

UNSOLICITED LETTERS WITH NEWS, NOTES, AND COMMENTS FROM OUR READERS ALWAYS WELCOMED

Submit all Letters to the Editor online at <http://ees.elsevier.com/jen/>

How Throughput Can Affect the ED Waiting Room

Dear Editor:

I related to the article "Improving Patient Safety in the ED Waiting Room."¹ The authors were evaluating a new program based on a 5-tier triage system that used a triage reassessment associate (TRA). The goal of the TRA was to help reassess triaged patients while collaborating with the triage nurse to identify deteriorating patients waiting to be seen. This system is very similar to recent changes we made to our triage process in an effort to reduce adverse events.

Our system uses 2 triage nurses and an EMT to help quickly identify patients who need immediate attention from those considered non-urgent. After the initial triage is completed, the second triage nurse carries out a complete triage or in some cases the patient may go directly to a treatment room. In the event of overcapacity like the authors were experiencing, the EMT would help reassess patients who have been triaged and are experiencing extensive delays in treatment times.

I do agree with the authors that this system can help identify deteriorating patients, reduce triage stress level, and reduce the number left without treatment. However, I am left wondering why we are experiencing such overwhelming situations. These types of programs are just band-aids for the overlying issues that face emergency departments nationwide. Even with beefed up triage systems in place, I feel throughput is the major road block to a successful patient outcome. If we are continuously holding admitted patients, our ability to treat new patients is affected significantly. Identifying urgent patients is important but without a bed to treat them in, adverse events will continue to be a major problem facing emergency department nurses.

—Peter Kamon, RN, BSN, ED Supervisor, Holmes Regional Medical Center, Melbourne, FL; E-mail: snookizer@gmail.com

doi: 10.1016/j.jen.2007.09.025

J Emerg Nurs 2008;34:100-1.

0099-1767/\$34.00

Copyright © 2008 by the Emergency Nurses Association.

REFERENCE

1. Blank F, Santoro J, Maynard A, Provost D, Keyes M. Improving patient safety in the ED waiting room. *J Emerg Nurs* 2007;33:331-5.

Response to "Use of EMT-Paramedics in Hospitals"

Dear Editor:

I was happy to see that the "Use of EMT-Paramedics in Hospitals" is a topic that generates a lively discussion. I am employed currently as a staff nurse in an Emergency Department that utilizes a team of RNs, EMT-Paramedics (EMT-Ps), and Patient Care Technicians (PCTs). In response to Mr. Cormier's letter in October 2007 issue of JEN, I can identify several problems that arise from this model of care.

First, I have to disagree with Mr. Cormier's assertion that this system allows for an efficient, cost-effective use of skills. I believe that having 3 different levels of healthcare professionals can be wasteful. Because each team member has a defined set of responsibilities, the disproportionate distribution of such skills creates a team that may not all be able to conform to the ever changing needs of emergency patients. For example, in our department, a large percentage of patient population comes from local nursing homes. These patients require "total assist" with their basic needs. In this case scenario, EMT-Ps, who do not want to be used as "nursing assistants," are not valuable. Toileting, repositioning, skin care, and providing nourishment are all "lower level skills" that, according to Mr. Cormier, paramedics should not be used to carry out. However, as a direct result of hiring paramedics, we now do not have enough nursing assistants to help us with these time-consuming tasks. This leaves the RN, the "highest paid professional," to concentrate not only on their "higher level of skills," but also on other tasks that could be done by unlicensed assistant personnel. These could potentially lead to poor patient outcomes because, as mentioned above, the nurse is unable to concentrate on her higher level skills, or, at best, leaves a less qualified paramedic monitoring the patient.

Another problem that I see with hiring both EMT-Ps and PCTs is that it generates resentment among PCTs. Patient Care Technicians often carry out the most physically difficult and least desirable work while getting the lowest pay. Many of our PCTs have been employed by the hospital for 10 to 20 years, and had to orient paramedics to our department. In contrast, our paramedics are mostly young men and women who either use this job to supplement their income at the fire department, or use it as a temporary step while they are waiting to be hired by the rescue. In either case, I find that paramedics view their jobs in the emergency department as temporary and are not motivated to do their best. This attitude is disruptive to the team mentality.

Last, staffing the emergency department with 2 types of unlicensed assistive personnel is difficult, and oftentimes there is an unequal representation of a certain skill set. This is not cost effective because the distribution of the skills on a certain day many not meet the needs of the patients that come in on that shift.

In summary, I think that paramedics are a great asset to the emergency department when used appropriately, such as during telemetry transports. Paramedics are competent professionals who are trained to deliver episodic emergency care with emphasis on primary assessment and

performance of emergency care skills. To meet the needs of our patients, however, it is best to increase the number of RNs within the department. Registered nurses emphasize holistic patient care approach, and address not only physical, but psychologic and emotional needs of the patients and their families. In addition, research studies have indicated better patient outcomes when cared by nurses, as compared to unlicensed healthcare personnel.^{1,2} Although hiring more nurses seems to be more costly, having several groups of healthcare professionals with separate scopes and sets of skills can lead to poor patient outcomes, prolonged hospital stays, inefficient use of labor, and unnecessary burden on emergency nurses.—*Renata Graef, RN, MSN, 1601 Clint Moore Rd., Suite 100, Boca Raton, FL 33487; E-mail: Lorinrenata@comcast.net*

doi: 10.1016/j.jen.2007.10.017

REFERENCES

1. Cho SH, Ketefian S, Barkauskas VH, Smith DG. The effects of nurse staffing on adverse events, morbidity, mortality and medical costs. *Nurs Res* 2003;52:71-9.
2. McGillis Hall L, Doran D, Baker GR, Pink GH, Sidani S, O'Brien-Pallas L, Donner GJ. Nurse staffing models as predictors of patient outcomes. *Med Care* 2003;41:1096-109.