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TSG PEDS EM NEWS

SAVING LIVES - REDUCING RISK

From The Editor

Welcome to the spring 2013 issue of Peds EM News. In this issue, we will take a look at a useful ED tip as you prepare for your EDAP certification; we provide some insight into how to handle checking head circumference in your little patients. We will also explore the waiting room and provide some useful tactics to help you manage your pediatric patient flow. Finally, we will wrap up with two useful reviews that could be beneficial to you and your staff: the ED's responsibilities prior to the transport of the ill child; and what it means to be a mandated reporter. Thanks again for subscribing to the Peds EM News. As always, we encourage suggestions for future articles. Thank you!

Dr. Todd Zimmerman

Peds ED Tip: Head Circumference

Many of you have probably heard of EDAP, which is an acronym for Emergency Department Approved for Pediatrics. EDAP is a designation awarded to an ED that has proven through a site review that it is capable and prepared to meet a certain standard when it comes to treating and taking care of children. The EDAP team reviews credentialing, CME, ED drugs and equipment, policies and procedures / guidelines, just to name a few. Additionally, the EDAP team reviews your ED's patient trends and looks for Quality Assurance data for your site's specific high-acuity patients; in other words, they take a look at how you compile and track data for the "sickest of the sick."

The EDAP reviewers will sometimes ask to see how the ED addresses a young child's head circumference. Head circumference is typically measured by the general pediatrician up until two years of age. The purpose for EDAP asking to see this in the ED is likely multivariate, but a key reason is that parents often use the ED for

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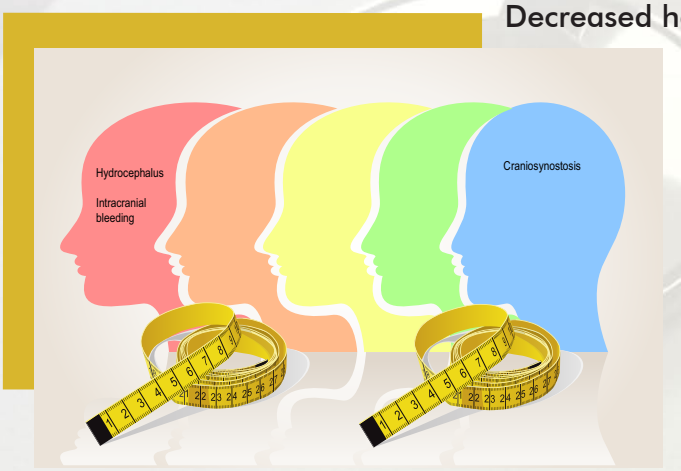
their children's illnesses and don't take them to regular primary care visits; therefore, many of these children do not have head circumference measurements taken unless they go to the ED.



There are certain conditions in young children that can result in either an enlarged or a small head circumference; some of these conditions can have serious sequelae if left untreated. If your patient has an increased head circumference, there are two conditions you should consider:

1. Hydrocephalus (congenital, obstructive and post traumatic)
2. Intracranial Bleeding

If a young child has intracranial bleeding and an enlarged head circumference, there would likely be other obvious signs and / or symptoms that would point toward this conclusion. However, a brain tumor or a space-occupying lesion can cause an increased head circumference. If the practitioner misses this and the child is subsequently diagnosed with a brain tumor, the physician will be at risk if a lawsuit is filed and the ED medical record shows that this child had a significantly increased head circumference at the time the physician saw the patient and did not act on it.

Decreased head circumference could be due to craniosynostosis. Craniosynostosis is a birth defect that causes the sutures in the skull to prematurely fuse; this can result in a limitation of brain development. This may not be viewed as a life-threatening emergency, but if the patient is eventually diagnosed with craniosynostosis and the ED medical record reveals that the patient had a head circumference at the 5th percentile, for example, the physician could be facing a medical malpractice suit.

As a result, we really need to view a child's head circumference almost like a vital sign. Not only does the physician have an obligation to review this information, but he or she also has an obligation to act on it.

In medicine we are often taught that if a data point is at or greater than two standard deviations from the mean, this should be considered potentially grossly abnormal. Most EMRs have the capability of "flagging" abnormal data points such as vital signs and lab results. We would encourage practitioners to work with their IT departments

and EMR systems to flag head circumferences; for example, have the abnormal data point turn red or highlight it when it reaches two standard deviations from the mean, or the 5th and the 90th percentiles.

Many pediatric ED Medical Directors have expressed a concern in that the measuring of head circumferences should not be routine; rather they feel a head circumference should be taken only under certain conditions. Here is an example of a reasonable approach of how to handle the measuring of a head circumference in the ED.

Addendum to the Vital Sign-Triage Policy

Measuring Head Circumference

1. Measure head circumference using a standard paper tape measure.
2. Measure at the widest part of the head, which is usually 2 finger breadths above the eyebrow around to the widest part of the back of the head.
3. Record head circumference in centimeters (cm).
4. Plot according to the head circumference growth charts as provided by the CDC / WHO.
5. Report to the physician if the head circumference falls at or above the 90th percentile OR if it falls at or below the 5th percentile.

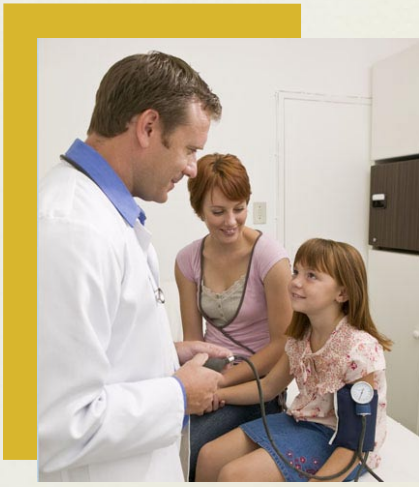
Conditions in Which the Head Circumference Shall be Checked

- If the head appears enlarged
- If a patient has a bulging fontanel
- If the patient has a fontanel bruit
- If the head appears small

Something similar to this should be a part your department's vital sign triage policy.

Managing The ED Waiting Room

Emergency Medicine is definitely changing, and it's changing rapidly. We are seeing our line of work moving more and more towards fee-for-performance and away from fee-for-service; furthermore, it is becoming more metric-driven. Customer satisfaction is a huge part of this equation, and managing the waiting room can help.



What do we mean by "managing the waiting room"? When I started in EM, the waiting room was an afterthought. I was not aware of what was

going on in the waiting room nor did I see it as my responsibility.

But I then began noticing that patients were incredibly upset about waiting times, which meant that the whole ED experience was tainted even before I saw the patient. Then it hit me - why not bring the patients back myself if I was between patients or ask a team member to bring the next patient back if we had open rooms.

Well, this was not the norm, so there was a lot of resistance to making this change, despite the fact that it really was in the best interests of the patients. A change such as this puts a real strain on the nursing staff, especially if there is not clear communication about your plan.

You should clearly communicate that you will start seeing patients, or at least "eyeballing" patients, if there are open rooms. This will also allow you to get something started on the patient such as an X-ray, a urine, or some basic vital signs.

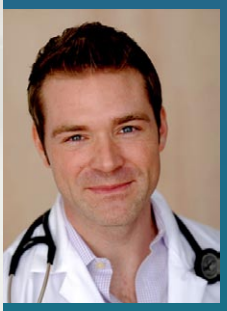
So what does this accomplish?

- More satisfied patients
- A decrease in your door-to-doc time
- A decrease in your length of stays
- A decrease in your LWOT percentage
- Most importantly, you are conveying to the team that every member is an equal

Patient Satisfaction Is Here

What's Your Plan?

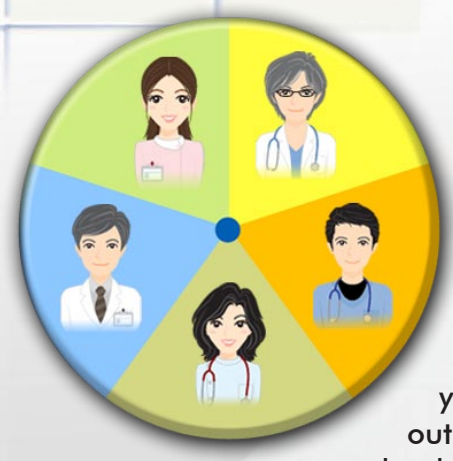
It has been a common belief that "Happy patients don't sue" and some organizations have relied on this as their risk management strategy. Furthermore, now that reimbursements have been tied to patient satisfaction scores, physician groups and hospitals have become even more invested in finding solutions that truly make a difference in their patient satisfaction metrics.



TSG has responded by developing a new Patient Satisfaction program called *Patient*SET™ "**S**atisfaction **E**very **T**ime." Championed by Dr. Doug Finefrock, *Patient*SET™ looks to the literature to identify certain elements of behavior that patients would like to see displayed during the physician /patient encounter. Delivered through an online course series, Dr. Finefrock uses multimedia videos to provide concrete examples that will help improve the patient experience.

In true TSG fashion, *Patient*SET™ extends beyond online education to include a real-time 'checklist' for the provider (*Patient*SET™ List) as well as an observational assessment tool (*Patient*SET™ Assessment) to be used by a case manager to analyze the clinician's compliance with key behavior elements of the visit.

If you are interested in learning more about the new *Patient*SET™ Program, please contact:
Brant Roth at broth@thesullivangroup.com



part of the wheel. It may go a long way when a tech or a nurse sees you helping them out with something that historically was viewed as "their job."

Bringing patients back into an open bed is the job of the tech and / or the nurse, but it is also the responsibility of the physician to ensure that patients are seen in a timely fashion. This inherently makes this the physician's job as well.

Let's take a look at some of the obvious concerns and questions that will likely come up.

How do you manage the waiting room?

It's pretty simple. Keep an eye on the tracker and see how long patients are waiting. See how many open beds there are, how many ambulances are coming in that you are aware of, and how many acutely sick patients you are expecting that were called in by their PMDs. You can actually accomplish this in about 15 seconds. If a patient is approaching a waiting time that hovers around your hospital's goal, that should be your trigger to make contact with the patient.

What do we do if the nurses and techs are really busy?

Communication is always key. Let the team know you have the time to see another patient and that you are going to bring the next patient back into the open bed to at least get him or her started. You can even let the patient know what is going on: "Mrs. Smith, I am Dr. Zimmerman. Right now the nurses and techs are super busy, and I had a moment and an open bed that has your son's name on it. This way we can at least get you out of the waiting room, although there still may be a little wait once he's in the bed." When you are done "eyeballing" the patient and have a chance, communicate your findings to the tech and the nurse so there are no surprises. Congratulations! You just decreased door-to-doc time, decreased overall length of stay, made a patient / parent happier, and demonstrated to the team your sense of ownership, pride and teamwork in your department.

"As always, I enjoy the educational content provided by The Sullivan Group. It is relevant and pertinent in my line of care. The way in which the material is presented makes interesting and ultimately enjoyable to take. Thank you."

Karen Black, RN
Trident Regional Medical Center (*Pediatric Infections*)

What if you brought the patient back, but the patient is really sick and the nurses are busy?

If the patient is really sick, he is better off in an ED bed than sitting on a chair in the waiting room. The hospital and everyone on the ED team have a responsibility to patients in the waiting room. The physician is part of the ED team; therefore, the physician has an inherent responsibility as well.

What if there are no beds and the patient has been waiting awhile?

Once again, communication is key. Go into the waiting room and let the patient or the parents know that you are aware they are here and waiting. Let them know that you appreciate it and that they are on your mind. Also communicate that you are working hard to free up a bed and will get them back as soon as possible. Congratulations! You just recognized a sick and / or worried patient / parent / caretaker. The fact that you took the time to recognize that your patient was there and waiting may go a long way toward their psychological well-being; it may also avoid a dreaded LWOT.

Doctors and nurses that have been practicing the same way for years are notorious for resisting change. However, a change that actually manages the waiting room provides for better patient care, better patient satisfaction, and better metrics - a real "win, win, win" situation.

Responsibilities Prior To Transporting The Ill Child

The AAP Section on Transport Medicine recently published a set of guidelines / recommendations on what a medical facility should accomplish as a baseline prior to using another transport team. A lot of this is "medical common sense," but the following is a review of the basic recommendations.

- Establish the relationship with the transport team PRIOR to when the team is needed. All the medical directors should know the composition of the transport team: who the medical director is, the modes of transport available, and what the team's policy is on transporting the parent with the child.
- Each facility must obtain consent for transfer from the referring physician AND the transport team.
- Document any and all recommendations made to you by the transport team in the patient's medical record prior to the team's arrival.

- If necessary, use other medical personnel to document in their notes all others who provided care for this patient.
- Leave your patient ONLY if equivalent coverage is present; i.e., signed off to another physician. Communicate with the transport team who the physician will be that will be present when the team arrives.
- Remember that you are the responsible physician for this patient until there is documented sign-out to the transport team AND the transport team has left your facility. Assure that all medical records and radiology studies are copied and available to the transport team. Keep in mind that if any radiology studies are going to be e-mailed, you MUST get parental consent in order to be in compliance with HIPAA.
- Always try to follow up on your patient after he or she leaves the ED (e.g., callbacks, etc.). This can be an invaluable tool for teaching, process improvement, quality assurance and risk management.

This is a summation with intercalated comments by Dr. Todd Zimmerman from an article published in *AAP News*, Volume 29, Number 10, October 2007, page 15.

RSQ® Peds e-Learning Topics

- Appendicitis
- Appendicitis in Children
- Cognitive Errors in Medicine Part 1
- Cognitive Errors in Medicine Part 2
- Community-Acquired MRSA
- Head Injury
- Neonatal Emergencies
- Optimizing Communication in the Emergency Department
- Orthopedic Injuries
- Pediatric Abdominal Emergencies
- Pediatric Infections
- Pediatric Medical-Legal Documentation Setting The Record Straight
- Pediatric Meningitis
- Pediatric Meningitis Case Studies
- Pediatric Meningitis Case Study: A 14-Month-Old Child with a Fever
- Pediatric Meningitis Case Study: A 23-Month-Old Child with a Fever
- Pediatric Respiratory Emergencies
- Testicular Torsion
- Testicular Torsion Case Study: A 15-Year-Old Male with Abdominal Pain
- Wound Care

Click on course name to see course description.

Mandated Reporter – A Brief Review

A mandated reporter is a person who, by virtue of his or her job, is legally required to report to authorities any suspected or confirmed abuse of children. Physicians, nurses and other healthcare workers are considered to be mandated reporters.

The U.S. Department of Health and Human Services published an article entitled Mandatory Reporters of Child Abuse and Neglect. The following are some important points from this publication:

- You should file a report when you suspect or have reason to believe a child is being abused or neglected.
- A report should also be filed if you either have knowledge of or see a child being subjected to conditions that would reasonably result in harm to the child.
- States have specific statutes regarding what is considered to be privileged communication. Privileged communication is the recognition of the right to maintain confidentiality between the mandated reporter and the parent per se. This privileged communication is frequently limited by the states in order to protect potentially abused children; for example:
  - Physician-patient relationships / privileges are commonly denied.
  - Husband-wife relationships / privileges are commonly denied.
  - Attorney-client privilege is commonly allowed.
  - Clergy-penitent privilege is often, but not always, affirmed, but it is limited to confession.
- In some states, a mandatory reporter does not have to give his or her name, but this is obviously counterintuitive since your involvement in the case as a medical professional is often critical in helping the child.

You can find your state's specific statutes regarding mandated reporting in this publication. It can be found at the Child Welfare Information Gateway web site: http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm

It would be a good idea to revisit this with your team from time to time to assure that the entire ED team is on board and each person understands his / her responsibilities while helping to heal and protect their young patients.

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