnecessarily, assigning a triage acuity score too low can be deadly.

TRIAGE QUALIFICATIONS

The Emergency Nurses Association's *Position Statement: Triage Qualifications and Competency* recommends triage qualifications and outlining methods for competency assessment. According to ENA, "Competency is an ongoing validation process that is part of safe practice in the ED; it includes observation and chart review to ensure accurate clinical decision-making" (Emergency Nurses Association, 2011).

Triage competency begins with the recognition of the importance of expe-

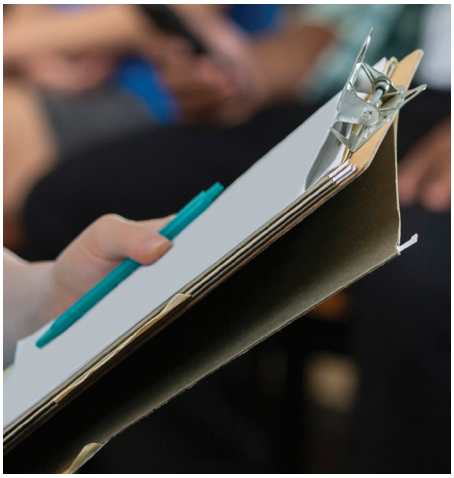
rience. ENA recommends that triage be "…performed by a registered nurse or nurse practitioner with a minimum of one-year of emergency nursing experience…." accompanied by appropriate additional credentials (Emergency Nurses Association, 2011). Other ENA recommendations include:

- Certifications in emergency nursing
- Ongoing education in trauma, pediatrics, and cardiac care
- Clinical orientation with an experienced preceptor
- Completing a comprehensive, evidence-based triage coursed
- Demonstrating knowledge application and situational awareness

(ENA, 2016)

Courses and Certifications that enhance a nurse's competency include:

- Certified Emergency Nurse (CEN)
- Certified Pediatric Emergency Nurse (CPEN)
- Trauma Certified Registered Nurse (TCRN)
- Basic Life Support (BLS)
- Advanced Cardiac Life Support (ACLS)d
- Pediatric Advanced Life Support (PALS)
- Basic Disaster Life Support (BDLS)
- Advanced Disaster Life Support (ADLS)



ENA posts a list of recommended triage nurse qualifications at **https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/triagequalificationscompetency.pdf?sfvrsn=a0bbc268_8**

- Emergency Nurse Pediatric Course (ENPC)
- Geriatric Emergency Nurse Education (GENE)
- Trauma Nursing Core Course (TNCC)

(Visser & Montejano, 2019)

STANDARDS OF CARE:

In 2011 the American Nurses Association formally recognized emergency nursing as a specialty practice. This significant achievement validates to the public that emergency nurses "are dedicated to meeting high standards of care and patient safety" (American Nurses Association, 2011; Nurse.com, 2011). The general standards of care for nurses in the ED are provided through the Emergency Nurses Association's *Emergency Nursing Scope and Standards of Practice* (2nd edition). Besides professional organization standards of practice, hospital often have specific ED Standards of Care usually identified as a policy or clinical practice. These standards of care typically spell out specific expectations regarding the care provided to patients e.g. frequency of re-assessment.

Finally, standards of care and expectations are defined by the State Board of Nursing and Nurse Practice Act.

SUMMARY

Understanding the complexity of the triage nurse role is critical. When reviewing a case involving ED care, the LNC should first obtain hospital policies to determine whether the triage standard of care was met and to learn the hospital's specific qualifications for a or other triage expectations. The LNC should also review the orientation process, required competencies, required education, and any auditing and quality improvement processes designed to verify and maintain competency.

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In 2011 the American Nurses Association formally recognized emergency nursing as a specialty practice. Standards of care and expectations are also defined by the State Boards of Nursing and Nurse Practice Acts.

Another JLNC
SideNOTE

What Do the Acronyms Mean?

CEN	Certified Emergency Nurse
CPEN	Certified Pediatric Emergency Nurse
CFRN	Certified Flight Registered Nurse
CTRN	Certified Transport Registered Nurse
TCRN	Trauma Certified Registered Nurse
CCRN	Certified Critical Care Registered Nurse
FAEN	Fellow of the Academy of Emergency Nursing

Deb Jeffries RN, MSN-Ed, CEN, CPEN, TCRN is a registered nurse with 35 years' experience in critical care and emergency nursing. She has been a passionate advocate for triage education participating in many projects and programs directed toward emergency department process improvement and triage education. She has presented triage education nationally and internationally while faculty with Triage First, Inc. She is a TNCC, ENPC, ACLS, PALS, and BLS instructor. Deb is a member of Alpha Sigma Nu and has positively affected triage nurses globally. She can be contacted at http://www.triagefirst.com/contact/

Legal Aspects of Patient Handoff in the Emergency Department

Anthony M. Angelow PhD, CRNP, ACNPC, AGACNP-BC, ACNP-BC, CEN
Dawn M. Specht PhD, RN, APN, CEN, CPEN, CCRN, CCNS

Keywords: Handoff, Quality, Education, Competency, Legal, Safety, Errors

Patient handoff is an essential aspect of care that can be a source of medical errors and adverse patient outcomes. Standardized policies to foster safe patient handoff between pre-hospital, emergency and in-hospital providers are critical. Competency-based education and quality improvement initiatives enhance quality of care and successful patient outcomes. The legal nurse consultant must critically analyze handoff processes to ensure policies and procedures are in place and effectively implemented.

Colleen is a charge nurse in the emergency department of a large academic medical center with 500,000 emergency room visits a year. Emergency medical services (EMS) frequently transport patients to this emergency department. Some await triage in the waiting room; others present to the charge nurse for immediate bedding.

A 50-year-old male patient with history of cardiovascular disease and chronic obstructive pulmonary disease is brought to the emergency department from home after a fall related to

Figure 1. Eight tips for effective handoffs. © The Joint Commission, 2019. Reprinted with permission.

syncope. EMS report he denies chest pain and had a head laceration with no uncontrolled hemorrhage. He is immediately placed in a room. Colleen signs the EMS tablet to verify receipt of the patient. Within five minutes of arrival, he develops ventricular tachycardia and subsequent cardiac arrest. The team successfully resuscitate him and implement hypothermia protocol. However, he suffers severe anoxic brain injury and will now require indefinite twenty-four-hour care. A hospital-based risk management review of the pre-hospital record finds that the patient had a chief complaint of chest pain with a systolic blood pressure of 80 mmHg. Furthermore, field 12-lead electrocardiogram (EKG) showed an episode of ventricular tachycardia and anterior wall cardiac ischemia.

I-PASS. (Calaman et al., 2013).

Illness severity	
Patient summary	Events leading up to admission, hospital course, ongoing assessments, and plan for care.
Action list	Receiver's "to-do list," timeline for completing it; receiver takes ownership for completion.
Situational awareness / contingency planning	Allows receiver to understand what is going on with the patient and prepare/plan for possibilities
Synthesis	Receiver summarizes the communication, obtains clarification, and restates key action or to-do items

SBAR (Hunter et al., 2017).

Situation	A concise statement of the patient problem
Background	Pertinent information related to the situation.
Assessment	Provider's assessment, analysis, and considered options
Recommendations	recommended actions for patient car

THE HANDOFF PROCESS

Patient handoff is a process of transferring care from one provider to another (Agency for Healthcare Research and Quality [AHRQ], 2019). In 2017, the Joint Commission issued a sentinel alert entitled "Inadequate Handoff Communication," describing the risk to patients when an inadequate handoff process occurs in any healthcare setting. Ineffective communication is a major contributing factor, which leads to medical errors and the increased risk of patient harm (Nether, 2017). Insufficient, inadequate, untimely, and misinterpreted information during a handoff process are the major contributors to harm and adverse outcomes (The Joint Commission, 2017); in 2012, they estimated that 80% of serious medical errors involved miscommunication during handoff.

The Joint Commission (2017) recommended healthcare facilities embrace quality improvement measures to increase patient safety (Figure 1 on previous page). The Emergency Nurses Association (2018) issued a position statement supporting standardized handoff approaches and challenging organizations to develop, implement, and continually monitor policies and procedures to support them. At a minimum, the position statement calls for a policy and procedure that includes a description of the content expected in every handoff process.

EVIDENCE-BASED PATIENT HANDOFF TOOLS

A meta-analysis of standardized handoff protocols shows they improve the quality of information communicated between providers and fosters positive patient outcomes (Keebler et al., 2016). Shahian, McEachern, Rossi, Chrisari, and Mort (2016) reported on a large-scale implementation of the I-PASS mnemonic focusing on five key communication aspects. (see Sidebar) Physicians using I-PASS increased synthesis and contingency planning by 40%. A second study reported a 23% reduction in medication errors and a 30% reduction in preventable adverse events (Starmer et al., 2014). Parent et al. (2018) studied modified IPASS use in critical care and found providers reported feeling more prepared to deliver safe patient care.

The Institute for Healthcare Improvement promotes the SBAR (see Sidebar), a standardized tool with moderate evidence for improved patient safety during telephone handoff. (Muller et al., 2018). One study showed a significant statistical difference between the performance scores in all areas before and after the implementation of this tool in a critical care setting (Inanloo, Mohammadi, and Haghani, 2017).

There are other tools available. Although evidence supports use of a standardized tool, there is no evidence to support the use of any given tool over another.

PATIENT HANDOFF POLICIES AND PROCEDURES

LNCs should look for a policy and procedure incorporating an evidence-based tool, and training and documentation regarding implementation and correct use.

Previous research supports healthcare provider training on handoff procedures as an essential step in ensuring the effective implementation of any process. Broad-focused training sessions could cover the appropriate handoff procedure, regardless of the location where handoff takes place. Inanloo et al. (2017) discovered SBAR improved critical care nurse performance after the training and implementation when compared to performance before the training and implementation. The Joint Commission (2017) suggests standardizing critical content during patient handoff, verbal and written, and standardized institutional training on these tools (The Joint Commission, 2017).

Likewise, there should be evidence of ongoing institutional quality-improvement measures and follow up. Fryman, Hamo, Raghavan, and Goolsarran (2017) describe how adoption of the I-PASS model significantly reduced adverse events in one institution; however, compliance was poor six months later. They developed a model of weekly observation of handoff processes, as sustainability required an ongoing commitment.

IMPLICATIONS FOR THE LEGAL NURSE CONSULTANT

The American Association of Legal Nurse Consultants (AALNC) describes legal nurse consultants as collaborators and strategists, offering support in medically-related litigation and other medical-legal matters based on current evidence-based practice.

There are two care providers in the vignette beginning this article: a pre-hospital provider andan emergency department nurse. Insufficient, inadequate, untimely, and misinterpreted information during handoff are the major contributors adverse outcomes and may have occurred during this one (Joint Commission, 2017). Interestingly, but outside of the scope of this article, the ER nurse signing for receipt of the patient from EMS may present a new set of legal challenges that could be affected by a standardized handoff process.

Goldberg et al. (2016) performed an analysis of 90 patient handoffs and concluded poor quality handoff from pre-hospital to emergency department providers, specifically in critically ill and injured patients, remained an ongoing problem. Failed handoffs typically result from delinquent system factors (Colvin, Eisen, and Ng Gong, 2016). The case study depicts a handoff where both EMS and ER nurse are equally responsible for pertinent information transfer. When investigating a case where the patient handoff process is potentially responsible for a negative or adverse patient outcome, the authors of this article suggest a stepwise approach.

First, investigate organizational policies and procedure for handoff between providers. While the evidence-based literature does not recommend one handoff tool over another, institutional policy and procedure must include using a standardized tool. It should contain information, at a minimum, that

- describes the patient situation
- allows an understanding of the continuing patient care required
- focusses on information so the receiver can anticipate future event
- provides an opportunity to seek clarification and summarize information
- includes documentation requirements for patient handoff (Emergency Nurses Association, 2018; Joint Commission, 2017; Shahian et al., 2016).

Once the LNC confirms the presence of a policy and procedure, the next step is analyzing mechanisms in place to provide competency-based training (Gordon et al., 2018, Ivanloo et al., 2017; Starmer et al., 2013), evaluate competency, maintain competency, and quality improvement. Without these, providers are at risk for using nonstandard approaches, prone to error (Colvin et al., 2016). This documentation should be readily available.

Suggestions for quality improvement include retrospective chart reviews for appropriate use of handoff policies and procedures and a continual, real-time evaluation of the handoff process (Fryman et al., 2017). Regardless of the institution's strategy, the legal nurse consultant should look for documentation that supports ongoing quality improvement evaluation and actions to improve policy and procedure implementation for identified deficiencies.

CONCLUSION

Inadequate patient handoff processes are a source of medical errors, negative patient outcomes, and adverse patient events. This article provided an overview of the importance of implementing standardized institutional patient handoff policies and procedures. When evaluating a case to determine if patient handoff occurred successfully, the LNC should use a stepwise approach.

- Institutional policies and procedures must clearly delineate a process for patient handoff in the emergency department, including handoff between pre-hospital and emergency department providers.
- This must include using a standardized tool.
- There must be competency-based education so providers know how to effectively implement handoff policies and procedures, understand documentation requirements, and effectively use the tool.
- Institutions should also ensure continued competency with quality improvement initiatives.
- The identified quality improvement initiative must include a mechanism for improving patient handoff processes when deficiencies exist.

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Anthony M. Angelow PhD, CRNP, ACNPC, AGACNP-BC, ACNP-BC, CEN is the Interim Chair and Assistant Professor in the Department of Advanced Practice Nursing at Drexel University. He is a certified Acute Care Nurse Practitioner and currently works in Trauma Surgery and Surgical Critical Care. In addition, Dr. Angelow present on numerous topics at national, regional, and local conferences throughout the year. He can be reached at anthony.angelow@gmail.com

Dawn M. Specht PhD, RN, APN, CEN, CPEN, CCRN, CCNS is Associate Professor of Nursing with over twenty-five years of teaching experience. She is a Certified Adult Gerontology Acute Care Nurse Practitioner with bedside professional nursing experience in care of Trauma, Emergency and Critical Care patients. She is a Fellow of the Academy of Emergency Nurses. She is actively involved in improving geriatric emergency care. She can be reached at dawnspecht@comcast.net

Another JLNC SideNOTE

Hot Topics:

Some of the hottest topics in emergency nursing include:

Opioid crisis:
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Emerging infectious diseases:
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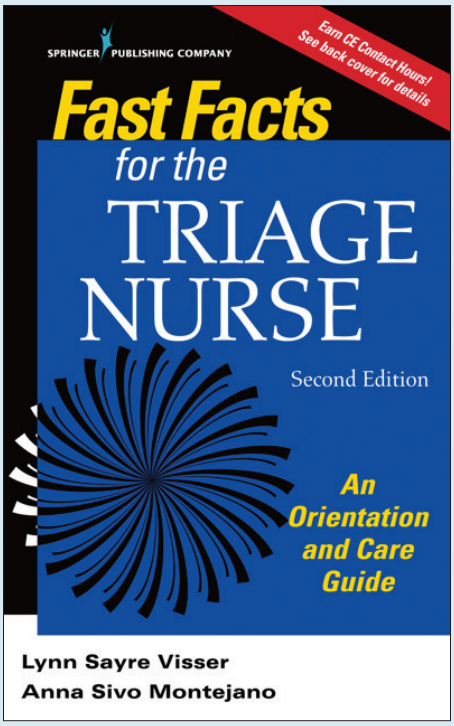
Human trafficking:
https://www.ena.org/practice-resources/human-trafficking

Editor's Choice: The Art and Science of Triage, 2nd Edition

Andrea Perry, MSN, RN, CNL, CEN, CPEN



The Art and Science of Triage, 2nd Edition

Lynn Sayre Visser, MSN, BS, RN, CEN, CPEN, CLNC and Anna Sivo Montejano, DNP, MSNEd, RN, CEN, Editors

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Triage is a foundation of emergency nursing—and mastering it is an ED nurse's most challenging task. Clinical experience, knowledge of policy and procedure, and intuition must come together seamlessly so that the ED nurse can quickly decide: sick or not sick. Triage is a dynamic process in a constantly changing environment, and resources must change in order to stay relevant.

Fast Facts for the Triage: An Orientation and Care Guide, Second Edition is a valuable resource for the triage nurse, regardless of experience level. Recognized by the *American Journal of Nursing* as a Critical Care-Emergency Nursing Book of the Year in 2015, this text is known to be a reliable, comprehensive tool. The first edition was written for orientees, preceptor, educators, leadership teams, and paramedics. Content covered included the orientation process, legal concerns, triage acuity levels, worst case-scenarios, and patient and staff safety among others. The newly released 2nd edition adds expanded "red flag" sections and information on human trafficking victims and military populations.

Don't miss the new sections of the 2nd edition!

- Active Shooter/ Active Violence and Emergency Management, with contributions from a FEMA certified Emergency Preparedness coordinator
- Triage Competency, including a sample validation form, education and competency plan, and triage audit form
- Pain management
- Endocrine emergencies

This book is a must-read for any legal nurse looking to understand the complex roles of the nurse and medical provider in triage. As a bonus, a testament to its relevance, contact hours are free with purchase. ❧

Andrea Perry, MSN, RN, CNL, CEN, CPEN is a Clinical Nurse Leader at an ED in Roseville, CA. In her role as CNL, Andrea is responsible for new hire training, policy and procedure development, and quality improvement. She is an active member of the Emergency Nurses Association, serving as an officer in her local chapter and presenting at national conferences. She has contributed to several publications, both professional and commercial.

Keeping Psychiatric Patients Safe in our Nation's Emergency Departments

Katherine Haney, MSN, RN-BC

Suicide is now the 10th leading cause of death in the United States and is also listed as one of the top five sentinel events when it occurs in a hospital setting (Centers for Disease Control and Prevention, 2016). In 2018, The Centers for Medicare and Medicaid Services (CMS) announced that they would be embracing Joint Commission's recommendations regarding ligature risks in the hospital setting (Patient Safety & Quality Healthcare, 2018). Based on CMS rules and regulations, there are two main strategies to keep patients with serious suicide ideation safe in emergency departments. Recommendations include specific guidelines on making the care environment for at-risk patients ligature-resistant and the need for continuous observation and supervision of a patient if such an environment cannot be provided.

INTRODUCTION

Suicide is now the 10th leading cause of death in the United States and is also listed as one of the top five sentinel events when it occurs in a hospital setting (Centers for Disease Control and Prevention, 2016). A sentinel event is defined as a "patient safety event that reaches a patient and results in death, permanent harm, or severe temporary harm" (Journal on Quality and Patient Safety, 2018). This comes at a time when there is national concern about access to mental health care in addition to the rise of the opioid epidemic. Hospital suicides have occurred in various locations, including psychiatric hospitals, general hospitals, medical-surgical units, and Emergency Departments. A recent study found that hanging, or "ligature" was by far the most common method of inpatient suicide at 70% (Journal on Quality and Patient Safety, 2018).

During the five-year period from 2012 to 2016, an average of 85 hospital suicides per year were reported (CDC, 2016). This statistic underestimates the true incidence of hospital suicides for two reasons. First, it does not account for unsuccessful suicide attempts or "near misses" where-in had safety interventions not be performed; the patient outcome may have been very different. Additionally, hospital suicide reporting to The Joint Commission (TJC) is voluntary, as opposed to reporting at the state department level, making it unclear if this accurately reflects the true number of suicides in health care settings. Despite the seriousness of inpatient suicides, the actual incidence is poorly understood (Journal on Quality and Patient Safety, 2018). This article aims to discuss the current state of Emergency Departments (ED) around the nation and the fight to keep all patients safe, regardless of mental health diseases.

The Centers of Disease Control and Prevention reported 136.9 million ED visits nationally for the year in 2015 (CDC, 2016). In today's EDs, patients waiting for inpatient psychiatric beds remain in the ED 3.2 times longer than non-psychiatric patients. The care process for psychiatric patients in EDs nationwide averages 7 to 11 hours, and often takes more than 24 hours when patients require transfer to an outside facility (American College of Emergency Physicians, 2008). Due to increased patient volume as well as longer times in the ED, heightened awareness is crucial to ensure the safety of all patients.

CASE DISCUSSION

A 22-year-old female is brought in to the ED by paramedics after being found running on a busy freeway. The paramedics reported that the patient swallowed an unknown amount of methamphetamine. Upon arrival, the patient was physically assessed and cleared medically. The patient was not screened or identified as potentially suicidal. It was assumed her psychosis was drug related. After several hours of observation, an emergency care technician returned to find the patient unresponsive, cyanotic, and hanging from the cardiac monitor with the monitor wires wrapped around her neck. Luckily, the patient regained consciousness after quick resuscitation efforts.

WHAT WENT WRONG?

First, the patient was not immediately identified as a risk for intentional harm to herself or others. The hospital had a policy outlining suicide screening questions for all patients admitted through the ED. This patient was not asked the hospital's standard suicide screening questions as part of her initial physical assessment. Psychiatric patients requiring medical care in a non-psychiatric setting (medical inpatient units, ED, etc.) must be protected when demonstrating suicidal ideation or harm to others (Centers for Medicare and Medicaid Services, 2018). Had this patient denied suicide thoughts on initial screening, it is the treating provider's decision to determine if the patient's actions prior to admission to the ED constitute suicidal behavior, as in this case study. It is imperative to stress that suicide screening will not identify all patients at risk for self-harm. Screening is dependent on the accuracy and completeness of responses received to the screening questions. Screening cannot predict psychiatric admission and near-term adverse events in the ED (Chang & Tan, 2015). Once identified, best practice requires suicidal patients to undergo continuous observation. This often looks like a one-to-one sitter who can be an aid, technician, etc. as outlined in the hospital's policy and procedures. However, even the implementation of a one-to-one sitter is not enough. The key is **continuous observation.** Even a few minutes lapse in visual monitoring can allow a determined patient enough time to attempt suicide, as proven in this scenario. Lastly, the patient's room was not a ligature "resistant" environment. Instead of providing a safe environment, the patient room contained items that could have led to a successful suicide attempt.

IDENTIFYING AT RISK PATIENTS

Psychiatric patients present to the emergency department in various conditions. Many patients suffer from dual diagnosis mental health disorders such as depression, Post Traumatic Stress Disorder (PSTD), addiction and drug abuse as well as a combination of the above. In the case discussion, there was no medical history suggesting that the patient suffered from mental illness, but the fact that she was positive for amphetamines suggests that she was an increase safety risk due to altered thought process and unpredictable behavior. Again, she was also not assessed for suicidal thoughts per the hospital's policy upon her initial evaluation. When screening for the risk of suicide is limited to patients reporting a mental health chief complaint, a significant number of positive screenings are missed (Boudreaux et al., 2015). According to Boudreaux et al. (2015), suicidal ideation is estimated to be present in as many as 11% of all ED patients, while only 3% are identified by screening.

Currently, hospitals are not required to perform universal screening for suicidal ideation on all patients. It is important for clinicians to assess every individual for suicidal ideation as part of their overall clinical evaluation. However, some organizations that care for vulnerable populations with a high prevalence of suicidal ideation have successfully implemented universal screening protocols (Schnieder, 2015). This is also true for facilities that care for a large number of the transient, homeless, and chemically dependent population.

It is a false belief that asking a patient about suicidal thoughts or plans incites or encourages suicidal behavior (Boudreaux et al., 2015). Providers are encouraged to ask specific questions about the nature and content of suicidal thoughts. Thorough assessment ensures that at risk patients are adequately screened and once identified, can be cared for a in a ligature-resistant environment while under continuous observation status. Care providers need to maintain an elevated level of vigilance and attempt to identify the potential risk factors and personal characteristics associated with suicidal behaviors.

There are numerous patient risk assessment tools available to identify patients

ENA Behavioral health resource:
https://www.ena.org/practice-resources/behavioral-health

Screening for suicide risk should begin during the triage process. The **Suicide Risk Assessment Clinical Practice Guideline** and **Suicide Risk Assessment Clinical Practice Guideline Synopsis** are valuable tools in understanding the risk assessment in the emergency department setting and can be located at **https://www.ena.org/practice-resources/resource-library/clinical-practice-guidelines/-in-category/categories/ena/resources/practice-resources/clinical-practice-guideline/suicide**

who may be a risk for harm to self or others. No one size fits all tool is available. Therefore, the type of patient risk assessment tool used should be appropriate to the patient population and care setting. All hospitals are expected to implement a patient risk assessment policy, but it is up to each individual hospital to implement the appropriate strategies. For example, a patient risk assessment strategy in a post-partum unit would most likely not be the same risk assessment strategy utilized in the emergency department. Two examples of instruments that have been validated to assess potential suicide or self-harm risk in the ED include the Ask Suicide-Screening Questions (ASQ) and the Columbia-Suicide Severity Rating Scale (C-SSRS). (Boudreaux et al., 2015).

For more information and resources that may be used to meet the requirements of the standard please visit: https://www.ncbi.nlm.nih.gov/pubmed/25826715

CMS REGULATIONS

In 2018, The Centers for Medicare and Medicaid Services (CMS) announced that they would be embracing Joint Commission's recommendations regarding ligature risks in the hospital setting (Patient Safety & Quality Healthcare, 2018). Recommendations include specific guidelines on making the care environment for at-risk patients ligature-resistant and the need for continuous observation and supervision of a patient if such an environment cannot be provided.

Two hospitals were cited by CMS in 2018 for putting their patients in immediate jeopardy after staff failed to keep a continuous watch over at-risk patients even though the hospital's own policy called for a sitter or other one-to-one observation (Patient Safety & Quality Healthcare, 2018). A finding of immediate jeopardy by CMS means an immediate threat to life and safety was identified making the hospital at risk of losing its ability to bill Medicare for services. Regardless of the organization a hospital uses for accreditation, it is important to assess the hospital's suicide prevention compliance against CMS recommendations.

SAFE ENVIRONMENT

Psychiatric patients requiring medical care in a non-psychiatric setting such as an Emergency Department must be protected when demonstrating suicidal ideation or harm to others. Although all risks cannot be eliminated, hospitals are expected to demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines (Centers for Medicare and Medicaid Services, 2018).

Based on CMS rules and regulation, Boudreaux et al. (2015) recommends two main strategies to keep patients with serious suicide ideation safe in emergency departments. First, the patient must be placed under demonstrably reliable monitoring (1:1 continuous monitoring, observations allowing for 360-degree viewing, continuously monitored video). The monitoring must be integrated to allow for immediate intervention by a qualified staff member when called for. Second, the patient should be placed in a safe room that is ligature-resistant or that can be made ligature-resistant by having a system that allows fixed equipment that could serve as a ligature point to be excluded from the patient care area (Centers for Medicare and Medicaid Services, 2018). Potential risks include but are not limited to, sharps, harmful substances, access to medications, breakable windows, accessible light fixtures, plastic bags (for suffocation), oxygen tubing, bell cords, etc. Patients cared for in emergency departments often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature-resistant (Boudreaux et al., 2015).

CONCLUSION

The case presented illustrates some of the risks and errors that occur when caring for suicidal patients in the emergency department. When reviewing these types of cases, it is important to remember that in addition to the individualized medical record, organizations should have policies, procedures, training, and monitoring systems in place to ensure these practices and procedures are reliable. Even when most of the safety guidelines are followed, a brief and minor lapse in protocol can result in attempted or completed suicide. Once an individual in the ED or hospital has

been identified as suicidal, the responsibility for ensuring the patient's safety falls entirely upon the staff, nurses and physicians involved.

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Katie Haney, MSN, RN-BC is licensed and board-certified Registered Nurse in the state of California with a background in Emergency Room nursing and expertise in Quality and Risk Management in acute care hospitals. She is the owner of Haney LNC, offering legal nurse consulting services for plaintiff and defense clients nationwide. She is a member of the WVUOV virtual chapter of AALNC. She can be contacted at Katie@HaneyLNC.com.

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Workplace Violence Prevention: Liability Recommendations

Jennifer Flynn, BA, CPHRM

Keywords: violence, workplace violence, risk management, Emergency Department, harassment, assault

Nurses, especially in the ED, have traditionally tolerated violence in healthcare as part of the job. However, when given tools and support to report violent incidents, nurses may tolerate them no longer. Through education and a reporting tool, nurses are empowered to identify issues and patterns in their workplaces and hold patients accountable for their behavior. Legal nurse consultants can consider the points in this article when evaluating any case involving workplace violence.

Workplace violence is a critical issue faced by the healthcare community. Emergency Departments (ED) staff members are at high risk of violence from patients and visitors. Myriad factors contribute to a volatile environment: 24-hour accessibility, high stress, lack of visible or trained security staff, pain, stress, lack of privacy, long wait times, fear, anxiety, substance abuse, and mental illness among them.[1]

Twenty-five percent of registered nurses and nursing students reported being physically assaulted by a patient or patient family member, and approximately 50% reported being bullied, according to an American Nurses Association study.[2]

California and Illinois lawmakers have enacted legislation requiring healthcare providers to create workplace violence prevent programs that comply with OSHA guidelines. The California program went into effect on April 1, 2018, and Illinois on January 1, 2019.

[1] Gacki-Smith J, Juarez AM, Boyett L, Homeyer C, Robinson L, MacLean SL. Violence against nurses working in US emergency departments. J Nurs Adm. (2009). Jul-Aug;39(7–8):340–9. DOI: http://dx.doi.org/10.1097/NNA.0b013e3181ae97db.

[2] The Joint Commission. (2018). Sentinel Event Alert: Physical and verbal violence against health care workers. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf

The federal government has followed, introducing the Health Care Workplace Violence Prevent Act in March 2018. Though H.R. 5223 is still pending, if passed, it would require employers to develop and implement workplace violence prevention plans like those discussed in this article.

Workplace violence resource from ENA:
https://www.ena.org/practice-resources/workplace-violence

DEFINING THE ISSUE

Workplace violence is defined as any act or threat of physical violence, harassment, intimidation, or other threatening, disruptive behavior that occurs at the work site. It can encompass a spectrum of behaviors, ranging from conduct that is inappropriate, to life-threatening attacks, including:

- **Harassment:** any behavior that demeans, embarrasses, humiliates, annoys, alarms, or verbally abuses another person, such as using offensive language, sexual innuendos, insults, arguments, bullying, or other inappropriate activities.
- **Verbal or written threats:** any expression of intent, verbal or in writing, to inflict personal pain, harm, damage, or psychological harm.
- **Threatening behavior:** acts such as shaking fists, slamming doors, destroying property, vandalism, theft or throwing objects.
- **Physical attacks or assault:** intentionally, knowingly, or recklessly causes physical injury. Examples include hitting, shoving, biting, pushing, or kicking. Aggravated assault is a more serious kind of physical attack as it typically accompanied by a weapon.

TYPES OF WORKPLACE VIOLENCE

According to the U.S. Department of Labor, workplace violence that resulted in healthcare worker injuries and missed days from work were caused by:[3]

- **Patients:** 92% of workplace violence in the healthcare setting is perpetrated by patients, family members and visitors.
- **Coworkers:** 3% of workplace violence in the healthcare setting were caused by coworkers.
- **Students:** 3% of incidents were caused by students
- **Assailants:** 2% were caused by assailants with criminal intent, such as robbery, or by persons with a personal relationship with the employee, such as when domestic violence spills over into the workplace.

HOW PREVALENT IS WORKPLACE VIOLENCE IN HEALTHCARE?

There are nearly as many violent injuries in the healthcare industry as there are in all other industries combined.[4]

- Healthcare and social service workers suffered 70% of all workplace violence injuries.[4]
- Rates of violence against healthcare workers are up to twelve times higher than the rates for the overall workforce.[4]
- Healthcare and social service workers are more likely to get injured at work than police officers and prison guards.[4]
- The most common causes of violent injuries result from hitting, kicking, beating and shoving.[3]
- Between 2005 and 2014, there was a 110% spike in the rate of violent incidents reported against healthcare workers.[5]
- Over 20% of registered nurses and nursing students report they have been physically assaulted and over 50% say they've been verbally abused during a year.[5]
- The healthcare industry files the fourth most sexual misconduct claims, 11.48% of all claims filed with the EEOC.[6]
- The highest rates of violence occur in the emergency room, behavioral health and geriatric long-term care settings.[7] 54% of ER nurses reported experiencing violence in the past seven days.[8]

HEALTHCARE WORKPLACE VIOLENCE UNDERREPORTED

Even with the information we have around workplace violence in healthcare, it is largely underreported. Studies suggest that over 50% of physical assaults and 80% of verbal abuse against nurses goes unreported.[8]

"Healthcare workplace violence is an underrated, ubiquitous, and persistent problem that has been tolerated and largely ignored," said Dr. James Phillips of Harvard Medical School. "Providers are reluctant to report these incidents because we have compassion for our

[3] Occupational Safety and Health Administration (OSHA). (2015). Guidelines for preventing workplace violence for healthcare and social service workers. Retrieved from https://www.osha.gov/Publications/osha3148.pdf

[4] U.S. Government Accountability Office. (2016). "Workplace Safety and Health: Efforts Needed to Help Protect Healthcare Workers from Workplace Violence," April 14, 2016. Retrieved from https://www.gao.gov/products/GAO-16-11

[5] Ladika, Susan. (2018). "Violence against Nurses: Casualties of Caring," NCBI, May 6, 2018. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/29763407

[6] U.S. Equal Employment Opportunity Commission (EEOC). Types of Discrimination - Harassment. Retrieved from https://www.eeoc.gov/eeoc/commission.cfm.

[7] Occupational Safety and Health Administration (OSHA). (2015). Preventing Workplace Violence in Healthcare. Understanding the Challenge. Retrieved from https://www.osha.gov/dsg/hospitals/workplace_violence.html

[8] Solheim, Jeff. (2018). "The realities of workplace violence for emergency nurses," The Hill, September 18, 2018. Retrieved from https://thehill.com/opinion/healthcare/407249-The-realities-of-workplace-violence-for-emergency-nurses

This just in:

In Massachusetts, state legislators have just put forth a bill to change assaults on health providers, emergency medical technicians or ambulance attendants from a misdemeanor to a felony offense, punishable by up to five years in prison. One sponsor said the legislation "will set a tone that the assaults on these workers who are trying to do their job will not be tolerated." The Massachusetts Nurses Association is pushing for the bill. The union is also pushing for a separate bill that would require healthcare employers to develop and implement programs to reduce workplace violence.

patients, and we don't want to treat them like they're the enemy. So, we all make excuses, when we probably shouldn't."[9]

Historically, the health care industry has been slow to focus on occupational hazards for its workers. Many factors contribute to the occupational risks facing nurses today, but a fundamental problem is a healthcare culture that focuses more on patient safety than on worker safety.

When violence does occur, some healthcare workers consider it "part of the job." Many injured nurses have said they have been told they should accept this reality and move on.

CASE STUDY: WESTERN STATE HOSPITAL

This case involves a 63-year-old female RN who worked at Washington state's largest psychiatric hospital, Western State. The patient was a 29-year-old male admitted to the hospital six months before the incident.

The patient repeatedly exhibited violent, aggressive behaviors, especially towards female staff. He grabbed, hit, or attempted to bite hospital staff members and patients five times, including an incident where he knocked a mental health technician to the ground and attempted to bite her thigh.

The hospital was previously cited several times by CMS for failure to take adequate precautions to protect staff members from patient assaults. In this case, the hospital kept moving the patient from ward to ward without invoking any additional security measures.

At the time of the incident, the nurse was the only RN on duty, despite hospital policy that requires at least three RNs per ward, per shift. The nurse was behind the nurses' station when the patient ran out of his room, jumped over the counter and knocked her to the floor.

The patient choked her and bit off part of her ear lobe before other staff could intervene in the attack. Besides her ear injury, the nurse suffered a concussion and a spinal fracture, which limits her mobility. The patient was arrested and charged with second-degree assault.

The nurse is suing Washington State for $5 million in damages for failure to adequately staff shifts, for placing violent patients on less-secure wards, and failure to implement measures to protect workers from this patient's violent behavior.

CASE STUDY: RISK MANAGEMENT RECOMMENDATIONS

- Workplace violence policies should outline steps employees should take in extreme situations, including emergency response procedures and de-escalation strategies.
- Everyone, including consultants, contracted employees, residents, and students should have to opportunity to learn how to respond to workplace violence.
- There should also be policies and procedures in place to identify, track, and mange patients and visitors at a high risk for violence.
- It is well-established that nurse staffing levels are crucial to optimizing quality of care, reducing the frequency and severity of workplace violence incidents, and controlling costs.
- Staffing models should consider patient acuity, and patient propensity for aggression and violence, rather than being driven only by census.
- Panic buttons or safety phones should be placed in areas where staff could be isolated with patients, though it is also important to ensure that staff have at least one other employee on the unit with them on each shift.
- In the aftermath of a violent event, provide emotional support to those who have been the victims of violence.

ROOT CAUSES OF VIOLENT EVENTS

The Joint Commission studied incidences of healthcare workplaces between 2013 and 2015, similar to the one discussed at Western State. Included in the study were 33 homicides, 38 assaults, and 74 rapes perpetrated by staff, visitors, other patients, and intruders.[10]

The Joint Commission identified that the most frequent contributing factors were:

- Breakdowns in staff communication,

[9] Jacobson, Roni. (2014). "Epidemic of Violence against Health Care Workers Plagues Hospitals," Scientific American, December 2014. Retrieved from https://www.scientificamerican.com/article/epidemic-of-violence-against-health-care-workers-plagues-hospitals/

[10] Advisory Board (2016). "Statistics likely understate the problem," Advisory Board, May 3, 2016. Retrieved from https://www.advisory.com/daily-briefing/2016/05/03/nearly-75-percent-of-all-workplace-assaults-happen-in-health-care

- Inadequate patient observation or assessment of patients with aggressive tendencies,
- Lack of, or noncompliance with, policies addressing workplace violence prevention.

These findings highlight the importance of regularly reviewing workplace violence prevention policies, trainings such as this one, and conducting regular drills.

CONTROLLING AND PREVENTING WORKPLACE VIOLENCE

There are three types of workplace violence controls: engineering, administrative and behavioral. Use the following information as a starting point in any discussion on workplace violence prevention.

Engineering Controls

Engineering controls protect the worker from potential hazards. Examples include:

- Physical and environmental safety and security measures
- Controlled access to the building and patient care units
- Monitored surveillance systems
- Programming emergency phone numbers into phones

Administrative Controls

While engineering controls seek to prevent a problem from occurring, administrative controls require the employee to change the way they work and may be less expensive to implement. Examples include:

- Proactive safety and security audits and security rounding
- Violence reporting and incident response processes
- Identifying, tracking and managing patients and visitors at high risk for violence
- Education and training for employees
- Implementing policies and procedures for employees at high risk for exposure to violence, such as employees who work alone or in unsecure areas

Behavioral Controls

Behavioral controls augment staff knowledge, skills, and conduct, to help prevent or lessen the severity of workplace violence incidents. Nurses should know:

- About incidents on their unit and in the organization
- Of any updates to unit violence policies
- How to respond to violent situations involving patients
- How to report violent incidents and threats
- How to de-escalate potentially violent situations
- The organization's emergency response plans and personal safety measures
- How to practice and promote respectful behaviors among their coworkers
- A neutral employee who can mediate conflict between coworkers

WORKPLACE VIOLENCE PREVENTION PROGRAM CREATION

Organizations should create a written program for workplace violence prevention and incorporate it into their overall safety and health programs. Consider the following:

Management Commitment and Employee Participation

Participation is key to success. Encourage involvement by having administrators, risk managers, and frontline supervisors acknowledge the value of a safe workplace. They can do this by showing that aggressive or violent behavior, from staff, patients, or visitors, is unacceptable and will result in appropriate consequences.

Management must:

- Allocate authority and resources to all responsible parties,
- Support and implement recommendations made by safety and health committees,
- Provide an environment where errors and incidents are viewed as opportunities to learn,
- Establish policies that ensure no reprisals are made against anyone who reports incidents in good faith.

Worksite Analysis and Hazard Identification

Although management is responsible for controlling hazards, nurses have a critical role to play. Because of their familiarity with facility operations they can help identify and assess potential threats.

Managers can collect key information through employee and patient surveys. Once the worksite analysis is complete, the organization should use it to identify the hazard prevention, control, and staff training measures needed to reduce the threat of workplace violence

Hazard Prevention and Control

Management has a legal obligation to provide employees with a safe and healthy work environment. Hazard prevention and control measures allow employers to minimize or eliminate risks where possible and thus lessen their potential liability.

Steps to control hazards include:

- Identifying control options,
- Selecting and implementing effective and feasible controls,
- Following up to confirm controls are being used properly,
- Evaluating the effectiveness of controls and improving upon them as needed.

Safety and Health Training

No risk management program can be effective without adequate staff training

to back it up. Training should cover all types of workplace violence, not just violence by patients against employees, and not just physical forms of violence.

Topics may include:

- A review of workplace violence policies and procedures,
- Location, operation, and coverage of safety devices such as alarm systems,
- Recognition of escalating behavior, warning signs, or situations that may lead to assaults,
- De-escalation techniques to prevent or defuse volatile situations or aggressive behavior.

Recordkeeping and Program Evaluation

All training programs should include an evaluation component. At least annually, the team or coordinator responsible for the program should review the workplace violence prevention program, periodically survey workers to learn if they experienced hostile situations while doing their jobs, and review incident reports for quality improvement opportunities.

RISK CONTROL RECOMMENDATIONS

OSHA Guidelines

The OSHA Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers is an excellent resource when creating your prevention program.

Created in 1996 and updated in 2015, the OSHA Guidelines calls upon employers to take actions to help reduce the hazard of workplace violence by:

- Identifying and assessing workplace violence hazards
- Taking steps to prevent or control the hazards identified
- Providing training on the early warnings and prevention of workplace violence
- Keeping records of threatening or violent workplace incidents
- Establishing a post-incident response procedure

Reducing the Threat of Workplace Violence

Zero-tolerance policies send a clear message to everyone working in the organization that all threats or incidents of violence and harassment will be taken seriously. If there are no plans in place, leadership and staff should work to implement one suitable for the organization using some recommendations discussed in this article.

Sexual Harassment

One area of frequent confusion related to workplace violence is what constitutes sexual harassment, and when harassment becomes illegal. Types of harassment include:

- Physical harassment, such as unwanted touching, grabbing, patting, pinching, brushing up against another's body, or cornering someone
- Verbal harassment can include requests for sexual favors, offensive jokes or language, and sexual comments about a person's clothing or looks.

Victims of harassment should document the situation and any conversations, including dates, verbatim comments, and any witnesses if the situation continues or escalates.

Bullying

Bullying and verbal abuse are a type of worker-on-worker violence quite common in healthcare. In studies of bullying and verbal abuse among nurses, it has been found that:

- 53% of student nurses report being "put down" by staff nurses, 40% being humiliated[11]
- 60% of new nurses leave their first position within six months due to verbal abuse by a colleague[12]
- 85% of nurses report having been bullied during their career[12]

Anyone who is being bullied, and feels comfortable doing so, should address perpetrators promptly and privately, report events through channels, and keep a detailed, written account of the incidents and their frequency if the problem escalates.

Patient Dismissal/Termination

If the decision is made to terminate a patient, to avoid accusations of abandonment and potential liability, treatment should continue until procedures already begun are completed and the patient is medically stable.

- Check the termination policies of the patient's health care plan before initiating any action.
- Send a termination letter by both certified mail and regular mail after communicating the reasons for the decision face-to-face.
- In the notice of dismissal state the reason(s) for termination.
- Indicate the patient's health status and include any recommendations for immediate care.
- Note the date the relationship will end (30 days from receipt is customary; 45 days in Georgia by statute).
- Agree to provide emergency care until termination.
- Retain a copy of the termination letter in the patient's health care records.

De-escalation Strategies

When encountering someone in the workplace who has lost control of their behavior, response is the key to avoiding a physical confrontation.

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[11] Smith, Carolyn R., PhD. (2016). "Seeing Students Squirm: Nursing Students' Experience of Bullying Behaviors During Clinical Rotations," Journal of Nursing Education, September 1, 2016. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5149060/

[12] Colduvell, Kathleen, RN. (2017). "Nurse Bullying: Stand Up and Speak Out," Nurse.org, April 14, 2017. Retrieved from https://nurse.org/articles/how-to-deal-with-nurse-bullying/

Agitation is a continuum, ranging from anxiety to full-on aggression. Managing a patient who is willing and able to engage differs vastly from trying to deal with a patient who may be on the verge of committing violence.

When working with an agitated patient to there are four main objectives when attempting to de-escalate the situation:

- Ensure safety of the patient, staff, and anyone else
- Help the patient manage emotions and maintain or regain composure
- Avoid using restraints or involuntary medication when possible
- Avoid further agitating the patient

Here are tips that may help regain control:

- Only one member of the team should verbally interact with the patient.
- Introduce yourself and explain you are there to help keep patients safe.
- Orient the patient to the area and what to expect.
- Respect the patient's personal space and keep safe by maintaining at least two arm lengths between you.
- Both you and the patient should be able to exit the room – do not block the door.
- If the patient tells you to get out of the way, do so immediately.
- Use nonthreatening language, and remain calm, rational, and professional.
- Be empathetic and nonjudgmental and keep your tone and body language neutral.
- Keep your language simple and concise, and don't fear silence.
- Allow time for the patient to reflect on the information you are providing.
- Repetition is essential – you may need to repeat your message until the patient hears and understands the information you are providing.
- The patient needs to know that actions have consequences and may affect your ability to provide desired actions or items.
- Once you have established a relationship with the patient and determined his ability to stay in control, teach him how to stay in control by using gentle instructions such as, "I would really like you to sit down. You could help me understand if you tell me your concerns calmly."

The most important thing to remember is that you must keep yourself safe. If at any point you feel as though you might be in danger, remove yourself from the situation.

Incident / Variance Reports

An incident report should be filed whenever an unexpected event occurs. Any time a patient makes a complaint, an error occurs, a device malfunctions, or anyone—patient, staff member or visitor—is injured or involved in a situation with the potential for injury, an incident report is required.

Active Shooters

Unfortunately, although we are seeing active shooter situations more frequently in the news media, hospital shootings are relatively rare. There were 241 hospital-related shootings between 2000 – 2015, an average of 15 per year.[13]

Studies have shown that trained individuals are more likely to responded according to their training. The FBI recommends:

- Accept that an emergency is occurring.
- Assess what you need to do next to save lives, depending on your location.
- Act to lockdown, lock and barricade the doors, turn off the lights, have patients get on the floor and hide, or evacuate.
- Alert law enforcement and security as soon as it is safe for you to do so.

Another JLNC
SideNOTE

- The Board of Certification for Emergency Nursing offers specialty certifications for emergency nurses working in emergency settings and on ground and air transport. The requirements to obtain these specialty certifications can be located at https://bcen.org

WHERE TO NEXT?

Violence in healthcare, and especially the ED, has been traditionally tolerated as part of the job. Given the tools and support to report these violent incidents, nurses may experience a decreased tolerance for the violence. Thorough education, and use of a reporting tool, nurses are empowered to identify the issues and patterns at their facility and hold patients accountable for their behavior. Staffers can use this document as a starting point to kick off a discussion on workplace violence. Together, nurses and leaders can build a safer, smarter workplace.

Jennifer Flynn, BA, CPHRM, is a Certified Professional in Healthcare Risk Management and licensed Property & Casualty agent. She is the Risk Manager for Nurses Service Organization in the Healthcare Division of Aon's Affinity Insurance Services, Inc., dedicated to educating health care professionals on professional liability risks and strategies to mitigate them using patient safety principles and developing quality management programs. In addition to being a frequent national speaker on healthcare risk and liability, she is also a published author on various risk management topics. She can be contacted at Jennifer.Flynn@aon.com

Legal Issues with Sexual and Gender Minority Patients in the Emergency Department

Edie Brous RN, BSN, MS, MPH, JD

Keywords: Lesbian, Gay, Bisexual, Transgender, sexual minority, gender minority, bias, liability, cultural competence, disparities, discrimination

The Lesbian, Gay, Bisexual, Transgender (LGBT) community experiences singular challenges in accessing health care, as well as in utilizing health care services. This also applies in Emergency Department (ED) settings. Nursing and medical education inadequately prepare providers to work with this population. An ED that does not provide culturally competent care to LGBT patients further exacerbates existing health care disparities and compromises the safety and well-being of this community. ED staff must be aware of these disparities and address implicit bias in their practice.

"If I can establish a rapport and earn a patient's trust it makes my job easier and their care safer. That is more than enough to justify the effort required, but beyond that I recognize that patients bring their world experiences into the ED with them. If they have been abused, discriminated against, disrespected, or even assaulted because of their beliefs or who they are, simply treating them courteously can sometimes be more important and lasting in its impact than, say, a cast for a fracture or a course of antibiotics." (Ovens, 2017)

INTRODUCTION

The Lesbian, Gay, Bisexual, Transgender (LGBT) community experiences singular challenges in accessing health care, as well as in utilizing health care services. This also applies in Emergency Department (ED) settings. Nursing and medical edu-

cation inadequately prepare providers to work with this population. An ED that does not provide culturally competent care to LGBT patients further exacerbates existing health care disparities and compromises the safety and well-being of this community. ED staff must be aware of these disparities and address implicit bias in their practice.

Failure to meet the unique needs of this community can expose the ED to liability. Civil litigation, loss of federal funding, citations from regulatory authorities, and adverse publicity are potential consequences for failing to provide adequate care to LGBT patients (Comerford, 2016). Cynthia Wallace notes, "[D]on't wait for a lawsuit to gain the organization's attention regarding what the Joint Commission calls an "overlooked community" of healthcare consumers (Wallace, 2016).

BACKGROUND

A recent Gallup poll indicated that the percentage of Americans who identify as LGBT continues to increase with each survey. Gallup first polled this measure in 2012. The percentage that year was 3.5%. In 2016 it was 4.1%, and in 2018 it was 4.5%. The increase is driven in large part by millennials (persons born between 1980 and 1999). In the latest poll, 8.1% of millennials identify as LGBT. Gallup estimates that the number of adults in the United States who identify as LGBT exceeds 11 million (Newport, 2018). Approximately 0.58 percent of American adults constituting 1,397,150 people aged 18 and older, identify as transgender (Flores, 2016). The percentage is higher for younger Americans – 0.73 percent or 149,750 people aged 13 to 17 identify as transgender (Herman, 2017) (Williams Institute, 2017). Estimates of these communities is made difficult by underreporting in polls.

LGBT individuals experience rates of illness and death that are disproportionate to the general population (Baral, 2018) (Moreau, 2018). Sexual minorities suffer health care disparities such as higher smoking rates, higher use of alcohol and drugs, higher HIV infection rates, higher rates of depression, suicide, and social isolation, higher rates of certain cancers, exposure to hate crimes and violence, and more barriers to competent care (Jalali, 2015) (ODPHP, 2019). These disparities are caused, in part, by marginalization. People who feel discriminated against are less likely to seek emergency services, or to feel safe when doing so. Fear of being mistreated, harassed, or discriminated against leads people to avoid seeking emergency care. (Samuels, 2018) (Baral, 2018). Delays in seeking care create health risks, increase morbidity and mortality, and increase cost (Willging, 2019). A recent study indicated that approximately 18 percent of LGBT people and 22 percent of transgender people have avoided medical care out of fear that they would be discriminated against (NPR and RWJF, 2018). Additional dangers are created when emergency providers are inadequately educated to care for sexual or gender minority patients who do present seeking treatment. Studies also reveal that transgender patients delay care out of fear that they will need to educate their providers about their health issues (Willging, 2019).

DISCRIMINATION

Discrimination against LGBT patients, particularly transgender patients, takes many forms, but most commonly involve denial of gender identity, disclosing transgender status to non- necessary parties, and delays in provision of care (TLDEF, 2016). A Minnesota lawsuit illustrates these forms of discrimination.

In June 2013, Jakob Rumble sought treatment at Fairview Southdale Hospital. Although he identified as male, the ED clerk gave him a wristband labeled "F" for female. Despite being febrile and in pain, he waited almost five hours to be seen by a physician. Patients with lower acuity levels were seen while Mr. Rumble waited in pain for a physician. When Dr. Steinman finally came to see him, he was accompanied by a female assistant and an OB-GYN. Dr. Steinman was hostile and aggressive, and conducted a rough physical examination, intensifying Mr. Rumble's pain. Mr. Rumble had to ask twice for him to stop the examination. Neither the assistant, nor the OB-GYN intervened. Dr. Steinman left the room and Rumble waited an additional two hours. The staff identified that other patients did not wait as long as he had.

Mr. Rumble was eventually admitted to the hospital. His mother was informed by another physician that he would have been septic within 12 to 24 hours from when she brought him to the ED and that he could have died. To his embarrassment, a dry erase board on the wall in his room identified one of his treating physicians as OB-GYN. An infectious disease physician examined his genitals, wiped his gloves on the blanket, then examined Rumble's eyes and mouth with those same gloves. Rumble also experienced hostility from the nursing staff. He remained in the hospital for six days and after discharge received a bill stating that "[T]he diagnosis is inconsistent with the patient's gender." As a result of this experience, Mr. Rumble developed of fear of doctors and would not return to Fairview, although it was the closest ED to his home.

Rumble filed a discrimination complaint with the Office for Civil Rights, alleging that his rights under the Affordable Care Act had been violated. He alleged that Fairview had discriminated against him on the basis of gender identity. He also filed a complaint under state law, alleging that the defendants had violated the Minnesota statute prohibiting unfair discriminatory practice. The defendants moved to have the case dismissed, but the court ruled

in Mr. Rumble's favor, finding that discrimination against transgender individuals is a form of sex discrimination (Rumble, 2015). In reviewing the Rumble case, Leah Tabbert noted, "[B]road legal protection from discrimination in health care would be a particularly important development for the transgender community, which has faced disproportionate barriers to health care" (Tabbert, 2015).

EDs and pre-hospital personnel can be exposed to liability when indulging in prejudices against LGBT patients. A startling example is provided by the Tyra Hunter case. In August 1995, 24-year-old Tyra Hunter, an African-American transgender woman, was involved a motor vehicle accident in Washington D.C. She was semi-consciousness and bleeding profusely when she was pulled from the car by onlookers (Bowles, 1995). Fire Department Emergency Medical Technicians (EMTs) arrived at the scene and began treating her injuries.

Ms. Hunter had participated in hormone therapy but had not undergone sexual reassignment surgery. When the EMT cut her pants leg open, he noted male genitalia. Despite Tyra's bleeding and respiratory distress, the EMT stood up, backed away from her, and made disparaging comments about her race and gender. Rather than rendering assistance to the injured woman, the other EMTs at the scene engaged in joking. For several minutes bystanders begged the laughing EMTs to resume treatment. The EMS supervisor arrived and Tyra was rushed to DC General Hospital. At the hospital, an ED physician refused to treat her. After not being diagnosed, transfused, or referred to surgery, Ms. Hunter died of internal bleeding from blunt force trauma a little over an hour after arrival. Evidence was presented that a chest tube inserted after her death produced 1,500 cubic centimeters (ccs) of blood (Howell 1998).

Tyra's mother, Margie Hunter, filed a $10 million-dollar wrongful death lawsuit against the District of Columbia, the fire department EMT, DC General Hospital, and the ED physician, alleging delayed and inadequate care. Upon hearing an expert testify that Ms. Hunter had an 86 percent chance of survival had she received proper medical care, a jury awarded Tyra's mother $2.9 million dollars (Roberts, 2007). Washington D.C. appealed the decision but settled the case with Tyra's mother for $1.75 million dollars (Rosendall, 2000).

An attorney attending the trial noted that evidence was presented that the ED administered Narcan rather than treating her for hypovolemic shock. The attorney noted:

> The administration of the Narcan supports the inference that a stereotype (namely that Tyra was an anonymous, drug using, TG street person) affected the treatment she received. The ER staff, as evidenced by their actions, did not consider her life worth saving; the post-death CPR and heart massage were merely perfunctory, CYA measures, or a practice opportunity. To the jury's credit, they looked beyond the stereotype, discovered the human being, and recognized the injustice done to her (Howell 1998).

Explicit legal protections against discrimination are lacking at the federal level and in most states, further jeopardizing the health and well-being of the LGBT community (MAP/NCTE 2018) (Thoreson, 2018).

DOMESTIC VIOLENCE OR INTIMATE PARTNER VIOLENCE

Most ED providers have been educated to recognize and respond to domestic violence in the heterosexual population, but are poorly-equipped to do so with LGBT patients. This form of marginalization further endangers sexual minorities and creates additional vulnerabilities. Intimate partner violence (IPV) in the LGBT community is comparable to that of the heterosexual community, but structural barriers uniquely compromise safety and fail to protect LGBT persons from their perpetrators (Brown & Herman, 2017).

Shelters might not be available, may refuse to provide services to LGBT people, or they might fail to protect same-sex partners from their perpetrators Dudley, 2017) (Brown & Herman, 2017). Transgender people can be excluded by others staying at shelters (Tesch, 2019).

ED providers might mistakenly believe that IPV is less severe or dangerous in the LGBT community, characterizing events as "sissy fights" or "cat fights" and not recognizing the potential for serious harm or death (HRC, 2017). Laws and processes that protect heterosexuals might not be in place or available to LGBT patients. Legal definitions of

domestic violence might exclude same-sex couples (Brown & Herman, 2017). Before same sex marriage was available, for example, many jurisdictions would not allow LGBT members access to the family courts for obtaining protection orders. Because LGBT persons did not meet the legal definition of family, these survivors needed to obtain protection orders through the criminal justice system. This required making police reports and pressing criminal charges. Police reports can be difficult to obtain when the officers do not take the threat seriously. Indeed, 45 percent of LGBT victims do not report IPV to the police because they do not believe it will help them (NCADV, 2018).

Health care professionals might not be able to provide the assistance same-sex couples need. This intensifies the perception that providers will be insensitive to their specific needs and further deter victims of IPV from seeking services (Barrett, 2015). LGBT patients have little confidence that providers have the necessary skills to assist them. This is particularly true for transgender issues (Brown & Herman, 2017).

HATE CRIMES

The epidemic of violent crimes committed against LGBT or perceived LGBT persons is increasing, rather than decreasing in the United States. LGBT persons are more likely to be the target of these hate crimes than Jews, Muslims, African-Americans, Asians, Hispanics, or Caucasians, making them more likely than any other minority to be targets of bias violence (Park & Mykhalyshyn, 2016). The Federal Bureau of Investigation released 2017 statistics indicating that hate crimes based on sexual orientation had increased five percent from 2016. In 2017, twenty-nine of the transgender individuals targeted by hate crimes were killed. Transgender women of color are at particular risk, facing the intersection of biases against race, sex, and gender identity (Dashow, 2018).

Hate crimes against the LGBT community are vastly underreported for a number of reasons. This population is overrepresented as victims, yet underreported to police for some of the same reasons as with IPV. This includes fears that the police will not take the complaint seriously or that they will be further harassed (Keith, 2018). And, like IPV, victims of LGBT hate crimes also fear discrimination from health care providers, illustrating the need for cultural competency training in ED staff (Coston, 2018). As with IPV, structural resources are inadequate to meet the needs of LGBT people experiencing hate crimes, including the education of providers to care for this population.

CLINICAL CONCERNS

A recent study polling 399 emergency physicians found that 88 percent of the respondents had cared for transgender and gender nonconforming patients. Most of them lacked the basic clinical knowledge to care for this population, however, as 82.5 percent of these physicians had never received formal training about transgender patients (Chisolm-Straker, 2018). Failure to perform medically-appropriate screening can expose an ED to liability and allegations that the Emergency Medical Transfer and Active Labor Act (EMTALA) has been violated.

As with all patients, ED staff need to be aware of any medications patients are taking and the potential interaction of those medications with drugs that are administered in the ED. It is important with transgender patients to know if and what hormone therapy the patient is undergoing and exercise caution in administering certain medications. ACE inhibitors, Digoxin, Angiotensin II receptor blockers, steroids, Lithium, Cholestyramine, skeletal muscle relaxants, norepinephrine, Heparin, Lovenox, NSAIDs and others can interact with Spironolactone (Pfizer, 2018).

Transgender women on hormone therapy might be at higher risk for cardiovascular problems which present in an ED such as myocardial infarction, cerebral vascular accident, thrombosis or embolism (Getahun, 2018). Because the prostate is not removed in gender affirmation surgery, transgender women must still be screened for prostate cancer. In fact, prostate cancer in

Another JLNC
SideNOTE

- The **Emergency Nurses Association** is the authoritative body for emergency nurses accessed at www.ena.org
- The **American College of Emergency Physicians** is the authoritative body for emergency physicians and can be located at www.acep.org
- The **Society of Trauma Nurses** offers education and information on the care of trauma patients at https://www.traumanurses.org
- The **Emergency Nurses Association *Emergency Nursing Scope and Standard of Practice*** includes the framework for emergency nurses and advanced practice nurses functioning in the emergency setting.
- A few primary resources published by the **Emergency Nurses Association (ENA)** for standards of emergency care include ***Emergency Nurses Core Curriculum*** (7th Edition) and ***Sheehy's Manual of Emergency Care*** (7th Edition). Both books can be purchased in the ENA store at www.ena.org

Transgender women on hormone therapy might be at higher risk for cardiovascular problems. The prostate is not removed in gender affirmation surgery, so transgender women must be screened for prostate cancer.

transgender women might be of a more aggressive form. Transgender men must be screened for breast, cervical, ovarian and endometrial cancer (Braun, 2017). ED staff must be educated in the clinical management of transgender patients to ensure that the standards of practice are adhered to. Clinical referrals that would be made for cisgender patients should also be made for transgender patients.

HUMAN TRAFFICKING

LGBT youth are at risk of homelessness from parental rejection and constitute about 40 percent of the runaway and homeless youth population (U.S. Dept. of HHS, n.d.). Homelessness is a risk factor for trafficking and forced prostitution (U.S. Dept. of State, 2017). LGBT youth are disproportionately trafficked and ED providers must know how to recognize potential trafficking victims. When suspecting that an LGBT youth has been trafficked, ED personnel should use a trauma-informed approach in their care and provide a social service consultation. Polaris identifies the top five risk factors for human trafficking as:

1. Recent migration/relocation;
2. Substance use;
3. Runaway/homeless youth;
4. Mental health concern; and
5. Involvement in the child welfare system (Polaris, 2019).

Because victims of trafficking are likely to have limited access to health care, the care they do receive is often provided in EDs (Mumma, 2017). ED providers, therefore, are in a unique position to rescue trafficked persons from their captors. The Office on Trafficking in Persons offers training to educate first responders on recognizing and assisting trafficking victims. The program is referred to as SOAR training and involves the elements of:

- **Stop** – Become aware of the scope of human trafficking;
- **Observe** – Recognize verbal and non-verbal indicators of human trafficking;
- **Ask** – Identify and interact with a potential human trafficking victim using a victim-centered approach; and
- **Respond** – Act effectively to a potential human trafficking victim (U.S. Dept. of HHS, 2019).

CONCLUSION

ED staff must be educated in the care of LGBT patients so as to not further marginalize them. The standard of care that would be provided to other patients must be provided to sexual minorities with the same vigilance. Additionally, because LGBT patients are more likely to present to the ED for domestic violence, hate crimes, depression, suicidality, or human trafficking, staff must know to screen this population for these particular risks (Sutter, 2018).

As the Emergency Nurses Association states, "When emergency nurses and other healthcare staff embrace an inclusive, affirmative environment within the emergency care setting and act as advocates for change, they can significantly promote equal treatment and access to healthcare for all patients" (ENA, 2016).

NURSING IMPLICATIONS

- Recognize and address implicit bias in one's own practice. Unchecked anti-transgender implicit bias results in knowledge gaps and poor treatment (TLDEF, 2016)
- Distinguish between gender identity and sexual orientation.
- Distinguish between transgender and cross-dressing.
- Recognize that LGBT patients might not feel safe in the ED and create a safe environment for them by making them feel welcome.
- Recognize IPV with the LGBT population.
- Maintain education regarding the clinical implications of medical transitions.
- Recognize hate crimes with the LGBT population.
- Recognize human trafficking with the LGBT population, particularly with LGBT youth.
- Know what community resources are available for this population.

- Distinguish when a presenting complaint is and is not related to a patient's transgender status. Questions about gender identity are inappropriate and offensive if they are not medically relevant. Transgender patients experience ED providers as being unable to know when and how their transgender medical history is relevant to their presenting complaint (Straker, 2017). Over-curiosity is a form of transphobia that makes patients feel unsafe and further marginalized. (Willging, 2019).
- Use appropriate pronouns. Misgendering a patient is abusive.
- Include sexual and gender minorities in cultural competency education.
- Include the care of LGBT patients in educational curriculum and orientation materials. The American Academy of Family Physicians provides a curriculum guideline (AAFP, 2016) and the Joint Commission offers a "field guide" for care of the LGBT community (TJC, 2014).
- Include pre-hospital providers in antidiscrimination training. LGBT patients need to feel safe in the ambulance as well as the ED (Kruse, 2018).
- Provide gender-neutral bathrooms.
- Use an identity-based model rather than a disease-based model in caring for transgender patients to avoid pathologizing gender dysphoria or further stigmatizing (Braun, 2017) (MacCarthy, 2015).
- Institute policies and procedures to document gender identity. The Centers for Medicare and Medicaid Services specifically address the need to have policies of non-discrimination which includes sex and gender identity as a condition of participation (Federal Register, 2016.)

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Another JLNC SideNOTE

Hot Topics:

- Early identification of sepsis leads to lower patient mortality and better outcomes. **Guidelines for early Recognition of Sepsis in the Pediatric Patient** can be found at https://www.ena.org/docs/default-source/resource-library/practice-resources/topic-briefs/early-recognition-of-sepsis-in-the-pediatric-patient.pdf?sfvrsn=bf003c0b_10
- A patient with an infection or suspicion of infection will likely need blood cultures. **Guidelines to help the emergency nurse prevent blood culture contamination** can be found at https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/bcccpg2c37f1815b664d2fa8d7e9fd0f475a41.pdf?sfvrsn=6d1899fb_12 Contaminated blood culture specimens can lead to a delay in the most appropriate care.

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Edie Brous RN, BSN, MS, MPH, JD is a Nurse Attorney in private practice in New York City where she concentrates in professional licensure representation, medical malpractice defense, and nursing advocacy. She has practiced in major litigation law firms representing nurses, physicians, hospitals and pharmaceutical companies. Edie is admitted to practice before the bars of the state courts of New York, New Jersey and Pennsylvania, the Southern and Eastern Districts of the New York Federal Courts and the United States Supreme Court. She is a member of many bar associations and nursing organizations and was the 2011 president of The American Association of Nurse Attorneys.

Ms. Brous has an extensive clinical and managerial background in OR, Emergency and Critical Care Nursing. In addition to her law degree, she holds masters degrees in Public Health and in Critical Care Nursing from Columbia University. She has been part time faculty at Columbia University, and has held adjunct faculty positions at several universities teaching legal aspects of nursing. Ms. Brous has lectured and published extensively on legal issues for nurses and co-authored the textbook *Law and Ethics for Advanced Practice Nurses*. She is the 2008 recipient of the Outstanding Advocate Award and the 2017 Outstanding Litigation Member Award from The American Association of Nurse Attorneys.

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