NURSING HOME TRANSFER SHEET INFORMATION

We are having difficulty with the information we receive with transfers from our local nursing homes. The patients either show up at the door with no warning, or we receive their entire chart. What has worked for others to improve appropriate communication with nursing homes?

Answer 1:
We were having chronic issues with our local nursing homes. We typically received 30 pages of photocopies of the patient’s long-term medications and laboratory results, but no report or indication of why the patient was sent today. Basic Life Support (BLS) ambulances, instead of the needed Advanced Life Support (ALS) paramedics, transferred many critically ill patients. We decided to focus on 2 problem areas: mutual understanding of what was important to each of us, and proper method of patient transportation.

Both of these issues required education. We sent a letter to the nursing home administration indicating that we would like to meet with the staff and what we hoped to accomplish. We started with the 5 closest facilities from which most of our nursing home clientele come from, but we are hoping to expand to all of our facilities eventually.

We developed a “Hot Shot” transfer form on bright pink paper (so it stands out) with the critical information areas for us. We determined the key information items that the emergency department needed to know from the nursing home. They included the following: (1) Why is this patient being sent today? (2) Who is the patient’s attending physician? (3) Does the patient have an advanced directive?

Interestingly, in our meetings, the nursing home administrators indicated concerns about the information we sent back to them. They needed a more specific discharge
plan. For example, did “wound check” or “suture removal” have to be done in the emergency department, or could it be performed at the nursing home? Were they to continue all of the same medications? When were they to contact the attending physician about change or follow-up in the regime? As a result, we included sections for what they need to know on the “Hot Sheet” paper. We also encourage a phone call report for both facilities.

For the second goal, we gave an in-service session specifically focused on when ALS paramedics versus BLS ambulances (with EMTs) should be called. Examples of when ALS ambulances should be called include new-onset symptoms of mental status changes, chest pain, or a stroke (brain attack). Part of the process was emphasizing that nursing judgment empowers a decision to do what is best for the patient even if it varies from the routine.

We have had a good response. A side benefit was our hospital personnel experiencing the nursing home environment. It is important to be reminded of their nurses’ patient loads and to remember that everyone is trying to do the right thing.

Most important, patient care has improved. We recently had ALS paramedics bring in a nursing home patient with new-onset of chest pain. That type of prehospital care would not have typically happened before our collaborative meetings.

—Stephanie Baker, RN, BSN, MBA/HCM, CEN, MICN, Director of Emergency Services, Paradise Valley Hospital, National City, CA; StephanieRN1@cox.net

Answer 2:
We recognized that both the nursing homes and emergency department wanted to do the right thing, but communication could be a problem because the nursing home is placed under pressure to transfer their patient rapidly when a need arises. We designed a 1-page, but 2-phase, transfer form based on a survey to determine what information the ED nurses needed.

The top 75% is completed on the patient’s day of admission to the nursing home facility. The staff then only has to fill in the bottom 25% with the details related to this visit. The concise form has been beneficial for everyone.

A problem has been the high turnover in the nursing homes, particularly in the nurse director position. We are working towards establishing a process so that the form’s completion will not be dependent on any particular individual’s oversight.

—Valerie Brumfield, RN, MSN, CCRN, ED Clinical Nurse Specialist, University of Texas Medical Branch at Galveston, Galveston, Tex; vcbrumfi@utmb.edu

STAFF NURSES ANESTHETIZING WOUNDS

Does any other emergency department have a policy for registered nurses to anesthetize a wound by infiltration (versus a topical application of EMLA [euteric mixture of lidocaine and prilocaine], LET [4% lidocaine, 1:1000 epinephrine, and 0.5% tetracaine], or TAC [tetracaine, epinephrine, and cocaine]) prior to cleaning it?

Answer:
At an emergency department where I once worked in Indiana, the nurses anesthetized the laceration prior to cleaning/irrigation before the physician sutured it. The physician ordered the procedure and specified the appropriate anesthetic (most often lidocaine or bupivacaine).

The procedure was written by one of the physicians. Training was accomplished by a video demonstration, with demonstration in practice several times before the nurse was allowed to perform the procedure under supervision. It was part of the orientation to our emergency department.

Overall, anecdotally, the process resulted in shorter treatment times. The nurses enjoyed expanding their skills and the additional time for communication with the patient.

—Dave B. Hunter, RN, BSN, former ED staff nurse, Memorial Hospital, South Bend, Ind; davehunter3@comcast.net

STRATEGIES TO COVER TNCC/ENPC COSTS

Hospital financial support for TNCC and ENPC costs is waning, and many of my staff do not feel able to personally handle the cost of the course. What are others doing about this situation?

Answer 1:
As hospital support waned, the North Carolina ENA State Council decided to step up to try to help fill the void. We made a commitment to provide TNCC and ENPC courses in every geographic region in our state.
To accomplish this goal, the state needed more instructors, directors, and instructor faculty. Our state council undertook the training and provided some of the monies needed to accomplish that so eventually we will be able to increase the number of courses offered in our state.

Our specific goals included the following:

- Train and maintain a minimum of 4 faculty for instructor training within each region of the state.
- Provide a minimum of 3 instructor courses (one per region) a year.
- Train and maintain a minimum of 30 instructors per region.

The participants pay for their books, travel, and food. The North Carolina ENA pays indirect fees and instructors honorarium and expenses. In return, each state-supported instructor candidate commits to teach a minimum of 2 courses per year for 2 years following instructor monitoring.

—Dianne Steele, RN, CEN (errn16183@aol.com), Janice Hales, RN, Ann Marie Tyrell, RN, CEN, MS (atyrell@charter.net), and Melody Sides, RN, BSN (Mel5124@aol.com), Chair, North Carolina ENA Task Force and 2004 NC ENA President

Answer 2:
In Texas, we have helped reduce the cost to our participants in these courses by having our instructors volunteer to forgo their honorarium. We do work with the hospital to ensure they receive an educational day and do not need to use a personal time off.

—Valerie Brumfield, RN, MSN, CCRN, President, Gulf Coast Chapter, Galveston, Texas, vbrumfie@utmb.edu

Answer 3:
I laughingly tell others that there is “a lot of drug money out there.” We find that our pharmaceutical representatives like the idea of providing free, quite nice lunches for our courses. We allow them to come in and talk to the participants during lunch. They like the undivided attention (compared to trying to haphazardly catch staff while working in a busy emergency department) and the guarantee of an all registered nurse audience. The nurses appreciate a free delicious lunch.

—Steve Rasmussen, RN, CEN, Clinical Coordinator, Emergency Department, VCU Medical Center/MCV Hospitals and Physicians, Richmond, Va, 2ernurses@direcway.com

Answer 4:
We are piloting a state-sponsored purchase of the course textbooks for a 4-month trial to lessen participant cost by $40. We are hoping this “bargain” will entice nurses to take the course.

—Sandra K. Weagle, RN, CEN, President, Maine State Council, skwen@ime.net

**NURSE RETENTION**

What strategies are working for others who are seeking to keep nurses?

**Answer 1:**
This focus is important because of the well-known current nursing shortage and an aging nursing workforce. Even more compelling was the VHA Workforce Data Advisory Board report that 23% to 33% of nurses plan to leave their current job in the next year. Most nurses demonstrate high levels of burnout and 55% would not recommend the profession as a career choice.¹

In addition, there is the consideration of the cost of turnover. For a medical-surgical staff nurse, it costs approximately $46,000 and can increase up to $60,000 to $64,000 for a critical care nurse.²

Nurse turnover affects quality patient care. Low-turnover hospitals (with rates lower than 12%) had the lowest risk-adjusted mortality scores and the lowest severity-adjusted lengths of stay compared with hospitals with turnover rates that exceeded 22%.²

At Centra, we created a special nursing enhancement budget for nurse and manager development and special functions. The initial priority was to develop nursing leadership by tracking individual unit managers on 20 management/leadership competencies. These competencies included communication, relationships, and motivating others. It is essential that staff feel connected to and appreciated by their leaders.

Centra Health surveyed nursing managers and staff to learn just what it would take to retain and recruit staff. The result yielded a document of “101 Ways to Recognize and Retain Staff.” This document is available at www.centrahealth.com or by contacting Linda
Youngblood, our Retention Coordinator, at lindayoungblood@centrahealth.com.

Some of our specific retention strategies include the following:

- **Budgeted monies specifically for retention**: Managers are able to budget money to use for retention. Some of the more successful approaches include off-site retreats for staff, instant bonuses for staff caught doing “something right,” recognition of anniversaries by our Senior Vice President of Nursing, roses presented in person for nursing staff in service for 25 years, and massage chairs for use on the units.

  Joan Deal, Unit Manager of Cardiovascular Recovery Unit, purchased the first massage chair, which she found in a health care magazine for approximately $200. There is a plastic blow-up palm tree by the chair in the nurses’ lounge, and staff are encouraged to take “5-minute vacations.”

- **No pulling staff/no travelers**: Staff communicated 3 years ago that a huge dissatisfier was being pulled to other units. We now have “closed staffing” in place, whereby the individual units fill their own needs. We also have a resource pool of Centra nurses who maintain competencies in the acute areas to work on units where there may be a need.

- **Power naps**: The research on the dangers of excessive fatigue and sleepiness in night shift work is compelling. Staff are encouraged to sleep 30 minutes, with 5 minutes before to unwind and 5 minutes afterwards to gear up (total 40 minutes).

- **Code of conduct**: Similarly, convincing research evidence exists that how health care providers treat each other influences patient care. Therefore, we have a Code of Conduct Policy in place that does not support verbal abuse or disruptive behavior by either physicians or staff.

As a result of our concerted effort, we have decreased nurse turnover from 14.3% in 2000 to the current 3%. There has been a decrease in our patient mortality, a shortening of our length of stay, and a decrease in our direct cost per patient.

In the year 2001, Centra had 77 fewer nurses leave the system than the previous average. Using the reported financial data for replacing nurses, one can make the business case that we saved approximately $3,540,000 to $4,920,000 for the first year of utilizing retention as a priority in our organization!

—Golden Bethune, MSN, RN, CNAO, BC, Senior Vice President and Chief Nurse Executive, goldenbethune@centrahealth.com; Cheryl K. Burnett, Med, RN, Education Specialist, Department of Education, burnch1@centrahealth.com; Centra Health, Lynchburg, Va

**REFERENCES**


**Answer 2:**

For the past 15 years, Labor Management Institute (formerly Lawrenz Consulting) has surveyed hospitals to learn about demographic and operating trends in nurse staffing. These data results have become a national benchmark for nursing departments across the United States.

Nationwide, our survey found that hospitals are operationally full (85% capacity), with RNs making up 34% of the hospital full-time-equivalent employees (FTEs) and 63% of the nursing’s staff. It is taking an average of 13 weeks to fill a medical-surgical nurse position and 16.2 weeks for a specialty nurse position. The length of time is highest in community hospitals.
Some of the strategies hospitals are using for retention include the following:

- Offering flexible schedules
- Working 36 hours for 40 hours compensation
- Night shift RNs work 3 months, and then get 1 month off with pay
- Giving extra vacation after 5 and 10 years of service.
- Adjusting the pay scale of nurses with 20+ years of service.

To order a complete copy of the survey’s results, call 602-404-7544.

—Carol Ann Cavouras, MS, RN, CNAA, Labor Management Institute (formerly Lawrenz Consulting), Phoenix, AZ; cavouras@lminstitute.com; www.LMInstitute.com

REFERENCE


Answer 3:

Most of the time nurses are satisfied with their salary but are unhappy about the way care is being delivered. Our hospital system did a nurse work analysis. We found the average staff nurse had 22 different location changes among 8 different locations and talked with 22 people each hour. The nurse only spent 20 minutes, or one third of the time, in face-to-face patient contact. Medication administration took 17% of their time, and charting consumed 20%. It appeared that nurses were “nursing” everyone else in the system but the patient.

We had achieved good results in the past with Total Quality Management, but the results did not stick. We now use a transformation model, based on the Toyota approach toward work processes. This process includes the following:

- Start with a single patient need
- Observe how the work is currently done
- Find a root cause for any identifiable problem
- Identify a potential solution
- Test the potential solution (every day we are testing several new solutions)
- If successful, institute the change

One of our successes from this approach was changing how intravenous Ancef is administered. The policy was to administer it intravenous push (IVP) unless the patient complained of discomfort. Then it was further diluted and administered intravenous piggyback (IVPB).

The IVP procedure took 7 minutes on average, compared with the 3 minute IVPB procedure, but it was used because it was $1 less per dose. Yet we found that 50% of the patients complained and eventually had to receive the medication IVPB. We changed the protocol to IVPB for everyone and saved 5000 RN hours systemwide (4 minutes per dose x 70,000 doses per year).

In another example, we eliminated documentation redundancy. Throughout our system, we were documenting the patient’s medical history on 36 different forms, the family medical history at 25 different places, and noting allergies on 26 different forms. We standardized from 3000 variations to 1 universal set of forms, which saves time and provides a universal place to check.

As a result of modifying some of our processes, we have made work conditions better for our nurses, which results in improved retention.

—Gail Wolf, RN, DNS, FANN, Senior Vice President and Chief Nursing Officer, UPMC Health System, Pittsburgh, PA

REAL-TIME CUSTOMER SATISFACTION SURVEYS

We are having difficulty getting a return on our ED customers’ satisfaction surveys and receiving them in a timely manner. Has anyone found a solution to these problems?

Answer 1:

We specialize in customer, employee, and physician satisfaction surveying. Historically, the industry has had the most difficulty in obtaining results from ED patients. While we offer the typical methods of patient data collection, we challenged ourselves to develop a method for emergency departments to increase patient response without significantly increasing the cost. We solved this by capturing patient responses before they leave the facility through 2 devices, a touch-screen kiosk and a small book-sized self-entry device with a numeric keypad.

We place a kiosk (similar to the check-in station used at an airport) in the ED waiting room. Staff are encouraged to become involved in the process and direct discharged patients to the kiosk to provide immediate feedback. (Admitted patients are captured through the inpatient surveying.)

The touch-screen kiosk’s audio and video capabilities provide quicker, user-friendly data collection and faster
report turnaround. The machine also can be programmed to show video clips, such as a message from the hospital chief executive officer or an advertisement for a special hospital health promotion. We ask that the touch-screen kiosk be plugged into a dedicated phone line so that we can periodically dial into the kiosk and make sure the computer is running properly and retrieve the information for reports.

The Jackson Group also has available smaller self-entry survey units (called Patient Entry Terminal for Satisfaction [PETS] Units) that can sit on a desk with the last person the patient sees before going home. This smaller device does not have audio or video capabilities. This device works especially well if an emergency department has one discharge point. The individual at the desk with the unit will ask the patient to take a survey while they get together the patient’s paperwork, and then the survey becomes a natural part of the discharge process. Unlike the touch-screen kiosk, this device requires the emergency department to download the information, a process that takes about 2 minutes.

No matter which methodology our clients choose, we encourage designing an individualized survey. While the percentage of participation varies between institutions, we typically find the emergency departments have a 30% to 55% return response. For more information, check our Web site at www.thejacksongroup.com.

—Wade Wolgemuth, The Jackson Group, Hickory, NC, wwolgemuth@thejacksongroup.com

Answer 2:
We switched to The Jackson Group’s kiosk system when I was the ED director at Huntsville, Alabama. At that time, our own generated survey returns were only around 302 respondents per month at a time when there was a high level of staff and financial expenditure.

We created a discharge desk that obtained co-pays and the kiosk survey at the same time. (We sent volunteers upstairs to capture the inpatients admitted through the emergency department with the handheld device.) Staff (including physicians) were required to mention the need to participate in the survey. I am considering adding “tent cards,” like in hotels, in each room to remind patients as well.

The survey included who was the physician, the day of week, and time of day. It became apparent if certain employees were not asking patients to take the survey. We tied the results of the survey into the physician’s compensation package.

In less than a year, we had increased to 2102 patient responses per month (around a 50% return rate), which improved my confidence in the results. The total time involvement was a monthly 5-minute download, and the cost was less than 10 cents per response.

Some of the advantages I found from this system included the following:

An ability to stratify data. This makes it easier to define the problems and monitor for improvement.

The capability to ask or change specific questions on short notice. When starting a new program or change, it is good to get such “instantaneous feedback.”

A timely turnaround of data. Instead of the typical wait of months, weekly data can be obtained.

We are now instituting the service at my current employer, even though we do not have the discharge desk. Staff is assuming an increased role in directing patients to the kiosk. We also put comment cards for those patient who have more to say or do not like using the computer.

The only drawback is the inability to benchmark with other institutions. We benchmark with ourselves, and for me, 100% “happy” is my goal.

—Barb Pierce, RN, MN, former Division Manager of ED/Trauma, OB/GYN, Queen’s Medical Center, Honolulu, Hawaii, and current Director, Critical Care/ER, Southeast Georgia Medical Center, Brunswick, GA.

Tell me more about this new Joint Commission for Accreditation of Healthcare Organizations (JCAHO) requirement for using only so many standard abbreviations.

Answer 1:
During a recent national lecture to a nursing audience, a JCAHO inspector discussed one of JCAHO’s new standards for 2004 (Standard IM.3.10, EP#2). The standard states hospitals are to “Standardize the abbreviations, acronyms, and symbols used throughout the organization, including a list of abbreviations, acronyms, and symbols not to use. This is interpreted by inspectors as (eg, in
recommendations that came out June 18, 2003) that hospitals should have the following:

- A list of at least 6 abbreviations (laboratory reports are exempt).
- Corrective measures in place if an improper abbreviation is used (eg, some way to correct the nonstandard abbreviation, such as calling the physician). It is not necessary to document the process of the correction, just the end result of the appropriate abbreviation being used.
- Achieve 100% compliance by January 2004. In surveys in the late 2003, an audit of 1000 concurrent medical orders found that 80% did not meet the criteria.

A related aspect of this subject is legibility. As much as possible, preprinted and electronic documentation is encouraged. If an inspector believes an order is difficult to read, 2 nurses will be asked to read the order independently. If they cannot both do it accurately, it will result in a citation.

The inspector emphasized that they do not want to hear, “We are working on it”; they want to see active processes. This type of evaluation may sound rigid, but the emerging philosophy is that incidents do happen without these processes and patient safety is always the primary goal. Additional information can be obtained on the Web site [http://www.jcaho.org](http://www.jcaho.org).

—Polly Gerber Zimmermann, RN, MS, MBA, CEN, Section Editor, Managers Forum, Journal of Emergency Nursing; pzzimmermann@ccc.edu

Answer 2:

Our hospital has a list of standard abbreviations that was generated from medical records. We recently added a proactive policy that addresses 6 specific abbreviations, known to be dangerous from errors nationwide, that must be written out in longhand. They are:

- MSO₄: must be written as morphine sulfate
- MgSO₄: must be written as magnesium sulfate
- U: must be written out as units
- .125 vs 0.125: must be written out 0.125
- vs 1 mg: must write out the whole number as 1 mg
- mcg: must be written out as micrograms

Physicians not using correct abbreviations are approached at the time by the nurse. A problem has been making sure all nurses are aware of the abbreviations that can be accepted. If an improper abbreviation is not found until a later date, medical records notifies the physician. Because the policy is hospital-wide, it has been addressed in all patient units and that helps conformity.

—Donna M. Roe, MS, RN, CEN, Clinical Education Manager, Emergency Department, St Joseph Hospital, Nashua, NH; lsmilie@aol.com

Answer 3:

We have helped compliance by printing the list of the most frequently used disallowed abbreviations (along with the approved alternative and rationale) on the back of the physician’s order form. Physicians were in-serviced through direct mail and the Medical Executive Committee. Some examples include the following: “every other day” cannot be abbreviated qod; “subcutaneous” must be abbreviated as subcut or written out, not sub q or sc; a zero must be used before dosage decimal points (eg, 0.5); and only the complete spelling may be used for some drugs, such as hydrochlorothiazide (HCTZ) and magnesium sulfate (MgSO₄). In addition, pediatric drugs must be ordered in mg/kg.

If the physician uses an abbreviation that is not approved, the nurse signing off the order calls the physician for clarification. In the beginning there was some resistance, but they are beginning to see the need to comply to avoid a large number of calls.

—Kevin Trainor, RN, CEN, Nurse Manager, Emergency Services, Christus Santa Rosa Hospital, San Antonio, TX; ktrainor@satsc.rr.com

### STANDING ORDERS FOR SEIZURES IN THE ED?

What are other emergency departments’ policies and procedures regarding a nurse witnessing a patient who starts to have an active clonic-tonic (“grand mal”) seizure in the department? Are there standing orders for the nurse to administer medication to a patient, or does the policy require that the nurse obtain a physician and a direct verbal order?

Answer 1:

We are required to have a physician give an order, and we find it is only a matter of seconds until the order is given. If the ED nurse can be at the bedside, the physician...
should not be too far behind. Usually the physician then gives a prn order for lorazepam (Ativan) after their patient evaluation.
—Oui Lester, RN, Staff ED RN, Western Baptist Hospital, Paducah, KY; Ouida509@aol.com

Answer 2:
We do not have standing orders for seizure medications. We usually do not have a problem obtaining quick access to a physician for a verbal order. In addition, it is our practice to “anticipate” the orders and be ready for immediate administration. We primarily use lorazepam intravenous push (IVP) or then midazolam hydrochloride (Versed) injection (intramuscularly) if we were unable to obtain quick intravenous access.
—Holly Peterson, BSN, RN, ED Clinical Nurse Educator, Sparrow Health System, Lansing, MI; hollymaria2@comcast.net

Answer 3:
A couple of our physicians order diazepam (Valium) “to the bedside” for patients who have a chief complaint related to seizures or status/post a seizure. Often they give us parameters with the order, for example, to give the medication if the patient begins to seize. We also have portable phones so we do not have to leave the bedside to find the physician.
—Kelly Arashin, RN, CEN, Charge Nurse, Trauma Coordinator/Registrar, Hilton Head Regional Medical Center, Hilton Head, SC, KelRN24@aol.com

Answer 4:
We would not have to wait for a direct order for medication when the patient is there for seizure activity. We “technically” are required to wait for a written order before any drug administration. However, the chief of emergency services has made it known to the staff that the expectation is to have the medications at the bedside and to administer as needed. Some of the physicians just automatically write a prn order for lorazepam, 2 mg IVP. If we waited for a written order every time before administration, our patients would surely suffer some consequences.
—Elizabeth Valter, RN, AET, Compliance Manager/Emergency Services, Sutter Community Hospitals, Sacramento, CA; RVALTER@aol.com

Answer 5:
We have a “standing order” for lorazepam (Ativan) 2 mg IVP for active seizures as one of our 25 Advanced Nursing Interventions (ANI). The ANI for new onset seizures also include directives for an accucheck, a pulse oximeter reading, saline lock placement, laboratory tests (CBC, electrolytes, and urine toxicity), and computed tomography of the brain.
—Melinda Stibel, RN BSHC, Administrative Director, Emergency/Trauma Services; Memorial Regional Hospital; Hollywood, FL; mstibal@mhs.net

**SUDDEN IN CUSTODY DEATH SYNDROME**

The local jail has sent us prisoners to assess because of the probability of Sudden In Custody Death Syndrome (SICDS). What does this involve?

**Answer:**
Our department was first exposed to this phenomena in the late 90s when a prisoner who resisted arrest and was hog-tied subsequently went into cardiac arrest and died at the local jail. Since then, the jail has adapted a protocol for their personnel to evaluate SICDS risk on all incoming prisoners who were involved in an altercation. Correction personnel use the national numerical assessment scale that considers various factors, such as alcohol use, drug use, history of mental illness, inappropriate or unusual behavior, and ineffectiveness of oleoresin capsicum (also known as “pepper spray”).

The emergency department’s role includes performing cardiac monitoring and determining current medical stability. Statistically, many of those with high scores eventually do have a cardiac arrest and die despite aggressive emergency interventions. It may be a result of the sudden excessive adrenaline release from the struggle and arrest experience in vulnerable persons. Unfortunately, there are no known preventative measures.

Our jail accepts the prisoner’s return if the person has been stable after at least an hour of monitoring. At a minimum, the potential liability is minimized.
in case an unavoidable cardiac arrest does eventually occur.\textsuperscript{1,2}
—Kay Sedlak, RN, MS, CEN, Clinical Nurse Specialist, Emergency Department, Saint Mary’s Health Network, Reno, NV; kay.sedlak@saintmarysreno.com

REFERENCES

DECREASING DRUG ERRORS

What can I do to lessen the likelihood of possible medication errors in our emergency department?

Answer:
United States Pharmacopeia (USP) establishes state-of-the-art standards to ensure the quality of medicines for human and veterinary use. USP also develops authoritative information about the appropriate use of medicines. To help ensure medication safety, USP operates 2 national medication error reporting programs, the Medication Errors Reporting (MER) Program\textsuperscript{*} and MEDMARX.\textsuperscript{†}

From its medication error reports, USP found that 23\% of medication errors were intercepted in the emergency department before reaching patients, compared with 93\% that were intercepted in other areas of the hospital. The emergency department is a high-risk area because of the interruptions, intense pressure, and fast-paced environment. Overall, 77\% of ED medication errors cited occurred during the prescribing and administering phase: improper dose was the most common ED medication error.

USP offers health care practitioners the following recommendations to help ensure that medication errors do not occur.

- Educate personnel about the types of errors that occur in the use of high-alert medications.
- Expand the use of decentralized pharmacists to cover the emergency department.
- Minimize verbal medication orders.
- Design workflow to minimize interruptions and distractions and provide for double checks and verbal confirmations.
- Purchase premixed intravenous solutions and unit-dose medications.\textsuperscript{1,2}

—Diane Cousins, RPh, Vice President, Center for the Advancement of Patient Safety, U.S. Pharmacopeia, Rockville, MD

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2. USP lists the most frequent med errors in the ED. RN WebMagazine [online] 15 Jun 2003.

HELPING IMMIGRANT NURSES ATTAIN US LICENSURE

Are there any programs to help foreign-trained RNs attain US licensure to help ease the current nursing shortage?

Answer:
Besides the well-known general nursing shortage, there is a shortage of Hispanic/Latino nurses. This ethnic group makes up 12.5\% of the United States population, but only comprises 2\% of US nurses. There also is a distinction between bilingual and bilingual/bicultural nurses.

Mercy Hospital became a part of Chicago Bilingual Nursing Consortium in an attempt to facilitate US nursing licensure for Hispanic/Latino nurses who were already residing in the United States. This seems to be an untapped market and is more fair than attempting to recruit practicing nurses from their home countries.

We began with a public announcement in June 2002, and more than 500 interested people responded, of whom we found 262 candidates who were licensed as nurses in their home country (of those, 162 had “documentation deficiencies”). We formed a number of groups, depending
on their current English ability and an evaluation of their previous nursing education.

The Nurse Practice Act in Illinois requires that these candidates pass an English proficiency test (TOEFL), the Commission on Graduates of Foreign Nursing Schools (CGFNS) test, and then the National Council for Licensing Examination (NCLEX). The curricula of some persons were not equivalent to approved US curricula, and these persons were encouraged to pursue the Licensed Practical Nurse (LPN) licensure and work toward an RN license.

If their English was proficient, the qualified candidates were put into a 180-hour review course, 96-hour clinical “refresher” course, and 84 hours of theory to enhance areas typically not emphasized in their programs or unique to the United States. Topics include leadership, pharmacology, technology, physical assessment, conflict management, and pain management. Funding for their tuition was available through the Workforce Improvement Act (WIA).

Thus far, our pass rate of first-time takers of CGFNS is 50%. Some of the lessons we have learned include the following:

1. Many people must be involved, including the homeland authorities. It is essential to have the help of consulates, and homeland college deans, in obtaining documents. We found they were very willing to get involved because they view it as a way to mainstream their native sons and daughters into the US culture.

2. English is key. We initially used conversational English to judge a candidate’s English ability but found that speaking is not the same as being able to read, comprehend, and apply written English concepts. We now use standardized tests and require that language deficiencies be made up before beginning the clinical review course.

3. Clinical employment makes a difference. We have seen a distinction between candidates who were/are employed in health care and those who are not. We have an additional regular “lunch and learn” session for these candidates employed at our hospital. It is an opportunity to further advance their knowledge and support one another.

4. Paperwork delays can be extensive. We naively thought the first candidates could be completely finished and be licensed as registered nurses within a year. However, we did not anticipate the 6+ month delays that can occur in just one step of the paperwork process.

It has taken incredible effort, but we find it rewarding to work with these persons. They have a real heart for nursing and are eager to practice their chosen profession. We are attempting to take this concept nationwide and are currently working with 7 other states.

We are now planning to start a similar program for the Chicago Polish population. Nurses from Poland all need one semester of mental health nursing because it is not part of the Polish nursing curriculum. However, they typically have difficulties fulfilling that requirement because there are limited openings in local nursing programs because the courses are full with the school’s own nursing students.

Our long-term goal is to encourage these newly licensed US nurses to value ongoing education, pursue advanced degrees, mentor others in a similar circumstances, and eventually lead these programs.

—Catherine D. Walsh, Vice-President of Patient Care Services and CNO, Mercy Hospital and Medical Center, Chicago, Illinois; cwalsh@mercy-chicago.org

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