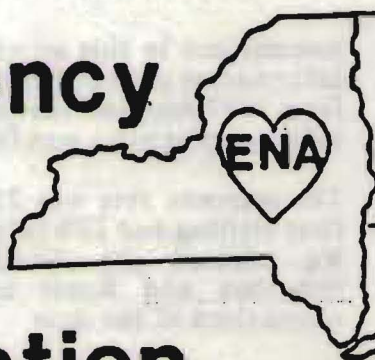


# Emergency Nurses Association



## New York State Council Newsletter

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Carol Sammann, Editor

### EXECUTIVE BOARD OF NYSCENA:

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### FROM THE PRESIDENT OF THE NEW YORK STATE ENA, KATHY CONBOY:

When I wrote my first article as President of New York State ENA, I was excited and apprehensive. I looked back at that article as I began this - my last article to you as State President. I am pleased that we have been able to accomplish some of our established goals this year.

My first goal was to strengthen the Council, to ease our workload, and increase our participation from the various chapters. Committee chairs must no longer be delegates to the Council and any New York State delegates can participate in the committee activities. By establishing a set term for each chair and vice-chair, the committees work is less fragmented and a rotation pattern prevents all chairs from changing in the same year. The committee

meetings are scheduled to allow each chapter to participate on all the committees and to facilitate as much work at the council meetings as possible.

My second goal was to assist the chapters to become more active. A leadership workshop was held last January and through its efforts the Brooklyn and Staten Island Chapters are being reorganized.

My third goal - to increase our exposure to the public, nurses and allied health professionals - has been achieved through the efforts of our committees. Our Newsletter is now mailed not only to ENA members, but to each Emergency Department in New York State. Our Government Affairs Committee is so active that our opinions are now being solicited by our legislators. The Trauma Committee continues to provide several TNCC courses throughout the year. Through our Nurse Practice Committee, we have responded to critical issues in our state such as the nursing shortage and holding patients in the Emergency Department. Our Education Committee had a successful conference in the Catskills and is excited about the plans for the 20th Anniversary of ENA and our next conference in Buffalo. Our goal to have nationally recognized faculty is met with our keynote speaker - Margaret McMahon. We continue our liaisons with ACEP and NYSEMS. I am also proud of our New York State nurses who hold national positions: Ginny Hens on the Ethics Committee; Jon Williams on the Resolutions Committee; Mary Ann Portoro on the Prehospital RN Task Force; and, of



course, Joanne Fadale, our next National ENA President. Our membership - at 1500 - is the highest it has ever been.

This year we funded 29 delegates to Washington, D.C. and the General Assembly. The visits to our Congressmen and Senators have allowed us to participate in the federal legislative process and we are excited about this expanded role and opportunity to express our viewpoint on health care issues.

I have already expressed my appreciation to all on the Council for their hard work this year and our achievements are due to their efforts. Leadership positions in ENA also require the support of one's family and friends and mine were no exception. They were behind me all the way. It has truly been the fastest year of my life. I feel equally fortunate that I am not relegated to a "has been" position (not that I ever could be for long!) as I have already begun to work on the National Scientific Assembly Committee. I am always a New York State ENA nurse first and am so very proud of our organization and its achievements.

Thank you for your kindnesses and support. See you in Chicago!

*Kathy Conboy*

**REPORT ON THE EMERGENCY  
DEPARTMENT QUESTIONNAIRE BY  
BONITA SHAW, RN, BS, CEN:**

In 1988 and again in 1989 the New York State Council of ENA sent out questionnaires to obtain information from Emergency Departments in New York State. In 1988 about 300 questionnaires were sent and in 1989 a total of 280 were sent. The difference in these numbers is due to identified hospital closings and hospitals without Emergency Departments. The information from these questionnaires is

summarized in this article. Note that the information on the 1988 questionnaire was from 1987 data and the information on the 1989 questionnaire was from 1988 data.

The response rate was 27% (82) from the first mailing and 22% (65) from the second. We selected the divisions of Urban, Suburban and Rural as the basis for comparison of the data.

The 1989 data has a shift of 9% as a percent of increase in the number of responses from suburban hospitals. The average hospital bed size, however, is fairly constant at 263 in 1989 and 265 in 1988 therefore I will use the data as comparable.

The average number of visits is also comparable when the outliers are removed showing an average increase of about 1500 visits per Emergency Department.

The overall numbers of staff seem to shift with the volume changes. The interesting factor is the percent of total staff that is RN staff. This number has decreased from 65.7% in 1988 to 62.3% in 1989 with the greatest change in the suburban responses (10%) and rural next with a 7% decrease. The largest increase is in the other category which included aides, attendants etc. Often this staff is EMT trained personnel. Clerical staff also increased by 2.7%. The percent of LPNs decreased from 3.9% to 3.3%. The highest percent of LPN staffing is used in the rural areas (7.7%). In both surveys the average number of RNs per ED was 20.

The responses showed 38% of hospital admissions come through the ED up from 31% in 1988. This points out the ED as an important revenue generator for the hospital. About half of the respondents reported that the hospital received Hill-Burton funds. All respondents in 1989 and all but one in 1988 reported receiving all ambulances.

The average number of transfers was less in 1989 for urban and suburban but higher in rural. This would match the trend to regionalization of patient care. The percentage of transfers with an Emergency Department RN increased across the board 12.5% with rurals reporting the greatest increase (19%). This means more of the ED



staff is leaving to make transfers and points to the increasing need for education of ED RN's in the transfer of patients.

In 1988 49% were unionized and in 1989 42%. About 90% of all the respondents required at least one year experience before working in the ED. One year of prior experience is now required in the State Code. In 1988 60% required ACLS but by 1989 80% required it. This is now, also, a requirement in State Code. The percent having ACLS increased from 53% in 1988 to 69% in 1989.

31% of the 1988 respondents had mandatory overtime with 1989 amazingly showing a decrease to 26%. Of interest is that mandatory overtime was not directly correlated with the presence of a union.

The percentage of respondents in each of the 4 JCAHO levels remained constant, however, more of the total respondents answered the question the second time. Are people becoming more aware of levels of care?

90 % of the respondents in both surveys had formal orientation programs in the ED. This is a requirement of JCAHO. The average length of orientation was 5 weeks and is usually accomplished by the Head Nurse and other staff members.

The percent of RNs with CEN remained about 18%, TNCC increased from 9% to 11% and BS degrees increased from 19% to 24%.

From both surveys it is apparent that most ED's do some form of triage which consists of patient history and assessment. About 70% do vital signs in triage. 66% have Triage guidelines developed with some method of review established. 18 hours per day was the average hours for triage. The percent of RN triage increased from 71% to 86%. It is interesting to note that in the urban responses there was 100% RN triage, in the suburban 86%, up from 38%, and in rural 75% up from 62%. The rural responses included clerks, LPNs, EMTs and 2 with triage by PAs. Some answered more than one category since off hours may have different levels of triage. About half the respondents noted the triage position as a unique assignment for that staff member.

This was related to volume of patients seen. Nationally it is recommended that 50 patients per 8 hours are required for triage staffing to be cost effective.

The percent of respondents with acuity systems in the ED increased from 56% to 62%. About 70% use the acuity systems for staffing and about half use them for billing. Some respondents noted they were not used well. The usefulness certainly would depend upon the users and the system. The charge nurse having only charge duties increased from 14% to 18% with the greatest change in the suburban responses.

The percent of ED's with holding areas has remained constant at 21%. These are staffed half by other RNs and half by ED RNs. The percent of nearby freestanding clinics nearby decreased from 21% to 18%. The impact of these was usually noted as reduced volume and waiting with increased acuity. 35% versus 22% now have Rapid Care areas in their EDs.

The average waiting times were a very interesting part of the survey. When we sat at the NY State Technical Advisory Group discussing waiting in the EDs the consensus was that all patients should be seen by an RN within 10 minutes and by a physician within 20 minutes. It appears these are rather unrealistic goals. The percent of respondents with waiting times greater than 40 minutes increased from 21% to 36% with the greatest increase (25% to 63%) in the urban responses. The waiting times for RNs also increased by 14% for over 30 minutes with only 18% being seen within 10 minutes. This was after triage time.

While we recognize the data from these questionnaires was not perfect it is clear that the surveys show an increasing patient volume in the ED's with decreasing RN percentages and increasing waiting time for patients for both physician treatment and nursing care. It is also clear that EDs in New York State will have difficulty in meeting the new state regulations. There is no magic answer but hard work and cooperation from all factions seems to be the step to take. To survive we must "Keep the Faith" and be creative-- things that Emergency Nurses do very well.



**REPORT ON THE HOSPITAL  
OVERCROWDING CONFERENCE BY  
KATHY CONBOY, PRESIDENT  
NYSCENA:**

The issue was Hospital Overcrowding and the Emergency Department Patient. The conference was sponsored by ACEP and the speakers represented every perspective possible: legislative to hospital associations; HSA's to prospective payment; and from the viewpoints of emergency care-givers - physicians, nurses, and EMT's. Included in these speakers representing ENA were: Joanne Fadale, National President; Kathy Conboy, NYS President; Ginny Hens and Sonia Liberatore, NYSCENA.

One of the most striking aspects of this conference was the national perspective which was presented. We can finally acknowledge, and statistically support, that holding / gridlock / overcrowding is a national issue and does not reflect ineptitude or some bizarre fluke common only to New York State! The other states are watching us closely as we proactively struggle to find solutions. We are moving forward from being reactive or inactive, now if only we had the solutions readily at hand.

Emergency care has always been a financial loss for the hospital. To ask for more money is laughable in light of our reimbursement climate, yet emergency care can not be eliminated. After years of growth and professional achievement for emergency nurses, we are seeing signs of stress and burnout as a result of holding patients in the ED at a time when other nurses do not exist to back up those leaving.

We know we need more health care dollars to provide more nursing home beds, care of AIDS patients, clinics for low-income patients, and increased home health care systems. Unfortunately, this comes at a time when legislators and taxpayers have decided health care is too costly.

The second most important aspect to

surface at this conference is that emergency departments did not cause the problem. We have not become inept or inefficient; we have not created the monumental backlog we face daily. Just as we have been the window for all the social ills of society, we are now the window to the financial and planning ills of the health care system.

Did the conference identify the definitive solutions to the problem? Possibly. We know what must happen to alleviate holding. Unfortunately, we do not control the mechanism to implement it. However, we do control (to a certain extent) public awareness. Our patients are still often unaware we are holding patients and are confident that emergency care will be as available as it was in the past.

The conference was a success because it brought together the individuals who know the problem and can articulate the solutions with those who must move mountains to implement them. We must continue to listen to the issues and contribute to the solutions. We need control at a time of great frustration. It is not an issue for administrators, CEO's and legislators. It is an issue for us all!

**FROM MARY MALLORY,  
PRESIDENT-ELECT NYSCENA:**

The first annual award of the state EMS Conference For a Nurse was awarded to Bonita (Bonnie) Shaw at their annual conference in October, 1989. The award was presented by Ruth Perrone, on behalf of the ENA State Council.

The recipient has been very active in the ENA and EMS for the past 15 years. She has contributed to EMS through leadership and education. She promotes the concept of team management for the emergency patient and we congratulate her.



**NURSE PRACTICE NEWS FROM  
GINNY HENS, CHAIRPERSON:**

**Clinical EMT Guide Experience  
by the New York State Department of  
Health**

**RESPONSIBILITIES OF THE NURSE  
PRECEPTOR DURING THE IN-  
HOSPITAL OBSERVATION AND  
TRAINING FOR BASIC EMT STUDENTS:**

The nurse preceptor should be a staff nurse, knowledgeable and experienced in emergency nursing, as well as pre-hospital emergency medical services, including the EMT training program. The nurse preceptor, in collaboration with the course medical director and the hospital administrator should provide an environment conducive to learning for the EMT student. The Nurse Preceptor should:

- Using the BUDDY ASSIGNMENT (one nurse per one EMT student maximum), host the EMT student during his/her stay in the emergency department.
- Work with the EMT student to ensure appropriate and relevant clinical training experience.
- Serve as liaison between the EMT observer and all other nursing and medical staff.
- Serve as a resource, resolving questions and issues regarding immediate clinical procedures, protocols, or other questions.
- Assist in improving public relations by setting an example for the purpose of fostering and demonstrating increased collaboration and communications, in order to make the transition from pre-hospital care to emergency department care a smooth and comfortable process for all.

**LEARNING AND EXPERIENCE  
GUIDELINES:**

During the ten-hour emergency department experience, the EMT student should learn how patients are received, triaged, and treated. Under direct nursing supervision, the EMT students should endeavor to improve their skills.

**TRAUMA NEWS FROM ANNE WALL:**

**SPRING 1990 TNCC PROVIDER  
COURSES:**

Sponsor: Adirondack Chapter  
Dates: March 3-4 in Albany  
Contact: Cindy Duncan

Sponsor: Central New York Chapter  
Dates: to be confirmed  
Contact: Chris Kehrner-Atkins

Sponsor: Genesee Valley Chapter  
Dates: March 30, April 1  
Contact: Eileen Lumb

Sponsor: Mark Twain Chapter  
Dates: February 24, 25  
Contact: Mary Ann Wylie

Sponsor: Manhattan-Bronx Chapter  
Dates: Jan. 23, 25, 27 at Roosevelt Hospital  
Feb. 20, 22, 24 at Mt. Sinai Hospital  
Mar. 20, 22, 24 at Jacobi Hospital  
Apr. 24, 26, 28 at Beth Israel Hospital  
Contact: Marie Browne

Sponsor: Mid-Hudson Chapter  
Dates: unconfirmed for Mar. or Apr. in  
Valhalla  
Contact: Sue Strauss

Sponsor: Suffolk Chapter  
Dates: unconfirmed for April  
Contact: Dottie Walker



**GOVERNMENT AFFAIRS NEWS BY  
FRAN SISKI, CHAIRPERSON:**

Mel Miller, New York State Assembly Speaker, set an optimistic tone for 1990 when he announced that the governor and the legislature must address the "crisis" in the health care system in New York state this session. He noted that the lack of nursing home beds, the ED gridlock and the nursing shortage as the major health care issues.

This committee will actively follow all actions that deal with health care problems. The primary goal in 1990 will be the "grass roots" participation by all of our members. Each chapter will work to establish an active Government Affairs Committee in order to keep all members informed and to allow participation in this important activity. All nurses should realize how legislation affects their practice and the well-being of their patients.

During this coming year I challenge each of you to take part in just one legislative activity. It won't hurt a bit and I promise that the impact from these 800-1000 activities will contribute towards a very successful year. Ask your chapter chairperson what you can do!

**EMERGENCY NURSES ASSOCIATION**

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