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An Emergency Department Staff Tackles the Healthy Workplace Initiative

A Staff Nurse Perspective

Paul R. Clark, BA, BSN, RN, MAT

This article describes the Healthy Workplace Initiative in the adult emergency department from the staff nurse perspective. Examples of one action planning team's processes and outcomes are delineated. The Rapid Diagnostics action planning team is delineated as lived while caring for patients in today's high-pressure emergency department. The Healthy Workplace Initiative empowers staff, with the guidance of facilitators, to make changes that improve the workplace and to create a healthy workplace for staff and patients. The result is greater staff ownership of the emergency department which leads to greater job satisfaction and improved patient care. **Key words:** *emergency department, empowerment, healthy workplace*

"Denise, have you called report to the nursing home yet?" asked the charge nurse. "I was about to," Denise replied. "Let me find the nursing home phone number." Denise had just received 2 new patients into her treatment rooms. Her third patient was awaiting the results of a cardiac work up. A fourth patient, an elderly female diagnosed with a UTI and discharged to a nursing home 10 minutes earlier, was just pulled to a hallway space to make room for one of the new patients. Denise was in overdrive attempting to call report to a nursing home so that she could work with her 2 new patients. After 5 minutes of searching the paperwork for a facility name and phone number, checking a phone book, calling directory assistance, and calling a number that put her into voice mail, Denise was at wit's end. "Why don't we have this basic information?" was her frustrated reply.

From the Methodist Hospital, San Antonio, Tex (Mr Clark).

The author thanks Robert Roddy and Scott McConnaba for their editorial assistance and his colleagues in the Adult Emergency Department whose efforts made the article possible.

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This fictionalized account is representative of a frequent occurrence in the emergency department (ED). Emergency department staff (physicians, nurses, technicians, and unit secretaries) are under pressure to perform a variety of tasks with increasing speed. Patient ED visits are rising yearly. Patients are sicker and have multiple diagnoses. These additional demands are placed on staff sometimes without the benefit of other resources like augmented staffing.

Compounding the problem is a host of other requirements placed on the ED staff. Emergency nurses and physicians are required to be up-to-date on the latest information and current trends in patient care and disease. Family and friends of patients, stressed by longer waits for assignment to a patient care room or for test results delaying disposition, are more impatient and often aggressive with staff. Sick calls of emergency nurses, technicians, and unit secretaries add to an already-burdened workday. All of these factors are causing decreased job satisfaction. Staff turnover is the unfortunate result of this situation and occurs at a time when these professionals are needed more than ever.

THE HEALTHY WORKPLACE INITIATIVE

The ED staff at the Methodist Hospital in San Antonio, Tex, was undergoing many of these frustrating conditions, ones similar to those Denise, in the fictionalized example, experienced. Burdened under heightened acuity and increased census, the ED was looking for a way to increase efficiency and decrease staff frustration, which causes staff turnover and staff vacancies.

The ED staff was given the opportunity to participate in a beginning nursing research program to create healthy workplaces. For a full description of the theoretical framework and intervention, please see the article by Parsons in this issue; and, for an overview of the process and outcomes in the ED, please see the article by Parsons, Cornett, Sewell, and Wilson, also in this issue.

In April 2003, the Healthy Workplace Initiative (HWI) was initiated. ED technicians, unit secretaries, nurses, and physicians gathered for their first Future Search Conference at a retreat center away from campus. The purpose was to learn about the HWI and participate in the planning process, called by the staff, the "Creating Our Future Program." At the end of the 1 $\frac{1}{2}$ -day conference the ED had developed a desired future, set priorities, and developed 4 specific action plans. Staff volunteered for the action planning team they wished to participate in developing. The 4 action groups were named: the Rapid Diagnostics Team, the Rapid Disposition Team, the Rapid Initiation of Care Team, and the Organized Patient Care Team. Each team had a specific set of issues identified by the staff on which to work. Over the next year, these teams tackled these issues and addressed other related topics as they arose.

Implementation of HWI

The author of this article participated in the Rapid Diagnostics Team. Over the next year, our team would grow in number and find specific challenges. We would solve some problems, identify others, and encounter tricky obstacles. Our manager facilitated us in our work

and, once a plan was agreed upon, gave us the "green light" to lead the change with the staff. The team felt that the process was working well and good progress was being made. The mission of our specific team was basic. As the name implies, the overall team goal was to improve processes to facilitate developing a diagnosis for each patient rapidly. Specifically, our purpose was 2-fold: (1) to uncover and define problems that arise during a patient's stay in the ED, which increase the time between their entry in the department and the determination of their diagnosis, and (2) to find solutions to those barriers that will enable diagnosis to be made more quickly in the future.

The team was composed of individuals from all roles in the ED (unit secretary, technician, nurse, and physician) and our department's radiology technician and housekeeper. The wide variety of experience and job function was helpful. Problems were identified, and each person brought his/her unique thoughts to the table in an attempt to find solutions.

The issues which the Rapid Diagnostics Team initially identified were uncovered during the 1 $\frac{1}{2}$ -day HWI retreat (Future Search Conference). However, as the year progressed, more issues became evident. These issues were identified by staff and sometimes by management. The problems were significant: ED/lab processes for blood drawing and transportation to the laboratory; urine dipsticks were not being completed in a timely fashion in the department; laboratory and radiology test reports were coming back to the department well outside the expected time parameters; and laboratory, radiology, and electrocardiographic tests were not being ordered in a timely manner. The goal was not simply identifying the problem, but in identifying why the problem occurred and, more importantly, finding a solution.

The process

The task of the Rapid Diagnostics Team was to uncover problems which delayed patient diagnosis. For instance, if laboratory test

ordering was delayed, was it because tests were not being entered by the unit secretary in a timely fashion, or were the charts not given to them by a preoccupied physician or RN? If blood specimens were not arriving in the laboratory correctly and on a timely basis, where was the problem occurring? As we worked through the issues, nurses had one perspective, technicians another, unit secretaries a third. By uncovering the layers of issues and perspectives, the team began to understand that problems were multifaceted and no one solution could be our “magic bullet.”

The next step was to develop solutions. This task proved challenging because solutions were oftentimes not obvious. Team members occasionally needed to study the way a certain problematic process occurred before a solution could be developed. For instance, to determine why laboratory results were taking longer than expected, team members observed what happens from the time the blood is drawn from the patient until it is processed in the laboratory, and staff went to the laboratory to observe the testing process. This seems like an easy problem to solve, but 3 different issues were uncovered during this process analysis.

Solutions proposed by the team were then implemented after sharing the plan with all members of the ED staff. E-mail, word of mouth, peer reinforcement, and memorandums from the team and management communicated these changes in processes. However, this was usually not the end of the search for a solution. As the changes were implemented, staff would identify additional problems that required the team to reconvene and discuss additional measures. At times the manager’s facilitation would help in refining the new process, and then, help the team with further implementation.

The final step was to assign a team member to follow through on the implementation of the solution. The person assigned to monitor this change determined if the solution was viable by checking with staff to see if the problem recurred and if the implemented changes were progressing without problems.

If the problem recurred or if the solution was difficult to implement, then the action planning team adopted a different approach.

An example: Developing the adult ED pocket guide

One member of the Rapid Diagnostics Team had begun to uncover specific issues before the opportunity arose to participate in the Healthy Workplace Initiative. As a staff nurse in the department for 3 years, the author had uncovered a lot of information located in different parts of the ED. Some information was taped to specific computers (passwords or patient test-ordering mnemonics for the Meditech order entry system), or information was located in specific areas, such as inclusion or exclusion criteria for our Fast Track minor emergency care area located in a notebook at the triage area. Some of it was not readily available to nurses, such as phone numbers for report to nursing homes.

Staff had to scramble to different parts of the department to find specific information, which increased the time it took to complete patient care. Frustrated by the lack of centralization of this information, the author began to accumulate this information in a notebook that was always with him at work.

This notebook began to develop into a small tome. Utilizing it often and realizing the time savings the book provided, the information was typed in a word-processing program. The final product was printed on pages of pocket-sized, cardstock paper that he carried in his pocket at work.

It was *The Methodist Adult ED Pocket Guide*. The pocket guide went through several revisions as staff suggested additional important information or as information was updated. Staff noted how helpful the guide was in providing hard-to-find information, and asked for copies of it. The guide was reproduced on his printer, stapled together, and gladly shared.

The 20-page guide is broken down into several constituent parts. The first pages contain laboratory tests and imaging studies that the emergency physicians have authorized nurses

to order on patients who meet certain criteria. For instance, patients more than 35 years of age with chest pain may have an electrocardiogram, IV saline lock, portable chest x-ray, chemistry 7, complete blood cell count, and cardiac enzymes even before being seen by a physician.

After the procedure protocols are pages containing pain management protocols authorizing the administration of medicines by nurses to control pain and fever of patients meeting certain criteria. Fast Track admission criteria follow the protocol section. Mnemonics for ordering tests in Meditech occupy 4 pages of the guide. Prayers in Spanish assist staff in providing for the spiritual needs of Spanish-speaking patients, and the staff also has requested these prayers be offered in English in a future revision. Short-form patient-registration instructions, instruction on printing the Medication Administration Record of an admitted patient, and trauma activation criteria are included as well. The ED Sterile Procedures Set-up page provides instructions to staff on sterile tray setup. The phone numbers relating to the following round out the guide: (a) patient care areas at nursing homes, (b) frequently called departments in the hospital, (c) 24-hour pharmacies, and (d) the dispatchers of the various city and private ambulance services that are served by the ED.

One particularly helpful aspect of the guide is the "Clinical Notes" pages. These 4 pages carry a variety of subject matter which is not lengthy enough to warrant its own section, but which is helpful to know. Information in this section includes setup instructions for a patient-controlled analgesia machine or Buck's traction, wording for both cardiac catheterization permits and the risk/benefit section of the Left Without Being Seen/Leaving Against Medical Advice paperwork, instructions on mean arterial pressure calculation, appropriate staff passwords to "unlock" computers and to access various programs, and guides identifying paperwork required to complete patient restraint protocols or cardiac stress test inpatient orders (Fig 1). Finally, there is a drip-rate chart for the

administration of IV nitroglycerin. This chart identifies the drip rate to be entered into our IV pumps for the specific dose of nitroglycerin ordered.

In the early process of the pocket guide development, the HWI began to be implemented, and the author of the guide became a member of the Rapid Diagnostics Team. Two interesting things occurred: (1) through the pocket guide, the team had at its disposal a tool to disseminate solutions to problems, and (2) as staff utilized it in daily practice, they uncovered other useful information that helped to speed patient care. Staff requested this information be entered. The guide began to take on a life of its own as information was added.

For instance, nurses requested that numbers of 24-hour pharmacies be added. One nurse asked for drip rates for our hospital-specific concentration of IV nitroglycerin. Another nurse noted there was not specific risk-and-benefit wording for our Left Without Being Seen or Leaving Against Medical Advice forms. Family members of patients arrived ahead of ambulances only to find that the ED was on diversion to EMS patients. They requested numbers to the various ambulance dispatchers to determine to where their family member was diverted. All of these items were added to the guide.

A member of the Rapid Diagnostics Team noted that certain physicians required certain-sized gloves, certain-sized needles, on their suture trays, epistaxis trays, etc. If technicians scrambled to find additional equipment for the physician after initially setting up treatment trays, time was wasted; therefore, a list of equipment required by specific physicians was listed on a "Sterile Procedure Set Up" page. This solution enabled trays to be set up more efficiently with less interruption of physician, nurse, and technician. Patient diagnosis occurred more quickly as a result.

The Rapid Diagnostics Team used the guide to implement changes in other processes. The team noted that when a large number of new patients entered the ED or when new patients were assigned to rooms during very busy times, the initial entry of diagnostic tests was

Clinical Notes

The following procedures require a specifically named MD to read or interpret test results: **EEGs, Carotid Doppler Studies, Echo Cardiograms, and Cardiac Stress Testing**

“Banana Bag” Ingredients:

-10 cc Multi Vitamin, 100 mg Thiamine, 1 mg Folate

Bucks Traction

-Call OR for bed frame and 5 or 10 lb. weights (x 54555)
 -Order S, M or L size Bucks boot from CS (x 54872)
 -Obtain a medicine floor bed from Housekeeping (x 54418)

Cardiac Rhythm Strip Parameters:

-*P to R interval:* 0.12 – 0.20 -*QRS Interval:* 0.6 to 0.10
 -one large block on the Y-axis (up and down line) = 5 mm,
 so one small block on Y-axis (up and down line) = 1 mm
 -5 large blocks on X axis (left to right line) = 1 second
 -*Heart Rate* = # of beats in 30 squares x 10
 -**Junctional Rhythm:** 40–60 bpm

Heart Blocks:

1st degree: distance between beginning of p-wave and beginning of QRS complex is greater than 0.20s (5 small blocks on the x axis [left to right line])

2nd degree, type I: p-waves increasingly further (marching) from QRS complex until there is a dropped QRS complex

2nd degree, type II: p-waves at regular frequency and distance from QRS complex, with occasional dropped QRS complex

3rd degree: p-waves are at regular intervals, as are the QRS complexes, but no relation of p-wave to QRS complex. (p-waves sometimes hidden by QRS complex or t-wave)

Cath Lab Permit Wording

Cardiac catheterization, possible rotobladder, percutaneous transluminal coronary angioplasty with stent placement

Filter for Central IV line:

-Baxter Interlink Extension Set, Pyxis Room 1, and 15/16

Figure 1. This page is an example of the information available to the nurse/staff member in the Clinical Notes section of the pocket guide. Reprinted with permission from the Methodist Healthcare System.¹

delayed. The team learned that one reason for the delay was that patients were not entered into the Meditech computerized registration and test ordering system. Patient tests could not be ordered until this occurred. A page was added in the guide, outlining instructions on

short form or quick registration of the patient so that protocol tests could be ordered.

The team is now in the process of training the staff on a basic or short-form registration process as well as entering basic protocol tests. The guide has 4 pages detailing

mnemonics that are used to order tests in the Meditech system. Once trained, the staff have a valuable resource at their hands to help them enter patient information into Meditech and thus be able to initiate protocols and send specimens to the laboratory much more quickly. They will also not have to interrupt a unit secretary to ask how to order ordinary test mnemonics. Diagnosis times also will hopefully be shortened.

The guide has been recently printed and bound by the hospital's print shop and distributed to the ED staff. Technicians, nurses, and unit secretaries have utilized it for almost 5 months. The feedback has been positive. Both nurses and technicians have appreciated the information that is relatively easy to access. The guide's "cheat sheets" for short-form patient registration and Meditech order entry, along with the protocols section, are probably the most used sections. While no formal study has been undertaken, the staff feedback at the conferences and meetings is that having all of that data in one easy-to-access guide has increased the speed of patient care.

From the standpoint of our Rapid Diagnostic Team, the guide has been very helpful. Part of our group "mission" was to provide solutions that shortened the time between a patient's arrival into the ED and the development of his or her diagnosis. Having a medium that provides the staff with information that assists them in doing that job more efficiently and shortens diagnosis time has proven to be highly valuable.

The HWI turns 1 year old in the ED

Twelve months has passed since the staff's original encounter with the HWI at Wesley Retreat Center. The 4 action teams have contributed positively to the ED by addressing problems and developing and implementing solutions. Empowerment abounds. There are exciting things which have developed as a result of these 4 teams' work.

For instance, one team has experimented with the nurses' daily assignment of patients. They changed the grouping of rooms to which a nurse would be assigned. The assignments

now reflect a good mix of monitored and nonmonitored rooms grouped relatively close together. Another team developed a new call schedule on which staff can sign up to cover shift shortages which may occur as a result of illness, family emergency, etc. A dedicated gynecological examination room was established, and then was moved as new problems were identified with the previous room. The Rapid Diagnostics Team, as mentioned above, has focused on creating new ED and laboratory processes that enabled a faster ordering of laboratories, accurate labeling of specimens, and more efficient delivery to the laboratory. The staff is preparing to be trained on basic order entry to assist the unit secretaries, when they are swamped or when there is no secretary present. The staff is also continuing to keep track of information for the next edition of the *Methodist Adult ED Pocket Guide*.

One year following the ED Future Search Conference, the staff and HWI facilitators met to review the achievements, lessons learned, and plan for the next year. The staff, manager, and ED physician's evaluation was that "tremendous positive change" has been implemented to enhance both patient care and the work environment. The staff now had ownership in the ED as they decided on not 4, but 5 action-planning teams for the next year.

The staff holds a very positive view of the HWI. All staff members, inclusive of all roles, express more interest in the department and its operation because of their involvement in bringing about change. The staff members are interested in their respective action groups, and meetings are held monthly by most teams. Some meetings are held at nearby cafes, which add a bit of social energy to the work of the groups, or at hospital conference rooms.

Staff satisfaction is evident in recent statistics. The nurse manager and assistant nurse manager noted that staff retention is at a high level. They also noted that of the 30 vacancies that existed 12 months earlier, prior to the implementation of the HWI, there are currently no nursing, technician, or unit secretary vacancies in the department. The hospital

administration is pleased with the stabilization of staff, and the unit has been closed to outside agency for a year as of this writing. This also enhances staff teamwork and satisfaction with working with each other in a high-pressure ED. The increase in patient satisfaction has been a positive outcome for all.

SUMMARY AND CONCLUSION

This illustration from the HWI provides a lived example of shared leadership among the ED staff, managers, and physicians. The managers practiced participatory management guiding and supporting the changes proposed by the action planning teams. They supported the ED staffs' participation and decision making, and the staff reported that they felt empowered. There are numerous examples in the literature showing that staff who had the opportunity and resources to participate in creating change were empowered.²⁻⁵ Applicants to work in the unit learned of the HWI and wanted to work in a department where their opinions mattered. As a result there are essentially no staff vacancies and there is continuous focus on improving patient care and

the department. The staff now have ownership in the place where they work. The staff's process and tangible practice and unit improvements have been described for one action planning team. As a result the following example is a lived reality:

The police officer hung up the phone in frustration, after pressing several numbers on the keypad of the phone. She was there to investigate the death of a patient who had suffered a cardiac arrest at a nearby nursing home and died in the ED. She needed information from the nursing home about events leading up to the patient's death, but was stymied. "I was in the voice mail system for four minutes, and after selecting all of those options, it hung up on me. I know someone is there, why won't they answer?" The nurse sitting across from the officer pulled out his Pocket Guide, looked up the number of the nursing home, and leaned over to the officer. "Try this one," he said, pointing to a number on the page. The officer dialed the number from the pocket guide, and was immediately connected to the patient's nurse at the nursing home. The officer was grateful, as was the nurse, who could prepare the patient for the morgue a bit faster. The next patient, waiting in the waiting room, could now be seen in a timelier basis due to the staff leadership in developing the Pocket Guide.

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