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Operation Iraqi Freedom
CAMP TAQADDUM, Iraq—Navy en route care nurses of 1st Force Service Support Group (Forward) (FSSG [Fwd]) Surgical Shock Trauma Platoon pose in a CH-46 Sea Knight helicopter here. From left to right the four Navy nurses are Ensign Virginia Hinrichs, Lt. Cmdr. Susan M. Pennebecker, Ensign Kelly J. Bowman and Ensign Cheryl Niega. The nurses frequently risk their lives to provide quality medical care and ensure the stability of wounded Marines and other patients during transport from the SSTP to higher-echelon care. First FSSG (Fwd) passed the reigns of the program to 2d FSSG (Fwd) recently when they assumed operational responsibilities in a routine rotation of forces throughout Iraq.

Photo by: Lance Cpl. Ryan B. Busse
This is an official US Marine Corps photograph.

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Abstracts

Studies require a structured abstract—250 words or less—roughly based on the IMRAD style. The format should be as follows: Introduction, Methods, Results, and Discussion. Abstracts must fit in one printed column and will be edited for space requirements.

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Standard abbreviations should be used consistently throughout the article. Unusual or coined abbreviations should be spelled out at first mention and followed in parentheses by the abbreviation. The policy of the Journal is to abbreviate the term “emergency department” when it modifies a word (eg, “ED procedure”) and to spell it out when it is used as a noun (eg, “in the emergency department”). The term “emergency nurse” should be used.

The generic name of a drug should be used instead of the proprietary name whenever possible. If it is necessary to use a trade name for a drug, it should be capitalized and inserted parenthetically after the generic name when first mentioned. Product names should be treated similarly; and the manufacturer’s full name, city, and state should be cited in a footnote or in parentheses in the text.

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A Time for Giving

As we enter the holiday season, it seems only appropriate to think about giving. During traditional holiday seasons, we often think of the giving of gifts and it is easy to get caught up in events and forget the underlying reason for the celebration. This year, it seems especially important that we all remember to focus on the things that are important in our lives, the things we can’t replace. Family and friends, faith, good health, and being safe and able to work as an emergency nurse come immediately to mind. These are the true treasures in our lives, treasures that enable us to give to others.

2005 began with many emergency nurses giving of themselves in the aftermath of the Tsunami disaster in Southeast Asia. The devastation and chaos caused by Hurricane Katrina revealed a generosity of time, money, and personal sacrifice by many. These two disasters touched hearts around the world and many responded. We will never know the depths of human compassion and giving displayed by many of you, but I for one am thankful that you were willing to give to those in need.

As emergency nurses, we give so much of ourselves to patients and families, from a simple smile, to advocating for better treatment. It is unfortunate that the giving done by each of you on a daily basis often goes unnoticed. You are the unsung heroes making a difference for the people you encounter on a daily basis. Your time for giving is every day.

During the 2005 General Assembly, I mentioned a quote Sue Sheehy had used in reference to the many blessings and gifts in her life. The quote from Luke -12:48, “to whom much is given, much is expected” reflects each of you. As emergency nurses, we have been given the unique ability to affect others in so many ways. We all need to be ever mindful of the need to give on a daily basis to improve access to care, address capacity demands, and ensure that we have the resources to care for the next patient. Much is expected of all of us. As emergency nurses, we do not need a special season. It will always be our time to give.

As I complete my term as the 2005 ENA President, I would like to commend all of you for your part in ENA’s successes this year: membership numbers are on the rise, we have greater collaboration with our nursing and physician colleagues, and have a clear focus towards the future with a strategic plan developed around our three clinical priorities: crowding, patient safety, and the nursing shortage. It has been my honor to serve my colleagues in ENA. Emergency nurses have been, and will continue to be, at the forefront of issues impacting emergency care in this country. Emergency nursing has much to give. To each of you, I say a sincere thank you!
This is an important time to remember our colleagues serving overseas, away from family and friends, and in harm’s way. For the third year, the Journal pays tribute to military nurses—US Navy nurses for this issue. An email from a military surgeon, Col. Brett Wyrick, on page 577 brings home a picture of just how much respect the emergency teams in Iraq and elsewhere deserve. No matter how we feel about the war, emergency nurses everywhere join in supporting the individuals who serve.

Military nurses were among those who provided assistance and support with the recent US hurricanes. We are indebted to Iris Frank who enthusiastically helped emergency nurses from across the country share their stories and lessons learned in this issue. We are certain there are many more stories, so we invite others to write us about their “lessons learned,” from this or others, in the form of a letter or article.

Emergency nurses also shared many of their lessons learned at a recent conference, the 5th International Conference for Emergency Nurses in Sydney, Australia. It is interesting to go half way around the world, only to find things to be so similar. Our colleagues “down under” may be experiencing summer during our winter, but they share the same frustrations and gratifications as emergency nurses in the United States. The commonalities are oddly comforting. Someone experiencing an MI or someone who is intoxicated looks exactly the same, no matter where they are. It’s always been striking how fundamentally “at home” and capable any American ED nurse would feel in any ED I’ve ever visited. American nurses would instantly grasp who was sick and what a team member needed, as would any Australian ED nurse in the US.

The conference topics were all familiar. One Australian emergency nurse (jack15@austarnet.com.au), concerned about the rights of nurses and patients, reported on using a client information leaflet to reduce the incidence of violence in the emergency department. The leaflet explained the reason for waits, and noted that staff could have abusive [verbal as well as physical] persons charged by the police and removed from the ED. Consequently, violence in that ED dropped by 52%. Over lunch one day, an experienced Australian ED nurse mentioned a recent episode: a disadvantaged teenage girl, on drugs and alcohol, who jumped up and down on a stretcher one night, screaming demands. Reluctant to seem heavy handed, and trying to avoid reading about the incident on the front page of the next day’s newspaper, the helpless staff tried cajoling and pleading with the patient. An elderly woman with a hip fracture lay just inches away. We all face challenges every day—some that make the news and some that we hope don’t. The frustrations participants shared were balanced by the many promising new initiatives, roles, and solutions that were discussed, and a touch of humor. My favorite slide? A military medical apparatus sign: “This machine has no brain. Use your own!” Accounts of the work of those responding to the bombings in Bali, the tsunami in Banda Aceh and the Maldives, a helicopter crash, and the war in Iraq were reminders of the ultimate gratification that ED nurses all share.

Happy holidays from JEN to emergency nurses around the globe. May we never forget the sacrifices of our colleagues at this time, and may the gratifying moments of 2006 far outweigh the frustrations.
All letters must be typed double-spaced and should be sent on disk to Annie Kelly, 77 Rolling Ridge Rd, Amherst, MA 01002 or via E-mail to: awbkelly@comcast.net

Head for the Hill

Nurse/Victim: The Fallacy of the Divide

Dear Editor:

The article “Head for the Hill,” in the August 2005 issue of the Journal gave me hope for the future of nursing. I recently started my master’s study in Administrative and Financial Leadership in Nursing and Health Care and work full time in a busy emergency department. As a staff nurse, I have become increasingly frustrated with many of the “trend-lines” you cited in your article, such as “...crowding, compromised patient safety, and nursing shortages,” to mention a few. I am one of those nurses who found myself saying, “what do I have to do to give my patients the care they deserve?” As a staff nurse, I felt like I was unable to effect change, which lead to my pursuit of leadership in nursing. I have started my study of nursing leadership and came across this article and found the statement, “We need to start thinking big again” echoing in my head. I think this statement will play a profound role in the future of nursing and nursing leadership.

Aspiring to be a nursing leader, I feel it is of major importance for Americans and our leaders to be aware of the crisis facing nurses and emergency departments across the nation. It is really great to see that the ACEP and the ENA are joining forces and heading for the hill. Hopefully this will raise some eyebrows and give many other nurses a feeling that change is around the corner. I have always thought if nurses could unite and “think big” change will become a reality.—Peter Kamon, RN, BSN, Tamarac, Fla; E-mail: snookizer@comcast.net

Nurse/victim: the fallacy of the divide

Dear Editor:

My career as an emergency nurse began in 1984. Currently I am working in Iraq in US Government contracting as an administrator performing policy and monitoring government property Iraq-wide. This is part of the $18.5 billion Iraq Reconstruction apportioned by the US Congress in March 2004.

Nowadays, I travel throughout Iraq. For example, in the health care sector, we are building 150 medical clinics (more like mini hospitals) that will require the installation of about $120 million worth of medical property. In dealing with every contractor, I “pitch” the following message as to what I am trying to accomplish:

- Establish and monitor standards.
- Standards promote organizational and individual accountability.
- Accountability creates stewardship.
- Stewardship creates efficiency and increased capacity.
- Greater capacity drives our Mission for developing more energy output, creating better health care and educational access, cleaner water resources, and freer mobility for the people of Iraq.

As for the future? My year in Iraq is coming to a close. With my current experience in program management, my hope is to sign on with an NGO (Non Governmental Organization—International Red Cross, Care, Doctors without Borders, etc, all humanitarian organizations). Increasingly, they are supplanting government interventions worldwide and are some of the most progressive forces in combating the major ills facing human kind in the developing world.

I thought JEN readers might be interested in the following occurrence, from the perspective of my emergency nursing background.

Back in January 2005 on the eve of the Iraqi national election, our office was struck by a rocket. Fortunately, it did not fully detonate and most were spared. The rocket landed 15 feet from my desk, instantly killing 2 friends. There is no precognition of such an event; I felt like I simply exploded. Suddenly, I realized I was alive...that my wounds were minimal and that I needed to get out quickly before smoke and fire overcame me. I urged those around to move out quickly. The smoke was engulfing the exit. I took a deep breath and moved forward and as I was passing to safety in the haze, I noticed the outline of an exposed body on the stairwell.

My initial instinct was to evacuate and I did so. But suddenly, all those years of being an emergency nurse...in another lifetime a decade ago...urged me back into the din. No choice was involved.

At once I knew I had gifts to call upon; I would know how to act. As a nurse, I had been close to this center before. They thought I was composed and decisive. Already I was helping those around me to process the inevitable grief. I was kneeling, helping a young troop place their first victim into a body bag, and in spite of the chaos, somehow it was done gently and with quiet dignity for those who had passed but who were still in my care and escort.

Much later...I stole away and made a longing call home to loved ones, but I said little. When I finally hit my bunk...I didn’t dare remove my flack vest, my stained clothes, or clear the debris from my hair. I just went into a tight lateral ball and waited for morning...and then began again.

This experience was much like when we were in the emergency department in 1989 when the Loma Prieta (Northern California) earthquake struck. At once we are both victim and caregiver. But the best nurses know the fallacy of that invisible divide. That patient crisis of the moment is always potentially ours, or a loved one’s in the future...we never truly stand outside.—James MacColl, Government Property Administrator, Joint Contracting Command—Iraq, Presidential Palace, Baghdad, Iraq; E-mail: james.maccoll@pco-iraq.net and dsvn@msn.com

A Descriptive Study of the Perceptions of Workplace Violence and Safety Strategies of Nurses Working in Level I Trauma Centers

Introduction: Workplace violence is a significant occupational hazard in health care. As the largest group of employees in health care, nurses are particularly vulnerable to workplace violence, with those who work in emergency departments being especially at risk. The purpose of this research was to study the phenomenon of workplace violence by interviewing emergency nurses who had experienced violence while on duty.

Method: A descriptive study approached the issue of workplace violence from the perspective of 8 registered nurses from 2 level I trauma centers who volunteered to be interviewed. Cross-case comparison of the interview responses was used to analyze the data from verbatim transcripts.

Results: Emergency nurses identified specific experiences of violence at work. Inadequate safety measures and vulnerability were the 2 themes that were consistently verbalized throughout the interviews.

Implications for Nursing Practice: The emergency nurses who were interviewed discussed their experiences with patients, family members, and others who exhibited violent and aggressive behavior. They identified safety measures that they believed were inadequate and discussed their feelings of vulnerability because of violent incidents at work. Further research with larger samples could confirm specific safety problems in emergency departments that must be addressed to provide a safer workplace for emergency nurses, their colleagues, and their patients.
Violence in the workplace is a significant occupational hazard and public health problem, particularly in service facilities such as hospitals. Nurses have reported safety issues related to decreased numbers of staff, less familiar co-workers, and, in some instances, decreased security.\(^1\) Other factors contributing to workplace violence in hospitals include (1) caring for acutely ill patients with fewer staff, (2) working in areas where money and drugs are available, and (3) working alone.\(^2\)

According to Simonowitz,\(^3\) the type of workplace violence that nurses are most likely to experience is type II, which is characterized by nonfatal assault occurring in service settings such as hospitals. Type I is the most frequent and fatal, occurring in high-risk public settings, such as convenience stores. Type III is the least frequent but receives the most media attention, occurring when a disgruntled individual carries out acts of aggression in the workplace, often related to employment grievances such as that experienced in the early 1990s by the United States Postal Service. Hospitals can, however, have incidents of all 3 types of workplace violence. In 1991, Karla Roth, an emergency nurse, died from a gunshot wound after a gunman entered a Utah hospital and fired his weapon.\(^4\)

Emergency nursing has received increased attention in the literature as an area of practice at high risk for assault and violence. In a frequently cited survey of 124 Pennsylvania hospitals, Mahoney\(^5\) reported a 60% (n = 1209) response rate of the 2000 emergency nurses surveyed. A full 97.7% of nurses reported that they experienced some type of aggression at work during their nursing careers. Of those, 60% reported adverse effects on their work performance, such as assaults strongly associated with the time of day and assailants’ use of alcohol and drugs. Mahoney recommended that schools of nursing and staff development departments provide instruction to nursing students and nurses to better prepare them for preventing and coping with workplace violence.

To find participants, the researcher met with RNs in 2 level I trauma centers at the change of shifts, provided refreshments, and presented a brief description of the research question: How do RNs in hospital emergency departments describe the experience of workplace violence?

**Method**

A convenience sample of 8 RNs who practiced in 2 different level I trauma centers that were not the author’s place of employment were interviewed. The criteria to qualify to be interviewed were that the participant (1) be an RN, (2) practice in a level I trauma center, and (3) experienced exposure to violence while on duty. Although 2 of the nurses had experienced physical assault, criteria for participation was not restricted to assault. For the purpose of this study, violence was defined as the victimization of an RN practicing in a hospital setting by another person or persons characterized by fear, physiological or psychological hardship, or loss.

To find participants, the researcher met with RNs in 2 level I trauma centers at the change of shifts, provided refreshments, and presented a brief description of the how to manage and prevent workplace violence and for post-assault debriefing interviews for all assault victims.

In 1996, the Occupational Safety and Health Association (OSHA) published *Guidelines for Preventing Workplace Violence for Health Care and Social Workers*, which included the “general duty clause.” That is, employers have a “general duty to provide their employees with a workplace free from recognizable hazards likely to cause death or serious harm.”\(^7\) In response to the many changes that hospitals have undergone in recent years, efforts to empower nurses to gain more of a voice within their work environment have increased. Nurses seek to be involved in workplace problem solving and decision making. Research on nursing workplace violence can provide essential insights to address the concerns of nurses in their specific areas of practice.

Much of the current emphasis of workplace violence research has been on identifying common environmental risk factors. There is a scarcity of workplace violence research specific to nursing that focuses on the experiences and perceptions of the nurses who work in high-risk areas, particularly emergency departments. The purpose of this study was to describe the phenomenon of workplace violence as experienced by RNs who work in emergency departments by interviewing them to answer the research question: How do RNs in hospital emergency departments describe the experience of workplace violence?
The nurses who were interested either mailed or E-mailed their response to indicate their willingness to participate. The researcher contacted each nurse by phone and scheduled the interview. The interviews were scheduled at the change of shift when the nurse was not on duty and held in a private area away from the emergency care environment. Prior to the interviews, the researcher knew none of the participants.

The research design for this study incorporated 4 components of analysis that paralleled 4 fundamental patterns of knowing. The four phases of design included bracketing (ethical inquiry), analyzing (empirical examination), intuiting (personal insight), and describing (esthetics). The bracketing phase required that the researcher set aside preconceived ideas that might influence the collection of data. During the data collection process, the researcher kept a journal to enhance self-awareness and identify biases that could adversely affect data collection.

For the analysis phase, the researcher transcribed each interview verbatim using a transcription machine. The tapes and transcriptions were kept in a locked file cabinet to which only the researcher had access. Each participant approved his or her own verbatim transcript for accuracy of data. The data analysis phase followed 4 steps in which (1) the transcriptions were read and reread to gain a sense of the whole, (2) meaning units were discriminated from the text of the interviews and then individually placed on index cards, (3) the researcher devised a coding system, and (4) categories, subcategories, and themes were extracted to create a structure. The intuitive phase required that the researcher approach the data with empathy in order to become engaged in the participants’ perceptions.

The age ranges of the 8 participating nurses were 20 to 29 years (2), 30 to 39 years (3), and 40 to 49 years (3). Six nurses were women and two were men. Their educational preparation in nursing included master’s degrees (2), bachelor’s degrees (3), and associate’s degrees (3). All worked full time, with 4 working 7 AM to 7 PM and 4 working 7 PM to 7 AM. One participant was a clinical specialist, 2 were nurse managers, one was a charge nurse, and 4 were staff nurses. All participants had spent the greater part of their nursing careers in emergency nursing, with the years of experience ranging from 1.5 to 20 years and an average of 9 years.

The instruments used for data collection included a demographic profile form and an interview guide, both developed by the researcher. The topics for the questions on the interview guide came from the findings of a pilot study conducted by the researcher in which 5 nurses working in a level I trauma center volunteered to participate in unstructured interviews to share their experiences and perceptions of workplace violence. Table 1 provides the format of the interview guide used for each of the interviews conducted in this study.

Approval for the study was secured from the research review boards of the 2 level I trauma centers prior to the data collection process. Each participating nurse signed an informed consent prior to the interview, which included permission to tape the interview. The nurses were each assigned an alias to maintain anonymity. Refreshments were provided during each interview.

The researcher who conducted the interviews has a master’s degree in psychiatric-mental health nursing and is skilled in talking to individuals about sensitive topics. Supportive counseling was available in both facilities if needed after the interviews; this counseling was not necessary.

### Results

Table 2 provides a summary of the findings according to category, subcategory, and theme in response to the research question, “How do RNs in hospital emergency departments describe the experience of workplace violence?”
Throughout the interviews, 2 themes were recurrent: (1) inadequate safety measures and (2) vulnerability (Table 2). The following is a discussion of these 2 themes according to the interview question topics.

**THEME: INADEQUATE SAFETY MEASURES**

A primary point of concern of the nurses was how easily people from outside the hospital could gain access, with their weapons, to the emergency department, and how the responsibility of surveillance placed a burden on the already busy nursing staff. Participants noted: “Once they make it through that door and past the police officer, they have free run of the department with the exception of what we have the ability to stop, and in the process of taking care of patients, taking care of family, taking care of visitors, you just don’t have the time to protect yourself the way you should.” “We have locked doors and people get impatient waiting on those to open, and people slide through...the doors have a 3-second delay. And you know, you can’t watch it every second.” “The police just can’t handle the influx of people; lots of persons come through that door. They can’t absolutely stand there and search everyone.” “It’s a lot easier to ignore those

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**TABLE 2**

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Theme</th>
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<tbody>
<tr>
<td>I. Degree of feeling safe at work</td>
<td>Feeling unsafe</td>
<td>Vulnerability</td>
</tr>
<tr>
<td></td>
<td>Concerns regarding access to entry</td>
<td>Inadequate safety measures</td>
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<tr>
<td></td>
<td>Concerns regarding effectiveness of security equipment</td>
<td></td>
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<td></td>
<td>Police officer presence</td>
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<td></td>
<td>Gang violence</td>
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<tr>
<td>II. Specific experiences of violence at work</td>
<td>Interactions with family/visitors</td>
<td>Vulnerability</td>
</tr>
<tr>
<td></td>
<td>• Experiencing fear and worry</td>
<td>Inadequate safety measures</td>
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<tr>
<td></td>
<td>• Experiencing frustration</td>
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<tr>
<td></td>
<td>Interactions with patients</td>
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<td></td>
<td>• Psychiatric problems</td>
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<td></td>
<td>• Substance abuse</td>
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<td>• Trauma victims</td>
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<td>• Dementia problems</td>
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<td></td>
<td>Interactions with co-workers</td>
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<tr>
<td></td>
<td>• Physical aggression not a concern</td>
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<tr>
<td></td>
<td>• Attitude of understanding and tolerance among co-workers</td>
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<td></td>
<td>Importance of communication</td>
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<tr>
<td></td>
<td>• In managing interaction with others</td>
<td></td>
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<tr>
<td></td>
<td>• In preventing violent incidents</td>
<td></td>
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<tr>
<td>III. Coping with work-related stress</td>
<td>Ventilation, humor, leisure time</td>
<td>Vulnerability</td>
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<tr>
<td></td>
<td>Wear and tear of stress</td>
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<tr>
<td>IV. Personal understanding of workplace violence</td>
<td>Aware, but seldom talked about</td>
<td>Vulnerability</td>
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<tr>
<td></td>
<td>Thankful nothing has happened yet</td>
<td></td>
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<tr>
<td>V. Workplace violence prevention concerns</td>
<td>Feeling unprotected</td>
<td>Inadequate safety measures</td>
</tr>
<tr>
<td></td>
<td>Feeling something could happen at any time</td>
<td>Vulnerability</td>
</tr>
<tr>
<td>VIII. Educational preparation for dealing with violence</td>
<td>Lack of education in basic nursing curriculum/ lack of education on the job</td>
<td>Vulnerability</td>
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</tbody>
</table>
people than to tell them that they have to go. If you tell them they have to go you are going to make them angry, and they might file a complaint...I know how hard it is, it’s easy to control in the beginning, but as the day progresses, you get tired.”

The nurses discussed the unreliability of methods used to help spot weapons. Most agreed that metal detectors at the ED front entrance were not enough and that other methods were needed to detect weapons: “We had one person who had one (a weapon) in their pocket, and they went to X-ray and it showed up on the X-ray, and we’ve had several in the trauma room when we’ve cut their clothes off of them.” “The patients that come by ambulance, they are not going through the metal detector. So there is potential. They could grab a needle from the IV bucket sitting right there, if we turned our backs. A needle, to me, is a weapon, especially a bloody needle; it might as well be a loaded gun as far as I am concerned.”

While the nurses agreed that the presence of police officers and security guards offered some sense of security, they were unsure of the policies relating to what the officers were allowed to do to maintain order: “I do not know the policy, if they are allowed to use their weapons.” “I think this hospital thinks they are more of a presence than a force, because, once they get through them, there are no safety catches past the police officers.” “We have a uniformed police officer, which is good, it’s a presence, but we have a lot of problems with what their actual ability is.”

The nurses discussed how neither their basic nursing education program nor their emergency department orientation provided adequate instruction on the reality of dealing with aggression and violence at work: “They may very well in school have had some component, but you can bet it was about as much as they give for the emergency room, which is nothing. I mean, ‘Here’s the emergency room, you may work here some day, let’s go’...we didn’t get anything, I didn’t learn a thing.” “It was never talked about that this is what you are going to be working in and if you have a patient that presents with this, you might want to be aware that they are a victim of domestic violence and that their husband might come in...but it was never taught, but it would help.” “I’ve been to violence classes, I’ve been to ‘How to Manage the Violent Patient,’ you know—how to help them without hurting them and how to take somebody down without hurting them. That is all fine and dandy in a controlled environment.”

THEME: VULNERABILITY

The nurses continually commented on situations at work that created feelings of being vulnerable to the occurrence of violent incidents. Most of the nurses stated that they did not feel safe at work and that safety improvements were needed in the emergency departments where they worked. Some nurses displayed sarcasm and referred to some protective measures as “a joke”: “We have a sign outside the door, which to me is really a joke. It says, please leave your weapons in the car, well you know...so I don’t think we do a real good job of providing safety for our staff.”

The participants described why they believed an incident of violence could happen, but said little about prevention of such incidents: “We see the worst stuff, and we’re prime candidates for a situation to happen. If anything bad happens, it is going to happen to us.” “I think that’s why things get overlooked until something actually happens, and it brings it close to home. They don’t realize the type of people we bring into the emergency room.” “I hope nothing happens here...we do have 50% protection, but we also have lots of problems.” “There is something going on all the time and that makes it even harder to maintain control and to be consistent.” “We make a lot of people mad, not only employees and hospital people, but patients too. I think it’s just waiting to happen to us. It has happened all over the country, I think we are just waiting our turn.”

The nurses’ most frequent and strongest expressions of vulnerability were in relation to psychiatric patients. They voiced concerns regarding the unpredictability of what to expect from the psychiatric patients, which caused a sense of anxiety in caring for them: “Usually it’s more with the psychiatric patients because they are the ones that in a moment’s notice can become really combative...it’s not that they have a weapon...it’s impulsive, they are going to take whatever they can and kick, fight, spit, bite; they become their own weapon.” “A psych patient was in the evaluation room, and he took a chair and hit the sprinkler and flooded the emergency department with the sprinkler. No one thought he would do that, but he did.”

The nurses also described the uncertainty of caring for patients who were overtly suicidal: “Somehow one of
the little IV baskets got left in a room, and a patient took a needle and stabbed himself with it. Who would ever think that someone would do that?” “I had a patient night before last who looked at the monitor cable and said, ‘If you leave that there, I’m going to wrap it around my neck.’...We had to pull the monitor off the wall with the cables because he said that.”

Another source of vulnerability and increased risk for violence was identified in caring for patients under the influence of alcohol and drugs. Caring for these patients were described as time-consuming and anxiety provoking: “We had a patient last night that we tied down 4 times; we had police at the bedside 4 times. She had overdosed on something, and she had alcohol on board. She was very manipulative, and we redirected her...we found her smoking in the room, we found her pouring her charcoal down the sink...we restrained her with the police 4 times.” “She had tested positive for cocaine and was acting out. We were trying to physically restrain her, we had tried other means of restraints, we were restraining her with soft restraints by policy, we had an order, and there were 3 of us explaining the procedure. She came out of the bed with the heel of her foot and knocked me clear onto the floor; she got me in the corner of the eye.”

The nurses also expressed feelings of vulnerability when family members became impatient during interactions that were already emotionally charged. They reported that the most common type of violent behavior exhibited by family members and visitors was verbal aggression, but that physical aggression also occurred. They acknowledged that many times family members were already upset and became more so because of lack of information and poor communication: “I would venture to say that you could average it out about once a week....Dealing with irate family members.” “A doctor actually went into the room to tell the family about a very unexpected death, the patient had died, and the family member actually hit her. She was punched in the chest.”

Implications for nursing practice

LIMITATIONS OF THE STUDY

The findings from this study have limitations because of the possibility that some of the nurses may have been reluctant to share all aspects of their experiences and that outside factors may have affected the interview process. In addition, the findings are relevant within the context of the study but cannot necessarily be generalized to the population of emergency nurses.

Discussion

Throughout the interviews the nurses identified environmental risk factors that increased their vulnerability to workplace violence and contributed to feelings of frustration. The nurses interviewed stated that there was a need to improve the safety of the emergency departments where they worked. A primary issue of concern was the control of access to the emergency department. This included access concerns in regard to weapons, unauthorized family members, and others who could be seeking retaliation for unknown reasons, such as gang members.

The most common type of aggression from family members was verbal. Patients who were most likely to display physical violence were those with psychiatric disorders, followed by those under the influence of alcohol and drugs.

Emergency departments are identified throughout the literature as having an increased risk for incidents of workplace violence; however, the nursing profession and other health care professions have been slow in recognizing this risk. As one of the nurses participating in this study noted, the patient’s time in the emergency department is temporary. The patient and the factors that contribute to violence are often passed on to nurses in other areas of the hospital, which spreads the risk beyond the emergency department.

The emergency nurses who were interviewed believed that safety measures were inadequate, which made them vulnerable to violence at work. This study provides evidence that emergency nurses practicing on the front line of patient care have first-hand experiences with workplace violence on a regular basis. It is essential to provide them with appropriate education on prevention strategies as well as to listen to their concerns, so that changes can be made to enhance safety. The data indicate that practicing nurses can provide essential input into the process of developing and enforcing effective safety policies and procedures. Schools of nursing and employing health care agencies share the responsibility to provide meaningful instruction on the prevention of workplace violence specific to the practice environment.
The 1996 OSHA guidelines were developed to provide information to health care organizations on how to conduct a work site analysis and establish a workplace violence prevention program. Although compliance with these guidelines is not mandatory, an employer can be financially penalized for failure to provided reasonable protection for employees and for not practicing “zero-tolerance for violence of any kind.”

A comprehensive plan for workplace violence prevention in emergency departments should follow the OSHA guidelines and include examination of existing policies as well as monitoring their enforcement. Policy revisions should target issues associated with access of entry to emergency departments. Revisions should be made to enhance the effectiveness of the police officers, security personnel, and security equipment and decrease the burden of surveillance on the nursing staff. Both day and evening shifts need adequate staffing to support a safe patient care environment. Educational programs on workplace violence prevention should be provided to nurses as well as other staff members, from physicians to environmental maintenance workers. Employment orientation for nurses and others going to work in emergency departments should include instruction on the types of patient situations in which nurses are at risk for violence and what measures to take to decrease their risk of occurrence.

Additional resources within hospitals should be developed and utilized to assist in developing an effective comprehensive workplace violence prevention plan. Nurses should be encouraged to take advantage of volunteer chaplain services and other support services that may already exist such as stress management classes and crisis debriefing following a violent incident. If such resources do not exist, hospitals should offer other ways for employees to access assistance to meet their needs.

Research on workplace violence specific to nursing is minimal. Data are needed on how risk factors differ across practice settings. Intervention studies are needed to test the effectiveness of educational programs and systematic, not just individual, prevention strategies. As the body of knowledge grows, so will the effectiveness of comprehensive workplace violence prevention plans. The support of the hospital administration is a key factor in how effective a workplace violence prevention plan will be.

Acknowledgment
I thank Dr. Pamela Fordham for her interest and foresight in the topic of workplace violence and her support throughout this study.

REFERENCES
Emergency Response to the Gulf Coast Devastation by Hurricanes Katrina and Rita: Experiences and Impressions

On August 25th, Hurricane Katrina hit Florida as a Category 1 hurricane, accounting for 11 deaths. Her path continued across the Gulf of Mexico, building to the first Category 5 storm of the 2005 Atlantic hurricane season. On August 28th, Katrina mushroomed into one of the most powerful hurricanes ever to form in the Atlantic, with winds blowing at 175 mph, and was dubbed a “potentially catastrophic” hurricane.\(^1\)

She reached landfall on Monday, August 29th, at 6:10 AM at Buras, Louisiana, as a Category 4 storm, with winds up to 145 mph. At 8:00 AM, Katrina hit New Orleans, with 120-mph winds and a storm surge of 18 feet. At 11:00 AM, the New Orleans levees were breached, resulting in more than 80% of the city being flooded. Katrina was the most expensive natural disaster in US history, with more than 1 million people displaced and more than 5 million people left without power. The Federal disaster declaration covered 90,000 square miles.\(^2\) More than 1000 deaths have been verified and the resulting damage is well over $200 billion.

Then, less than a month later, an unnamed tropical depression in the Caribbean intensified, was dubbed Rita, became a Category 1 storm, and crossed the Florida Keys, killing 2 people. Churning across the warm Gulf of Mexico waters, heading for Galveston and Houston, Rita grew to Category 5. With the tragedy of Katrina fresh in their minds, 2.5 million Texans living in the projected path of Rita took to the roads, resulting in what Houston Mayor Bill White called the largest mass evacuation in US history, and Time dubbed as perhaps the slowest evacuation in US history.\(^3\) But Rita didn’t hit as projected; she veered slightly eastward to make landfall on Saturday, September 24th, just east of Sabine Pass on the Texas–Louisiana line, as a Category 3 storm. Some of the worst
flooding occurred along the Louisiana coast, where transformers exploded, roofs were torn off, and trees were uprooted by winds topping 100 mph. Floodwaters were 9 feet deep near the town of Abbeville. A tornado that spun off the remains of the hurricane killed at least 1 person in Humphrey County in northern Mississippi. Rita knocked out power to more than 1 million customers, including nearly 300,000 in Louisiana. About 500 people were rescued from high waters south of New Orleans, some by helicopters, and a reflooding of portions of New Orleans occurred as the partially repaired levees were once again breached.

The following accounts, primarily from emergency nurses, are just a handful of the personal experiences of thousands of emergency personnel who were either in, or rushed to, the stricken areas, providing medical aid, sustenance, and support to the victims of these 2 devastating hurricanes. It is our privilege to share their experiences with you (see Figure 1 for location where each occurred), and we hope that others will be inspired to share their experiences, through letters in upcoming issues of the Journal.

Singing River and Ocean Springs, Mississippi

After Katrina, 7 of the RNs in our emergency department decided that we wanted to go help (see Impressions column). This was partially because of our ED director; she lives in Mobile, Alabama, and commutes weekly to just outside of Chicago to work. With her home in Alabama, she knew personally about hurricanes.

We initiated contact with the Mississippi Board of Health, and Delta Airlines gave us buddy tickets to fly to Mobile, where our director’s husband met us. From there, we were dispatched to Singing River, Mississippi, to help in a clinic. When we arrived, 5 RNs from Florida were already at the clinic, so our team split up, with half going to Ocean Springs Hospital to offer our services. When we walked in the door, a security guard met us. In talking with him, we discovered he was originally from our area of Illinois. He took us to human resources. They checked our nursing licenses and our drivers licenses, took our photos, and made us badges; 30 minutes later, we were cleared to work in the emergency department.

FIGURE 1
Locations of the experiences related in this article. (Map by J. Reese Frank.)
The clinic was in a shopping mall with damage to the roof and parking lot, with signs down and lots of debris, but the building was intact and we had lights and running water, although it was not potable. We had 2 bathrooms and we could flush, but we had no showers. We functioned as a clinic by day and a shelter, primarily for special needs patients, by night.

The US Army helped us obtain the supplies, equipment, and medications we needed and a nurse practitioner from Florida wrote the prescriptions as we initially had no physician. Thank heavens the Army brought cots and sleeping bags and inflatable air mattresses. We were asked to rescue a special needs couple who had been stranded for several days in their home on the kitchen table. We did, and the gentleman was oxygen-dependent and had skin breakdown. We gave him oxygen, but we had nothing to help with the skin problem...all we could do was basic care. We rigged up a cot with an air mattress so he could sleep sitting up. Someone even brought in a recliner from who-knows-where and we had a patient sleeping in it.

The clinic was seeing up to 85 patients a day, and the emergency department at times was seeing more than 200 a day. All this was in an 18-bed emergency department with a normal census of 80.

Our team worked for 5 days. During that whole time we wondered how we were going to be able to leave the clinic. Well, the US Navy came to our rescue. When Commander Mike Meadows of the USS Comfort says that they will turn something into a family clinic, they do just that. The Navy found locations for all of the patients that we were sheltering and then launched a full-fledged family clinic.

I am so proud and honored to have been able to serve alongside the Navy and the Army. They were just spectacular. The military is our “front line” to the world, and it was a privilege to be there and be able to say to them, “Let me figure this out with you.” I felt I was putting my two cents in by helping them here in the United States, even though I can’t help them in Iraq. And they were so impressed with us being there to help.

We as emergency nurses need to get politics out of emergency care. I see politics get in the way of disaster preparedness all the time...city politics, state politics, hospital politics. Foretold is forewarned and there are no excuses for not having good, workable disaster plans in place. On every level, people who have no experience are put into positions of authority because they are willing to dance to someone’s political tune. Creating an effective disaster management plan takes people with experience in emergency care at the hospital, in the city, in the state, and at the federal level. As a travel nurse, I know every hospital has their own way of doing things, but, in reality, a pretty high degree of similarity exists from hospital to hospital. As emergency nurses, we need to create some sort of uniformity so we can move fluidly from hospital to hospital and region to region.

I really appreciate being able to let others know what we did and how important it was, both to us and to the people we helped.

Mikki Grit, RN
Staff Nurse, Emergency Department
Edward Hospital
Naperville, Illinois

Covington, Georgia

I am an American Red Cross (RC) volunteer, and, after Katrina, I was asked to go to Covington as Disaster Health Services Supervisor of a Future Farmers of America Camp where Katrina evacuees were being sheltered. The camp census was maintained at 353 people, the maximum we felt we could safely and comfortably care for, and many people were turned away. I was in charge of a 24/7 clinic for 14 days and worked 18–20 hours a day.

*Since the RC doesn’t stock medications, one of the biggest initial hurdles was figuring out how to get the medications these patients needed and how to pay for them.*

At the camp, we had 156 children under 18 years of age and 35 under the age of 2 years. We didn’t have single families; we had extended families. We had groups of 20 to 30 who came together. Red Cross shelters don’t normally have physicians on duty, but eventually we did have a pediatrician and a physician’s assistant assigned to us.

The morning we opened, we had 30 to 40 people in line for care; that first day was pretty overwhelming. We had many people with asthma. One child had been discharged from an intensive care unit the week before. We had lots of patients with ongoing problems, for instance people...
who were diabetic and hadn’t taken their insulin for several days. Since the RC doesn’t stock medications, one of the biggest initial hurdles was figuring out how to get the medications these patients needed and how to pay for them. In the clinic, we saw 222 patients, with many requiring repeat visits. We probably saw at least 50% of them 3 or 4 times.

There were so many people who needed so many things, all at the same time. And we didn’t just provide medical care, we pretty much tried to help them with any problem they encountered . . .

One special memory is of an expectant mother who was 5 days overdue. She delivered at a local hospital 9 days past her due date and then returned to us several days later with her healthy baby son. She had lost everything, so we gave her a baby shower. Someone bought her a stroller. The RC gave her a Pak and Play. A local church gave her diapers, clothes, and blankets . . . and the other things she needed for the baby. It was very touching and she was so grateful.

We had 7 or 8 patients who required transfer to the local hospital, including a 13-year-old in a hypertensive crisis and a gentlemen with an oral abscess that needed incision and drainage.

The most difficult aspect of this assignment was meeting everyone’s health care needs in a timely manner. There were so many people who needed so many things, all at the same time. And we didn’t just provide medical care, we pretty much tried to help them with any problem they encountered . . . it was genuinely a holistic approach to care.

One of my fondest memories is of a gentleman we saw our first day. He came back the third day to tell me he’d found a job, and he brought me a stretch bracelet spelling “life changer.” He thanked me for our help and said he would never have been able to get back on his feet so rapidly had it not been for us. I’m not very emotional, but he brought tears to my eyes. The people were just the greatest. This was definitely one of the most challenging things I’ve
ever done in my life, but I learned so much and feel so blessed to have been able to help them.

I just have to add that when I received the call from RC, I’d only been in my job for 2 weeks, so I was very uncomfortable about asking my supervisor for the time off. However, she was very supportive and gave me her blessings to go. The emergency department is my home; I love emergency nursing and would never want to work anywhere else.

April Wood, RN, EMT
Staff Nurse, Emergency Department
Emory Crawford Long Hospital
Atlanta, Georgia

Slidell, Louisiana

I was 1 of 8 RNs sent by Tenet Health Care from Doctor’s Hospital in Dallas on September 29th to help with the evacuation of stranded patients and staff being helicoptered from the 5 Tenet hospitals in New Orleans (Figure 2).

At North Shore Hospital, on the north side of Lake Pontchartrain, we set up a staging area and sort of mini-emergency department in a rehabilitation facility that was not currently in use. We triaged patients. We started IVs. We cleansed wounds. We gave people food and water, although the diet was pretty much white bread and meat for everyone, including us. We readied the patients as best we could for transport via ambulance convoy to other Tenet hospitals in Memphis and Birmingham. Remember, these patients were coming off the rooftops of New Orleans hospitals and had been without water and food for more than 24 hours. Many were bed-bound prior to the hurricane and had been incontinent, with resultant skin breakdown. It was a great challenge to make them more comfortable and reduce their anxiety.

The staff members of the affected hospitals were so impressive. We always want to think highly of our profession, and these people truly made me proud.

I assisted in Louisiana for 4 days and, although it was a very sad experience, it was also a very memorable one, needless to say.

Jennifer Crate, RN, CEN
Manager, Emergency Department
Tenet Doctors Hospital of Dallas
Dallas, Texas

New Orleans – Charity Hospital (Medical Center of Louisiana at New Orleans, Charity Campus)

Over the last several years, we did a lot of planning for all types of hazards within our facilities and with West Jefferson Medical Center (see Marrero, Louisiana). We taught in each other’s classes and practiced drills and exercises together. We applied for MANY grants from agencies, such as Health Resources and Security Administration (HRSA), Metropolitan Medical Response System (MMRS), etc. We had done a lot of planning, and we knew we would be at the hospital for a while when a “big” one hit.

We went through the storm (Katrina) pretty well. We had heavy rain and wind, and some of the streets were flooded, but that happens pretty often. After the storm, the rain wasn’t even up to the curb on our campus. The university campus is much lower, and they did have up to about 2 feet of water. The next morning there was A LOT of water, and it rose pretty fast. Also, there was a gas odor, so we moved the 41 patients we had in the emergency department up to an auditorium on the second floor. We were without lights, power, food, and water. The care area reminded me of the scenes from Civil War movies; it was pretty primitive.

Just recently we received a MMRS grant for 15 diesel generators, which were operational and did provide some
light. We had some fuel left the middle of the week when the National Guard showed up with fuel trucks. We filled our 5-gallon containers, then found 20 to 30 big containers and filled them. Then we lined trash barrels with plastic bags and filled them. I filled anything I could find to keep us going. We kept our generators going—each intensive care unit had one enough to support 1 or 2 patients on ventilators at a time, provide a few lights, and run a couple of fans. With grant money, we had also obtained a number of oxygen-powered, portable ventilators, which came in handy.

We had 250 patients and about 500–600 employees stranded in the Charity Campus, and the University Campus probably had similar numbers. We had plenty of water in storage, but we were without a lot of food. We gave the patients a plastic cup per meal filled with vegetables, etc.

The one thing we were the most proud of was our amateur radio system installed on the University Campus in June 2004 and tested during Hurricane Ivan. It provided lots of intercampus communication and communication with the “outside world.” We were able to communicate to the New Orleans Emergency Operations Center (EOC) until the EOC went down on Tuesday or Wednesday.

I went in to work at 7:00 AM on Sunday morning, and I was there until late Friday night. I went through Hurricanes Betsy (Category 4, 1965) and Camille (Category 5, 1969) and thought I knew what to expect, but this was a million times worse.

Bob McBride, RN
Staff Nurse/Emergency Management Educator, Emergency Department
Charity Campus, Medical Center of Louisiana at New Orleans
New Orleans, Louisiana

New Orleans – University Hospital (Medical Center of Louisiana at New Orleans, University Campus)

I came in Saturday morning to begin preparations for the storm. My biggest concern was our ability to have enough food, water, medications, and electricity. We obtained additional supplies, and we had some 15 portable generators. When the winds died down, we initially had about 4 feet of water in the street. Hearing cries for help, University Hospital staff paddled a flat-bottomed boat out to rescue several people. One of the maintenance staff dove into the fetid water in an attempt to rescue a man, apparently in trouble, trying to swim to him, but the man drowned before he could be reached. We didn’t know that several levees were failing, and, by Tuesday morning, the water had risen to more than 8 feet. The emergency department is on the first floor, but we were above the water level. As for electricity, the generators were elevated and above water, but the transfer and switching system to activate them was in the flooded basement, so they didn’t work. Luckily, we were part of the MMRS grant and had also received a number of portable generators that we positioned in the nursery, in the intensive care units, in the blood bank, in an area to operate the ham radio, on the roof, and in the stairwell; we ran extension cords from these areas. With the same grant, we purchased about 30 or 40 automatic ventilators that were oxygen powered and could ventilate a patient without electricity.

For 2 years, we had been going to local and state disaster management meetings and planning for just such an event. Initially, we thought everything was going as planned, but then problems started occurring. We requested food, and nothing happened. We requested generator fuel, and nothing happened. Then the EOC told us to be ready to be evacuated in 30 minutes, and nothing happened. Taking matters into their own hands, University staff secured a boat, and began evacuating patients to safety (Figure 3).

About 80 patients and 500 staff were still in the hospital. We had lost communications with Charity. We were almost out of food and water, and we were rationing what we had left. Things were getting tight, so we began a nationwide media and lobbying blitz.

In the chain of command, Louisiana State University (LSU) and the Louisiana Hospitals HRSA coordinating network had more than 1 thousand beds ready for patients from the flooded hospitals, but their Herculean efforts were blocked by a complete and serious breakdown of our state system at the Louisiana Office of Homeland Security and Emergency Preparedness above them, and perhaps at
Federal Emergency Management Agency (FEMA) as well. The leadership at the very top literally just completely fell apart. We assumed the plan was working, but by Thursday we knew it wasn’t.

About 80 patients and 500 staff were still in the hospital. We had lost communications with Charity. We were almost out of food and water, and we were rationing what we had left. Things were getting tight, so we began a nationwide media and lobbying blitz. Our CEO, our residents, our nurses, any and everyone were contacting any news agency, government agency contact, and anyone else they could reach by any means possible saying, “Come and get us.”

Friday morning, someone came to tell us a helicopter had landed on our roof. I ran up to see, and was greeted by the crew of a Huey . . . I didn’t even know our roof would support a Huey. Someone said, “We’re here to take you out.” The staff began carrying the remaining patients up the 8 flights of stairs to the roof (Figures 4 and 5), transporting the adult patients on blankets. After all the patients were flown out, we turned around, walked to the ground floor, got in heavily armed airboats and were transported to busses (Figure 6). By this point, the federal government had taken over. Some of us were sent to the airport and some, to Baton Rouge; some were even taken to a highway overpass and told to continue patient care!! I was sent to an Air Base in San Antonio, where we were told to get in line to talk to FEMA. Two maintenance guys from the hospital and I went to a local hotel for the night, rented a car the next day, and drove out to rejoin our families.

The bottom line is everyone heard so much about what happened, but so much was reported that just was not true; the only way to know what really occurred is to talk to the people who were at the specific location. We did have one really ugly incident. On Thursday, we were told that some of our more critical patients could be evacuated if we got them to the helipad of a nearby hospital, which will remain unnamed. So, we carried the patients to our ground level, put them and supporting RNs and MDs in boats, then onto military trucks. When we got to that hospital, we carried the patients up 8 flights of stairs to the roof only to
be told by the person in charge that none of our patients
would be transported until all of the staff of that hospital
were rescued. Those doctors and nurses tried to get the
patients transported first, then asked to be allowed to help
take them down the stairs back to shelter at Charity, but
to no avail. Our patients and nurses ended up sitting in the
hot sun on that roof for more than 4 hours. One of our
patients was an infant on a ventilator, being hand bagged by
an RN. I am told several of these patients subsequently died.

Someone once said, “Disasters don’t build character, they reveal one’s real character.” Some of the looters and
“big shots” revealed their real character, and it’s not so
pretty. But despite the serious failures at the top, people
lower in the chain were unbelievable. Louisiana Wildlife
and Fisheries agents brought in their boats and rescued
hundreds of people, including many of us. Committed
hospital staff continued to give care under the most har-
rowing conditions. Volunteers came from all over the nation
to help. The support of the military was great. The out-
standing character of so many was revealed, and it was a
sight to behold.
Tim Butcher, RN, BSN, EMT-P  
Director of Emergency Management  
University Campus, Medical Center of Louisiana at New Orleans  
New Orleans, Louisiana  

Author’s note 1: We are particularly indebted to Tim Butcher for sharing his experience with us, in light of his current circumstances. His house has 8 feet of water and is a total loss.

Author’s note 2: CNN reports, “The big Charity and University hospital buildings were issued their ‘death warrant’ by Katrina and the cataclysmic floods it spawned. Both hospitals, which treated a total of more than 500,000 patients a year, are damaged beyond repair and must be replaced. Charity and University have anchored the health care system of southern Louisiana for over 100 years. We believe they should be replaced quickly to ensure they provide health care for the next 100 years and beyond.”

New Orleans – Adjacent to the Superdome

I am a member of the Disaster Medical Assistance Team from Providence, Rhode Island (DMAT RI-1). On September 2nd, we received orders to go to the Superdome. As a result of it, by then, having the reputation of being the most dangerous place to be in New Orleans, our convoy was accompanied by 16 armed federal police. We were told to take only the bare essentials, and nothing of value, with us.

The Superdome was surrounded by 3 to 4 feet of murky water (Figure 7), which we had to drive through. Our medical facility was actually set up in a basketball arena, just over a small bridge from the Superdome. We arrived around noon and literally “hit the ground running.” We began seeing patients immediately. Our mission was to treat any critical medical problems, but mainly to evacuate people out of the Superdome. The most critical were flown to hospitals by helicopter; the more stable patients were taken by the helicopters to ambulances waiting just outside the flooded areas, and those who were able were triaged and sent to the buses that had finally arrived to help with the evacuation.

We had all the necessary medical equipment and supplies, but we lacked the food, hygiene supplies, and
clean clothes that everyone so desperately needed. The first day we triaged out 160 people; the second day, between 40 and 60 the second day; and, by the third day, most of those left were able to walk to the buses.

We were warned ahead of time that if an order came to leave, we were to leave immediately, without question. The people we were treating had been without food and water for days. No bathroom facilities were available and they were sleeping wherever they could find a spot. Yet, they showed no anger toward us. We never felt threatened. We heard nothing but words of gratitude. We saw looks of desperation turn to looks of hope. We saw tears replaced with smiles.

By this time, we ourselves had been in the same clothes for 3 days. We had no toilet or shower facilities. There was no running water and only a generator for some light at night. We ate meals ready to eat (MREs) and believe me, they make even my cooking look good!!

After 3 days, we returned to Baton Rouge, and, a day later, we were sent to Jefferson East Medical Center, just across the river from New Orleans. The RNs helped out on the units, and the EMTs helped the local rescue and ambulance crews. We then set up a clinic in conjunction with the Medical Center to provide immunizations to members of the community. Hepatitis A, Hepatitis B, and tetanus shots were given to 750 people on the first day. In 2 days we gave more than 5,000 injections!!

Would I do it again?? In a heartbeat! This was such a humbling experience. People were just so grateful for what we did. I just wish we could have done more.

Sue Connell, RN
Staff Nurse, Emergency Department
Roger William Medical Center
Providence, Rhode Island

New Orleans – Airport

As a member of DMAT MA-2 (Boston) responding to Katrina, we were deployed to the Louis Armstrong New Orleans International Airport. We were met by members of DMAT TX-4 who arrived several days earlier. Other teams from Alabama, Florida, Pennsylvania, Alaska, Hawaii, and California were also working within the airport, as DMATs maintained an around-the-clock presence.
Our team was split into 2 groups, working 12-hour shifts, with one half assigned to the flight line. The first couple of days, the DMATs on the flight line were off-loading about 800 people an hour from the helicopters. After being off-loaded, the evacuees were triaged. Those not requiring medical assistance were sent to an outside area to await busses to take them out of the city. The others were sent inside (where I was). Initially, my group was assigned to the lower baggage claim area of the airport where we oversaw the needs of more than 500 people (at any given time). These were people who couldn’t care for themselves. Most were confined to wheelchairs or needed to lie on stretchers. Our job was to take care of their basic needs, clean them up, offer them food and water, and keep them warm. If medical treatment was required, we re-triaged them upstairs, where care was available.

_the Red Cross was tracking and reuniting family members_

That first day was nonstop (I never took a break), and by the end of the day when I got back to where we stayed (Northwest baggage claim area), I wondered to myself whether I had accomplished anything. Even though we sent many people onto aircraft or to be treated, just as many were still in the lower area as when we started. But even more troublesome was that some of the people we had seen when we initially arrived were still there 12 hours later at the end of our shift, with barely a clear spot to put anyone else.

Our primary objective was to identify these people by name, birth date, and social security number, and to manifest them for departure on a military aircraft out of New Orleans—to Houston, San Antonio, and other points. Over the first couple of days, the teams assigned to the airport processed about 10,000 people each day. One of our main frustrations was the inability to track people; we just had no means to do it. When people asked about a family member or friend who they believed had arrived on another flight, it was difficult to tell them we had no way of knowing where the person was, or even whether they had arrived yet. We tried to offer hope by telling them our objective was just to get everyone out of New Orleans and that the Red Cross was tracking and reuniting family members once they reached their final destination. If families were together, we made every effort to keep them together, even if one member was ill and needed treatment with eventual transport to a hospital.
One of the best ways to describe the people we saw is to envision the worse nursing home imaginable, and then add the fact that these people had lost everything they owned, except what they had with them. Despite this, they were great—patient and respectful and so appreciative of our meager efforts to help them. We did have water and MREs to hand out as people requested food and water. Many times someone would reach into their pocket for money, asking “How much?” My reply was, “You’ve just lost everything. Take it, please. It’s free.” Our supplies were limited, but we managed. As night approached, we realized many weren’t going anywhere. Somehow we were issued Korean War vintage Army blankets (the date of manufacture was early 1950s). Because we didn’t have enough, we ripped them into thirds so everyone at least would have some sort of cover.

we often heard, “Make a hole,” as litter bearers tried to get through the crowd with their litter. Then as a 91-year-old-woman on a stretcher was wheeled onto an aircraft, we heard her yell, “Make a hole,” in order for her and her litter bearers to get through. We had to laugh.

Pets and animals were prevalent. People held onto them, their only remaining worldly possession: cats, dogs, and even a couple of birds. Veterinary Medical Assistance Teams (VMATs) did a great job. A boxer and her puppies, born a few days before the storm, were doing well. A cat and her kittens were rescued and brought in by helicopter, but the stress was too much for the mother cat. She ran away as soon as the helicopter landed, leaving the kittens, which were quickly adopted by various rescue teams.

The next day, our area was just as busy, but more civilian aircraft were around, meaning, hopefully, that more people would be evacuated more rapidly. Because people were not being transported in the order of arrival, we re-manifested everyone and included a date of arrival to help the flight crews identify who should go first. In spite of the increased transports, crowds remained, and people just kept coming as they were off-loaded from the helicopters. Because of the crowded conditions, we often heard, “Make a hole,” as litter bearers tried to get through the crowd with their litter. Then as a 91-year-old-woman on a stretcher was wheeled onto an aircraft, we heard her yell, “Make a hole,” in order for her and her litter bearers to get through. We had to laugh.

After a couple of days, the flow of patients to the lower level baggage claim decreased and we shut down that part of the mission. We were then assigned to the medical treatment tents in the upstairs concourse. In addition to triage, we had 3 tent areas—red indicated critical; yellow, minor; and green, predominantly for medication refills. I was assigned to the “red” tent, which, on a previous day when so many people were arriving, had seen 169 patients in 12 hours. We had a few patients arrive with chest pain, a patient who was unresponsive and needed to be intubated, patients with seizures, and a local worker who probably had an intracranial bleed. Our capabilities were limited to stabilizing and transporting via helicopter, primarily to Baton Rouge.

On about the fourth day, I began working on the flight line. Helicopters continued to come, but not as frequently. We unloaded patients, put them onto baggage “tugs,” and drove them to an outside triage area. None of us who worked the flight line or drove the tugs will ever again look at an airport runway the same.

At one point, a federal air marshal explained to me that we “may” have unloaded a person who left a black briefcase containing all he owned. In spite of having 5 different kinds of military helicopters coming in on two sides of the runway, I put the word out, not believing the briefcase would ever be found. Yet, 2 hours later, a Huey landed with no passenger onboard, just a black briefcase. We had found it! As time passed, the arriving number of evacuees waned and, on Thursday, September 8th, all DMATs at the airport were demobilized. Our mission was complete.

This was a very emotional mission, running the full spectrum from tearful lows to laughter. We can tell our stories, but never truly express our feelings about what we saw. No matter how eloquently we word it, we can never convey how appreciative the people were for our help. One team member said it was as if you were trying to describe the Fourth of July fireworks to someone. You can tell them about the shapes and the colors, but you can never convey...
the impact of the sounds and the feeling in the pit of your stomach when they exploded.

Curt Audin, RN
ED Staff Nurse
Member, DMAT MA-2 (Boston)
Boston, Massachusetts
(See also, Beaumont, Texas. Curt was re-deployed after being home for 12 days.)

Marrero, Louisiana

(Marrero, Louisiana is a suburb of New Orleans about 1 mile from the Superdome straight across the Mississippi River, or 8 miles by road.)

Knowing that Katrina was headed for us, I came in early on Sunday to begin preparations. We had just received an order of 9 radios, purchased with HRSA grant money, which needed to be charged. We in the emergency department gathered a supply of flashlights, filled 55-gallon pails with water, made sure all the patients who could be discharged were, got all the staff in, and prepared to the extent possible. We had prepared for potential hurricane hits several times in the past, but this was the first one to actually occur.

One of the first patients was a 16-year-old boy who had a fight with his alcoholic father and had been outside between 2 buildings throughout the hurricane. He walked up, wet, cold, shivering, and hungry.

When Katrina hit, we had sustained winds of 110–130 mph for several hours. Then, the eye passed over and we had a 3- to 4-hour lull mid-afternoon. Then, the winds began from the reverse direction and we had heavy, heavy wind and rain again. Pieces of the building tore off. The fire escape from the fifth floor fell just outside the emergency department. We lost power during the first half of the storm, and the emergency generator kicked in, which meant we only had emergency lights, no air conditioning, no running water, and no flushing, so we bagged all the toilets. The most striking aspect of the power outage was the condensation within the building . . . it looked like it had rained inside. The walls were dripping and the floor was covered with water. Because the floors are tile, it was a pretty dangerous situation. One emergency department technician fell and broke her knee. We had limited radio communication, and what worked best was the old Hospital Emergency Area Radio (HEAR) base radio, which has been around for years.

As soon as the storm passed, we began getting patients. One of the first patients was a 16-year-old boy who had a fight with his alcoholic father and had been outside between 2 buildings throughout the hurricane. He walked up, wet, cold, shivering, and hungry. We fed him and gave him some dry clothes, and a couple of us gave him money out of our pockets. Most impressive to me was the Louisiana National Guardsman who gave him the last $5 in his pocket. This was a man who had 6 children back home in Alexandria, Louisiana. I called the boy’s mother in Houston to tell her he was OK and was being transported to a shelter. She was so grateful and was coming to get him as soon as she could.

We were the only hospital of 20 in 4 Parishes that was operational and accessible. Luckily, we had 8 officers from the Louisiana National Guard with their M16s who helped us secure the facility. We sealed all but one entrance with Guard Humvees or downed trees, and we sealed all the doors to the building except the emergency entrance, where I was stationed with a National Guardsman and his M16, under an 8 × 8-foot canvas cover. We stopped everyone who approached, turning away 300–400 vehicles a day. We were sending them to hospitals that were at least an hour away, as we could only take life-threatening emergencies—patients with gunshot wounds, stroke, MI, etc. The area was like a war zone. We received 3 or 4 police officers who were shot, along with looters who had been shot and were probably the ones who shot the police officers. We had a family of 5 who was caught in the crossfire. One child died on the scene, but we were able to save the other 4. One victim lost an arm and another was in danger of losing a leg from the large-caliber automatic gunfire wounds from the looting and shooting. We received a police officer with a severe head wound, and the injured looter who had shot the officer. The looters came with open, gaping wounds from the M16s, along with a “story” they expected us to believe as to how they were injured. I teach TNCC and I can tell you, I was proud of our trauma team, but there were tough times. We have a number of young nurses; this was a lot of experience in a very short time for them.
On about the third day, an elderly lady walked up asking for food and water. I asked her where she was from and she pointed to a building across the street. I said, “You couldn’t have come from there . . . those buildings have been evacuated.” “Oh, no,” she said, “There is a group of us still there.” When we went to investigate, we discovered 30 people in 1 assisted-living building and 30 in the next. The elevators were not working, and they hadn’t had food, water, or medications for 3 days. The staff had abandoned them except for 1 maintenance worker who came back. Then we discovered the cabinets and coolers were full of food, but they were all padlocked. When we asked the janitor to unlock the cabinets, he said that the patients were to eat the MREs provided by the National Guard and Fire Departments until they ran out, to save the facility food. I spoke with our Parish President, Aaron Broussard, who gave the National Guard and me an order under Martial Law to cut all locks and ensure that the elderly folks received everything they needed to sustain them; which we did gladly (Figure 8). The ED staff pretty much took care of those elderly people for the next 10 days or so. We took over food and their medications every day, and we made sure they had plenty of water. The staff even barbequed for them one day.

We received a police officer with a severe head wound, and the injured looter who had shot the officer. The looters came with open, gaping wounds from the M16s, along with a “story”

A couple of things involved the USNS Pollux, which was in port for some major repairs when Katrina hit. Shortly after the hurricane, the Captain sent word asking what the ship and crew could do to support us. We had no diesel or regular gasoline available, so we rigged up a pipe from the ship and kept the generators, ambulances, police cars, and fire trucks going. They gave us thousands and thousands of gallons of fuel.

Also, we had 2 patients who were probably going to die within 24 hours if they didn’t receive their overdue dialysis, which we were trying to figure out a way to do. The ship had electricity and clean water—the 2 things we needed...
for dialysis—and we had portable dialysis machines. The only problem then was that there were no dialysis nurses, or so their physician thought. However, I told him that that wasn’t quite true; 4 of the ED staff had dialysis experience. We transported the patients and the an ED nurse to the ship and jerry-rigged the dialysis machine, which, according to the physician, saved the lives of those 2 patients.

A few nights after this, the Captain of the Pollux came over to our parking lot in civilian clothes and asked to borrow a National Guard Humvee. I recognized him and asked why he needed it. As it turned out, his wife and the wife of his first mate had been evacuated to the Convention Center. When things got so bad they feared for their lives, they hid in a rental truck behind the center and, by some miracle, got a call through to him on their cell phone. He needed the Humvee to rescue them. The National Guard personnel stationed at the hospital were well aware of how much assistance the Pollux and crew had given us, and when the ranking Sergeant heard the Captain’s plight, he said, “Well, I can’t give you this Humvee, but I can sure go with you to get them,” and off they went, the Captain and a Louisiana National Guard sergeant with an M-16 rifle. And, yes, their effort was a success!

On the fifth day, 2 other hospitals in the area reopened, which eased the burden on us, but those first days were hard. We were understaffed, and, in addition to the severely injured patients we were getting, we were providing 24-hour care to about 20 admitted patients because there were no beds to admit them to.

The 2 most important things to me in all this were as follows: 1) training and preparation and 2) relationships between agencies. Interestingly, the first DMAT physician to arrive was one I knew and had trained with, so I was given the role of liaison with other agencies, which was right up my alley (Figure 9). During my years of training, I’d worked with many of these people. I knew them and they knew me. We were on a first-name basis. It was a thrill to see so much cooperation and support for one another. Everyone worked very well together and, believe me, we had a number of organizations involved: the Sheriff’s Office, Fire Department, Office of Emergency Preparedness, and the Hazardous Material Department of Jefferson Parish. The Louisiana State Police, Louisiana National Guard, and National Disaster Management System DMATs NY-2 (the absolute best), then NY-4, then MA-1, TN-1, California,
and Oregon had team members here, as did many other DMATs, including FL-6, and VA-1. Also the Louisiana Hospital Association, Metro Hospital Council, and the local Federal Bureau of Investigation were here. Agents of Alcohol, Tobacco and Firearms (the federal agency responsible for enforcement of laws related to these 3 products) were also here because of the number of stolen, dangerous guns in the hands of looters who hit the gun and sporting goods stores early on. These were heavily armed SWAT teams. Also present were Immigration & Customs Enforcement, Army 82nd Airborne, and many more military units and civilian volunteers. We were able to accomplish so much because of those 2 factors, and I am proud to have been a small part of it all.

Kerry Jeanice, RN, EMT-P
Flight Nurse & Clinical Educator, Emergency Department & Air Care
West Jefferson Medical Center
Marrero, Louisiana

Fortunately, here in Houma, we were affected only by a few broken branches and power outages from Katrina. The next Saturday as a volunteer I was sent to a newly opened second shelter in our area. Upon arrival, I became the nurse in charge, much to my surprise. I gave medications that had been missed for 5 days, bandaged wounds of people who had waded in chest deep water, and gave insulin, tetanus shots, and lots of hugs. Many of the people we sheltered were police officers and their families from the Orleans Parish jail. Hearing what they went through was unbelievable: having to move prisoners to higher floors as the jail flooded, having no food, water, or power, getting the prisoners out by boat, and then staying behind until they could be rescued. One of the jail nurses was at our shelter and she finally located her husband and children after 6 days. She gathered up clothes for her children and we found her a ride to meet them. She was so grateful.

As much as I love ED nursing, nothing in my “Taj Mahal” emergency department compared to the care I gave in that shelter. Those people who slept on the concrete floor of that building were beautiful, loving, appreciative Louisianans who needed our prayers, love, and support in so many ways.

And then last week Rita came. Our Parish had the most flooding because our levees were breached. We’ve had flooding in the past, but this was the worst we had ever seen. Katrina sent our water out because we were on the west side of the eye, and Rita pulled it inland—further in than anyone can remember—because we were on the east side. Because we are not strangers to flooding, most of the low-lying areas were evacuated and, to my knowledge, we had no deaths in the Parish.

This was such an eye-opening experience as an RN. I’ve never seen so many people who needed so much in such a little bit of time. The most difficult part of it all was not being able to do more.

Robin Page, RN, CEN
Staff Nurse, Emergency Department
Terrebonne General Medical Center
Houma, Louisiana

Baton Rouge, Louisiana

I was 1 of 11 members of an Illinois Medical Emergency Response Team (IMERT) dispatched the day after Katrina. Our team was two emergency physicians, five emergency nurses and 4 paramedics. We were dispatched upon a request from the Governor of Louisiana to the Governor of Illinois.

When we arrived in Baton Rouge, the local medical personnel had begun setting up a field hospital in the basketball arena at Louisiana State University (LSU). Building on the remarkable job they began, our team, a New Mexico DMAT, the US Public Health Service, and LSU helped establish an 800-bed “stand up emergency triage hospital,” the largest and closest to New Orleans. We established a formal triage at 1 entrance, tagging patients red, yellow, green, or black as they arrived. We had patients arriving by helicopters, which landed on the track field. We also had patients arriving by ambulance, bus, pickup truck, on foot after walking through that fetid water... any way you can imagine. We had a very tight security barrier furnished by LSU security, Louisiana law enforcement officers, and the National Guard.

We set up 300 acute beds in the basketball arena for the patients tagged red and “dark” yellow with an additional 500 beds in the field house for patients tagged “light” yellow and green. Our beds were mostly cots that came, we were told, from the federal strategic stock pile.
In the basketball arena we had portable x-ray, EKG, I-star, ultrasound, and dialysis capabilities.

The first day I functioned as triage officer, triaging 100 patients in the first hour. The next day I did helicopter triage. We never knew when one would arrive, and I have no idea how many came. We found the most effective method was just having a team awaiting their arrival on the “pad.”

In the 7 days we were open, we triaged more than 15,000 people and treated more than 6100. Many just needed placement, medications, treatment for their hyperthermia, or hydration and food. Fortunately, adequate power, air conditioning, and water were available. We did have to perform an emergency cricothyrotomy on the floor of the gymnasium at one point.

One major issue was the inability to communicate with hospitals. We were receiving patients from the hospitals and nursing homes in New Orleans, but after we provided the immediate care they needed, we had trouble getting them placed in other hospitals. We needed ambulances waiting for us, not the other way around, and we did finally manage to streamline the process.

One day we received word that we were receiving 40 patients who needed decontamination only to have 5 ambulances arrive with 8 patients, each from a nursing home. They didn’t need decontaminating, they need to be bathed and cleansed and we had incredible, incredible nurses who took very good care of these patients.

We had hundreds if not thousands of volunteers who came to help ... local volunteers and students in the middle of their own backyards ... victims themselves. We had plenty of food and water, and clothing was available for the victims, sorted by size, age, and gender.

I must say, this experience reinforced my belief in humanity. People sat in chairs with fans blowing on them for hours on end, awaiting a place to go, without a word of complaint.

*The biggest take-home lesson for me was that when a local infrastructure (including health care) dissolves, the essential element required to sustain life is nursing care.*

One little girl came in with her head down. Her family had lost everything. She was given a backpack and a stuffed animal, and she left with her head up and a smile on her face. No child should be without a stuffed toy.

I’ll always remember one woman in particular. She was diabetic and hypertensive, and she was caretaker for her home-bound, ventilator-dependent father. The first day she got him into a boat and they tried to leave, but couldn’t get out. So the next day she tried again and this time she made it. They were brought to us. We stabilized and transferred them. She had bagged and fed her father by hand for 2 days ... for 2 days. Who else would have done that?

The heroism of the evacuees, how these folks survived, really got to me ... to all of us. The camaraderie between all the medical and nursing personnel, everyone, was something to behold. I feel privileged to have helped. It was truly a life-changing event.

Bernie Heilicser, DO
Emergency Medicine
Ingalls Memorial Hospital
Harvey, Illinois

**Additional Note:** I was Chief Nursing Officer of the IMERT response to Baton Rouge, a total of 51 medical personnel: 3 MDs, 36 RNs, and 12 medics. In addition to the formal teams, hundreds of medical volunteers from throughout the region made their way to the LSU campus. Many were from New Orleans, displaced by the hurricane. Others worked locally in Baton Rouge, reporting to the field hospital after working long hours at their own hospitals. In addition to large numbers of health care providers, our ace in the “whole” (so to speak) was being on a college campus. Hundreds of students volunteered to assist, in any way they could. These students did an awesome job. We would never have made it without them. Just the physical energy required to move 6000 patients would have been impossible without the LSU students.

Likewise, they moved crates of equipment and built shelves to store it. They fixed broken wheelchairs. They organized donations of clothing. They passed out food and water. They comforted and talked with patients, and health care professionals alike. It was our good fortune to be on campus and, in many ways, it was ideal for patient care, under the circumstances. The biggest take-home lesson for me was that when a local infrastructure (including health care) dissolves, the essential element required to sustain life is nursing care.
Mary Connelly, RN, CEN
Administrator, INVENT (Illinois Nurse Volunteer Emergency Needs Team)
ICEP (Illinois College of Emergency Physicians)
Oakbrook Terrace, Illinois

Leesville, Louisiana

After Katrina, our census had increased a lot, and then Rita hit. I had called in as many people as I could get, telling them to be prepared to stay 36 hours. We were always short staffed, and I ended up working about 21-hour shifts because, as soon as the storm was over, people started coming. We have a 6-bed emergency department and on a busy day, we normally see about 40 patients. After the storm, we were seeing almost 100 a day. We soon realized things weren’t working, so we learned fast track, real fast. In the triage bay, we lined up tables and chairs and we divided the emergency department into critical beds and acute beds.

We had 9 paramedics from New York who helped us for 3 days. Three worked with us each shift and were very helpful. Minutes after they arrived, they transferred a critical patient for us to a hospital in Shreveport.

The hospital did suffer some damage. A major section of roof came off, so we had leaks, but the emergency department was fully functional and we were the only one in a 100-mile radius that didn’t close down. People came from as far away as that for us to treat them. We staffed 1 RN at triage, 1 in the fast track, and 2 in the emergency department. Lots of people were coming to the hospital needing oxygen because the area had no power; we were still on generator power. Because there was no medical reason to admit these people, we turned a couple of rooms on one of the units into oxygen rooms, seating the people in recliners. Our engineer rigged up an 8-way delivery system from each oxygen wall outlet and we gave them all oxygen, food, and water.

It was wonderful to see how nurses pull together when the chips are down. We accomplished so much, and I am so proud of what our little emergency department managed to do.

Jo Ann Edwards, RN
Staff Nurse, Emergency Department
Byrd Hospital
Leesville, Louisiana

Shreveport, Louisiana

Part of my role as Incident Commander in the Health Resources and Security Administration (HRSA) Region 7 Hospital Emergency Command Center was to coordinate with the Louisiana Hospital Association and the other hospital regions to help identify where patients evacuated from South Louisiana would go, how to get them here, and how logistical aid would be provided to Region 7. As hospitals and cities in the affected area were evacuated and moved north, communities took on new populations of patients, their care givers, and the health care needs for all. When patients and evacuees finally got to the New Orleans airport or the Baton Rouge staging area, we directed their reception to Region 7 hospitals from Regions 1, 3 and 9: the hardest hit. We were challenged to find enough adult psychiatric beds for those being “directed” into the Louisiana health care system.

As part of a federal grant we received in 2002 to develop a regional preparedness plan for bioterrorism, Louisiana put into place a hospital communications system on the statewide 800-MHz Louisiana State Police network. This enabled us to talk to our cohorts at hospitals not only in our region but throughout the state, including Charity, VA, and the other hospitals in New Orleans during Katrina and the aftermath.

Hospitals hired displaced nurses. Some hospitals told me, “If we just had more nurses, we could have done more.”

Many of the evacuees bused or flown into Region 7 general shelters decompensated. They had not been eating correctly. They had exposure problems. They had no medications and no money. So guess who supported all of them. The hospitals. General shelter clinics were staffed with volunteer physicians and nurses from Region 7 hospitals. Emergency department nurses volunteered to manage shelter clinics. Special needs shelters were established at hospitals throughout the region. Through the Region 7 EOC, we obtained needed supplies, pharmaceuticals, and equipment, and developed a distribution system that would make Wal-Mart proud. We had dozens of volunteers from our region’s 28-hospital pool helping . . . many took turns staffing the EOC, delivering supplies, or working in the local shelters.
After Katrina, the aftermath just being assessed, we had a little breather, and then Rita crushed the other side of the state. We’ve been hit really hard, and for 30-plus days we’ve been in disaster mode. We are almost afraid to look at a weather forecast for fear of another hurricane in the Gulf. The nurses and hospitals are tired, but they have been 110% committed. Hospitals hired displaced nurses. Some hospitals told me, “If we just had more nurses, we could have done more.”

There is a general belief that “the government is going to rush in to help me,” but it’s not, not for days anyway. Having a tested plan and being prepared to be self-sufficient for weeks is essential. I feel our communication between regions did work and worked well. Through twice daily conference calls, asset inventories, and hospital system assessments, we knew our health care capabilities 24/7 and were immediately responsive to their needs. As a result, I feel Louisiana’s supporting nurses and hospitals were well organized and responsive.

Knox Andress, RN
Emergency Preparedness Coordinator
CHRISTUS Schumpert Health System
Shreveport, Louisiana

Designated Regional Coordinator
HRSA Louisiana Hospitals Region 7

Region 7, consisting of nine parishes and 28 hospitals, is one of nine hospitals regions in the state, part of the Health Resources and Security Administration. Louisiana emergency preparedness is activated region-by-region as indicated.

Orange, Texas

I have been here for 11 days with DMAT FL-5 responding to Hurricane Rita. Our team was also in Picayune, Mississippi, in response to Hurricane Katrina for 18 days; we had a turnaround time of 5 days between missions. There are 36 of us on this deployment with a total of 150 active members on the team. The nurses are mostly emergency nurses from all areas: pediatric, adult, trauma, cruise ships, etc.

Our convey drove straight through from Ft. Lauderdale, arriving here Sunday night at 8:30 AM after 36 hours on the road. We spent until 2:00 AM getting our tents up and began seeing patients the next morning. We are a self-contained, mini-emergency department with 3 areas for treating patients: critical, urgent, and minor. Many of the people we saw initially had chronic diseases—COPD, CHF—and a tremendous amount had asthma, both children and adults. I don’t know what the cause is; maybe it is air pollution from all the refineries, but there are certainly a lot with it. We’ve also been seeing lots of patients with mental health problems and prescription drug overdoses.

We can’t fill prescriptions except for more severe conditions—hypertension, cardiac, insulin, and other things like that. We have a social worker who interviews patients needing other kinds of medications and she finds a local resource where they can obtain what they need. Of course, it may be an hour’s drive away. We had lots of patients who were oxygen-dependent, and their tanks were empty. We aren’t approved to refill the tanks, but we gave them a “tune up.” Finally a FEMA truck that could fill the tanks arrived and that helped. Lots of people needed nebulizers.

The destruction and damage is just catastrophic. It’s as bad as New Orleans, without the water. The first few days, we primarily saw patients with chronic conditions. Then, as the locals began returning and trying to make repairs, we began to see trauma . . . people who stepped on nails, those who fell off roofs and ladders, others who cut themselves with a chain saw. And we saw a number of gunshot wounds. Tempers flare, people are stressed to the max, the heat and humidity are awful; they can’t cope, so they just take out a gun and shoot.

Some things are difficult to explain, except by divine intervention.

Talk about hot and humid, the temperature inside the tents (other than the treatment tent, which is air-conditioned with our generators) has been up to 105°F, so some of us sleep in our refrigerator truck where medications and heat sensitive supplies and equipment are stored. And, of course, ear plugs help. We usually don’t get more than about 4 hours of sleep a night. When we are on duty at night, we do it all: take care of patients, do the blood draws, run all the labs, do the EKGs . . . everything. We are really Jills of All Trades.

Some things are difficult to explain, except by divine intervention. We have an “antique” x-ray machine that is always going down. We have a GREAT logistics guy who
just has a knack for keeping it running, but just barely. One day, a huge, beautiful van with 2 orthopedic surgeons, an x-ray tech, and a state-of-the-art digital x-ray machine arrived. The machine was owned by the Chicago Bears!! Heart to Heart International from Kansas arranged it, though I have no idea how they knew how desperately we needed a dependable x-ray machine. We are now able to take x-rays, and if a patient is transferred to Houston, we can send a CD of his x-rays with him. Also, if patients need a repeat x-ray, we can see them again instead of sending them off somewhere else for follow up. We can access the old reading and compare it with the new. We are sooo impressed.

We absolutely cannot survive without our logistics team. They are mostly fire fighters/paramedics, and they are amazing. Anything we need, they find. A Black Hawk landed, bringing medications and supplies that we said we need. They found us a washer and dryer and hooked it up. They do wiring, plumbing, inventory, restocking, acquisition, garbage, ice...anything and everything needed to keep us going. They even got us a supply of potable water and hooked up a shower with hot and cold running water...what a luxury!! They work 24 hours a day, outside in the heat and humidity. They are truly the unsung heroes.

Logistics and communication are the two big support components that are essential to being able to function, and ours are wonderful. Not only do our communications people assist in communicating with the EMS command to get air or ALS ground transports for our patients, they also send daily e-mail updates to our families and friends. They make leaving loved ones to go on deployments more bearable for us, and for those back home.

The emergency department of Memorial Hermann Baptist Orange Hospital is close to re-opening. They normally see about 30 to 60 patients a day, and we have been seeing 100 to 120. They are a little nervous, but we told them we would double staff with them until they are under control. As soon as they are able to take over, we’ll be packing up and heading back to Florida. This has been exhausting, but very rewarding. I know we’ve saved many lives both here and in Mississippi.

Sharon Cohen, RN, CNS
Emergency Preparedness and Weapons of Mass Destruction
North Broward Hospital District
Ft. Lauderdale, Florida

Beaumont, Texas

As a member of a DMAT MA-2 deployed from Boston, our first mission was to board a C5 in San Antonio for Beaumont, where we were to evacuate a hospital/nursing home. We worked through the night to complete the task and around 5:00 AM we were told to board another C5 headed for Atlanta, as this was our only way out of the area and the storm path. We arrived back to San Antonio around 8:00 AM after being up for some 35 hours straight. The next morning we packed up and hit the road back to Beaumont with our trucks and gear.

I treated at least 4 patients with temperatures in the 105 to 106°F range. I ran around and grabbed a couple of big fans. No spray bottles were available for wetting down the patients, so we came up with a pretty neat trick of taking an IV bag, puncturing needle holes in it and squirting the patient that way.

We arrived around 11:00 PM Saturday to augment the emergency department staff of Memorial Herman Baptist Beaumont Hospital, which had weathered the storm. The staff greeted us with hugs and tears. We split our team into day and night teams and went right to work. On Sunday, our first full day, I was on the 7:00 AM to 7:00 PM shift (we are all on 12-hour shifts) and we saw 140 patients. All of us were drenched in sweat with salt marks on our shirts as we were on generator power and without air conditioning. We had 8 ground ambulances and 5 aircraft crews that we maxed out transporting patients to outside hospitals.

I’d been assigned the trauma rooms and we were busy. On a regular basis, we were seeing patients suffering from overdoses, unresponsiveness, hyperthermia, and MIs. Within the first day or two, we intubated 10 patients. Hyperthermia was a real problem; I treated at least 4 patients with temperatures in the 105 to 106°F range. I ran around and grabbed a couple of big fans. No spray bottles were available for wetting down the patients, so we came up with a pretty neat trick of taking an IV bag, puncturing needle holes...
in it and squirting the patient that way. It worked great. The air conditioning was on in spots; luckily, the emergency department was one of them. It was so humid that the floors had a film of moisture, which made walking kind of tricky; now with air conditioning and dehumidifiers, that’s not a problem.

Two other DMATs were here until last night, FL-2 and KY-1, but they were sent to Houston for another assignment. This is the only hospital in Beaumont that is running, but they have no admitting capability. Apparently, the emergency department of the local Level 1 hospital is flooded.

Today (Sunday, October 2nd) we are beginning our eighth day here, and we have just reached the 900th patient of this mission.

For the first time since arriving, yesterday we had a chance to get out of the hospital for a few hours and we saw some of the damage from Rita: trees and electrical poles down, lots of property damage. There is still very little power to the area, and no one is sure when it will be fully restored. We now have full power and water at the hospital, so that battle is over.

Our patient load has shifted. As more people return to the city, we are seeing different types of patients. One prevalent issue is carbon monoxide poisoning from generators. With no power, people are buying generators for electricity. Because there is a problem with generators being stolen, people stop thinking and bring their generators into the garage, or even the house, to protect them. Earlier in the week we treated a family who brought their generator into the house (after police told them the night before to remove it). The next morning, 3 members were dead on scene and 2 were brought to us, intubated—a woman and an 8-year-old boy. Neither survived. We had about 15 patients yesterday for similar reasons, in spite of public service information being distributed about what NOT to do with a generator.

A lot of work still needs to be done in the area, but the local staff is so appreciative of us being here and of our help. On a happier note, one of our logistics people was asking everyone what little thing could make this deployment better. Not thinking of anything else, I finally I said I wanted a kite to go fly in the wind. The next day, I went to my room and found one inside.

Curt Audin, RN
ED Staff Nurse

Member, DMAT MA-2 (Boston)
Boston, Massachusetts
(See also New Orleans Airport where Curt was initially deployed with DMAT MA-2.)

Houston, Texas

As we watched the devastation occurring in New Orleans, the City of Houston, Emergency Management, and Harris County Hospital District developed a plan, along with the City of New Orleans, to evacuate those in the New Orleans Superdome to the Astrodome in Houston. At one point, the count of hurricane victims in Houston rose to more than 19,000. An intake clinic with ED capabilities to receive these refugees was set up, and, for several days, patients were screened, the ones with minor illnesses were treated, and those with more severe problems were transported to area hospitals, with the majority of them coming to Ben Taub General Hospital. At the same time, we were receiving many walk-in patients. For the many patients with complaints of diarrhea, we followed isolation precautions and admitted all of them. Many elderly patients arrived with dehydration. These are just 2 examples of the problems we were seeing.

One of the most poignant experiences for me involved a young mother with a 1-month-old baby who had come in with her severely dehydrated husband. I was standing next to her, noted her body odor, and asked if she would like to clean up while her husband was being treated. Almost in tears, she said it had been 5 days since she’d been able to take a shower, and she would love one. The nurses found her some clean clothes. While she showered and washed her hair, we bathed the baby. Of course, we didn’t have a baby bathtub in the Emergency Center, so we improvised with our scrub sink!

I see us continuing to do this for at least the next 6 weeks. It just doesn’t seem to end.

In preparation for Rita, our disaster plan was activated Friday morning and I worked continually from then until Saturday night getting ready for the onslaught. I can affirmatively say, had Rita hit Houston, Ben Taub would have been well prepared. We have a very loyal staff, even
when told to come prepared to stay at least 48 hours. We had a shelter for family members to stay with the staff. We even had a pet zoo. I told the powers-that-be that we have a lot of single staff with pets that are very important to them. If we have a place for their pets, the nurses will come. And they did. The staff came and they brought their clothing, their family, and their pets . . . In retrospect, we probably could have communicated a little better about that as one staff member brought 20 members of her family. We ended up with more than 600 family members coming to the hospital for shelter.

Lots of nurses volunteered to help at the Astrodome, but I decided my job was to stay in the emergency center to help ensure that everything was running smoothly here. We’ve basically been in disaster mode for 6 weeks. The staff is tired. First, we were “slammed” with thousands of Katrina victims who came to Houston. Then, we prepared for the onslaught of Rita. Now, we are meeting the challenge of the aftermath of Rita.

Although the emergency center is pretty much back to normal, people are beginning to come to us from the Port Arthur/Beaumont/Orange area. Patients are being brought from the state penitentiary outside Beaumont because none of their local hospitals are fully functional yet. I see us continuing to do this for at least the next 6 weeks. It just doesn’t seem to end.

Karen To’oto’o, RN, BS
Assistant Nurse Manager, Emergency Center
Ben Taub General Hospital
Houston, Texas

REFERENCES
The Creation of a Behavioral Health Unit as Part of the Emergency Department: One Community Hospital’s Two-Year Experience

Authors: Christina Lewis, RN, BSN, MPH, Gina Sierzega, BA, MA, Allentown, Pa, and Diana Haines, RN, MSN, CEN, Bethlehem, Pa

Christina Lewis, Greater Lehigh Valley chapter, is Administrative Director, Department of Emergency Medicine, Lehigh Valley Hospital and Health Network, Allentown, Pa.

Gina Sierzega, is Research Coordinator, Department of Emergency Medicine, Lehigh Valley Hospital and Health Network, Allentown, Pa.

Diana Haines, Greater Lehigh Valley chapter, is Patient Care Specialist, Department of Emergency Medicine, Lehigh Valley Hospital and Health Network, Bethlehem, Pa.

For correspondence, write: Gina Sierzega, BA, MA, 137 Windermere Avenue, Allentown, PA; E-mail: gina.sierzega@lvh.com.


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Introduction

In December 2000, the emergency department (ED) nursing director, the physician medical director, and the administrator of Clinical Services at Lehigh Valley Hospital and Health Network (LVHHN) proposed the development of a specialized area within the ED dedicated to providing care for the emergency behavioral health patient. The proposal for an ED-based behavioral health unit came in response to a decision that consolidated in-patient behavioral health services throughout LVHHN into the Behavioral Health Science Center (BHSC) in September 2000. Two environmental factors—the chronic nationwide shortage of inpatient behavioral health beds and the closing of other behavioral health units and/or beds in areas surrounding LVHHN—increased the LVHHN ED behavioral health patient census and generated a greater need for specialized behavioral health care in the ED.

The BHSC expanded the number of LVHHN’s licensed inpatient behavioral health beds from 24 to 65 (a 171% increase) and, within a few months, the LVHHN ED experienced an increase in behavioral health patient census and length of stay. Prior to the opening of BHSC, our ED treated approximately 125 behavioral health patients per month. Upon BHSC implementation, the behavioral health volume dramatically rose to more than 175 patients per month, representing a 40% increase in volume and an almost 50% increase in behavioral health admissions.

We identified limited literature on emergency behavioral health or the psychiatric patient in the ED. Available literature focused on the treatment of specific psychiatric disorders in the ED, such as depression\(^1\) and suicidal behavior,\(^2\) \(^4\) generalized psychiatric care in the ED,\(^3\) and
the triage of psychiatric patients in the ED.\textsuperscript{6,7} Research findings discussed the use of restraints and seclusion in the management of psychiatric patients.\textsuperscript{8-11} Specific strategies for the quality of care for patients with psychiatric problems in the ED focused on improvement of patient outcomes regarding length of stay, referrals at discharge, and screening techniques used to identify the psychiatric patient.\textsuperscript{12} Additional literature discussed the role of specialized psychiatric nurses in the ED and their effectiveness in assessing the patient, participating in direct patient care, coordinating and collaborating with ED staff, and working with the patient at times of discharge or admission.\textsuperscript{16,17} These articles illustrated many similarities between their objectives and those of the Emergency Behavioral Health Unit (EBH). Although they were carried out differently (specialized nurses in the ED vs. a specialized unit in the ED), they share common endpoints. Lastly, the literature often cited the dramatic increase in the number of psychiatric patients as a key motivating factor in evaluating current procedures.\textsuperscript{13-15}

In early 2001, a task force of both nursing and physician leadership began an initiative to simultaneously address current ED staff and behavioral health patient needs, while the specialized ED behavioral health unit took shape. The task force, made up of the nursing ED director, administrator of clinical services, and the medical director, secured vacated space adjacent to the ED. At the same time, management noted an increase in staff turnover. A chart review in September 2001 of ED behavioral health patients showed poor documentation and procedure compliance from staff. These results prompted management to initiate a documentation change in October 2001.

**Planning for the EBH**

Using a shared governance approach, ED nursing leadership, including a patient care specialist, patient care coordinator, and nursing and physician directors of emergency services, met with representatives of the risk management, behavioral health, and security departments to review patient care outcomes. This diverse group, which became responsible for the solutions and decisions associated with the unit, met with staff to assess their attitudes and concerns about the care of these patients. Results showed that more consistent staff practice patterns for early assessment to identify high-risk behavioral health patients (defined as any patient who is at risk for flight and/or exhibits suicidal or homicidal behavior) and provide for their safety, more consistent staff practice patterns for changing patients into hospital garb at the beginning of the visit, and an improved ED physical space would increase staff satisfaction and the ability to provide quality care in the ED. In response, ED nursing leadership developed and implemented a two-stage action plan. Stage one focused on short-term interventions, including an immediate change in practice to assure care consistency (e.g., physicians and nurses would assess seclusion needs for patients immediately on presentation to the ED, with patients changing to hospital garb before the nurse leaves the bedside from initial assessment), staffing pattern assessment for support for additional behavioral health patient census, and restraint use. Stage two identified long-term interventions, including new space, staffing to support new space, and policies for new space.

First, ED nursing leadership, risk management, security, and psychiatric evaluation services (PES) reviewed current processes for consistency, appropriateness, and clarity. Processes included the identification, assessment, and documentation of high-risk psychiatric patients and guidelines for use of seclusion and restraints. Risk management, behavioral health, and security conducted mandatory sessions between ED personnel. During these sessions, the ED patient care specialist discussed the revised and newly developed processes with ED staff with the expectation that these processes would be incorporated into daily practice.

As the ED was preparing to open its new behavioral health unit, the staff began determining guidelines for the new unit. A volunteer committee of nurses, technical partners, administrative partners, psychiatric personnel, and security met weekly for approximately 10 weeks to define the comprehensive sets of guidelines, which were developed with input from all caregivers and disciplines involved in ED patient care (e.g., non-licensed health professionals, nurses). All committee members shared a common goal: to ensure the safety of the patient and the safety of the staff.

While these new or revised policies focused on improved standard of care in the ED, the committee prepared for the opening of the new EBH and worked to ensure compliance with these new policies. The committee generated a comprehensive list of goals, including recommend
changes to provide increased unit functions and safety, develop processes to promote a safe environment with emphasis on the new unit, develop processes to promote patient and family satisfaction, recommend orientation and educational programs, design the new EBH, recommend ongoing performance improvement process reviews, ensure consistency with inpatient behavioral health patient guidelines, and evaluate the effects of the interventions.

The committee began addressing these goals by designing a flow chart that detailed patient movement throughout the ED and considered traffic patterns of both ambulance and walk-in patients (Figure 1). As a result of several studies on ED behavioral health patient volume and admission/discharge length of stay conducted in the ED, new triage criteria were developed to ensure an immediate transfer of a psychiatric patient from the waiting room to the EBH (Figure 2). If any one criterion on the revised screening tool is not met, the triage nurse may review the information with the ED physician who then determines whether the patient should be evaluated in the main ED before entering the EBH.

At the same time, the committee focused on safety issues related to patients, families, and staff. The committee developed an information sheet for the patient and family/visitors that lists the rules of the EBH (Figure 3). Ultimately, the committee concluded that there should be mechanisms in place to allow for a quick response to an escalating patient. In response, the ED implemented a security system, including monitored cameras in each patient room and each hallway and alarm buttons with an audio alarm and flashing lights in each room and at the main desk that are connected to the ED and security (regardless of activity, alarms are checked every 8 hours). Staff also wear portable alarms and carry a portable phone that connects to security at the push of one button.

### Physical plant and staffing of the EBH

In March 2002, less than 2 years after LVHNN opened the Behavioral Health Science Center, the ED introduced
the EBH (Figures 5-8). In addition to the 13,290 square-foot ED, the EBH offers a six-bed, 1700 square-foot secured area adjacent to the ED that includes observation and seclusion rooms equipped with full-time visual and audio observation provided by video cameras and a desktop display. This L-shaped unit consists of a nurses’ station, a workroom for medications and supplies, six patient rooms (two are equipped for seclusion), an office for the psychiatric social workers and the director of the PES office, sinks that are easily accessible for staff, a shower, a free public telephone, and a patient sitting room with a television and reading material, which is used by both patients and their families. All patient rooms, the sitting area, bathroom, and halls are monitored and alarmed; however, because of privacy issues, there is no camera located in the bathroom. Both the observation rooms and seclusion rooms have only one bed in them. The only difference is that the beds in the seclusion rooms are chained to the floor.

The EBH is considered part of the ED, and ED staff is responsible for the care of all patients in the EBH. After hospital administration approved additional staff to support the project, the committee decided to incorporate a new skill provider with a different skill level in the ED—a licensed practical nurse (LPN). The ED leadership originally planned to fill this position with two technical partner positions; however, ED nurses expressed the need for an additional RN. At the time, LVHHN experienced hospital-wide nursing shortages and had difficulty filling other nursing positions. An LPN position offered more flexibility in hiring someone for the unit and required less monetary resources, and, at the same time, provided someone with the skills necessary to properly run the unit. An LPN and a non-licensed technical partner staff the unit during each 8-hour shift. EBH staff conduct observations checks every 15 minutes, behavior and location checks every 15 minutes, Mental Health Observation Assessments every 2 hours for adult patients, and additional checks if the patient is restrained. Adolescent patients receive additional checks. The RN in the main ED is assigned as a liaison to

FIGURE 3
Visitor policy: emergency behavioral health unit guidelines.

FIGURE 4
Doctor’s order sheet: behavioral health patients.
the EBH, with responsibilities to evaluate new patients and assess current patients in the EBH every 4 to 8 hours.

Social workers are on duty 24 hours a day, 5 days a week. On weekends, they work 10 hours per day. They provide PES for all behavioral health patients in the ED. Their position in the ED is not new. They work in conjunction with the ED physician to evaluate patients for appropriateness of inpatient care or discharge. These social workers coordinate admission to our hospital inpatient unit or another facility, arrange transportation, and obtain pre-authorization from payors. Because the PES office is located right in the EBH, PES staff can more effectively serve as a resource for patients and staff.

Training for the new EBH

New processes in place for the EBH created a need for additional orientation and education programs for new staff. Until now, education on the care of the behavioral health patient was a small part of orientation and addressed tasks such as restraint policy. From January to March 2002, the ED patient care specialists arranged for and conducted education on topics such as assessment and prevention of violent behavior and active intervention strategies, in addition to the traditional ED orientation for all new staff. Because the LPN staff had limited or no experience in mental health care, senior staff from the inpatient behavioral health unit on each shift volunteered to be available for real-time questions or advice to LPN staff. New EBH staff also attended an intensive 12-hour training program that they must renew every 2 years. The LPNs also spent clinical time on the inpatient behavioral health units to gain practical education.

Evaluation

After implementation of the EBH, preliminary outcome measures for standard of care included the following: 1) documentation completion on the Mental Health Observation/Assessment form and 2) documentation completion on the Patient Behavior/Location form. The ED patient care specialists conducted monthly chart reviews, which assessed data and monitored improvements. Since the EBH opened, the ED received no staff resignations influenced by problems with the care of the behavioral health patient. Additionally, critical elopements in which patients experienced a negative outcome as a result of not receiving behavioral health care are zero.

An ED staff survey was conducted after implementation to evaluate staff opinions regarding the effectiveness of the EBH. The four-question survey asked ED staff at all skill levels about the following issues:

- Their ability to care for behavioral health patients since the EBH opened,
- Their level of satisfaction with their ability to provide care,
- Their satisfaction with personal safety needs, and
- Their satisfaction with the safety needs of the behavioral health patients.
Results showed that staff saw decreased patient frustration, a safer, more pleasant environment for patients, an improved staff-patient ratio, reduced wait times, and reduced elopements.

Utilizing a shared governance model for design of the unit and its operational processes was a positive experience for the staff involved. Instead of feeling powerless, staff became active participants and owners of the solution. Patients have verbalized appreciation for the confidentiality of private rooms, the availability of a shower, and the option to watch television.

Problems

The new EBH brought many improvements, and an interdisciplinary group of ED staff, PES, and security meets monthly to stay on top of problems and work towards consistency of practice. Revisions or additions to practice evolved from the problems identified at these meetings. For example, staff wanted to make the screening and treatment of patients more consistent. The interdisciplinary group, with input from the Medical Director, developed standing order sets (Figure 4). Three years after opening the EBH, the staff continually reviews the triage criteria to determine which patients are sent to EBH. They evaluated restraint data for opportunities to decrease use and revised the standing orders to include earlier medication use as necessary. Another improvement focused on staff safety. Although the EBH initially equipped staff with portable phones, EBH staff expressed safety concerns. As a result, staff members received personal alarms and a security team began regular walk-throughs of the unit.

Despite the success of the EBH, staff continues to encounter several challenges. In-patient placement of the behavioral health patient is still difficult, because there are still a finite number of psychiatric beds, especially for those patients with dual diagnoses; however, the EBH provides an improved care environment while the patient is in the ED. Another challenge is the education of ED staff. Although seasoned psychiatric nurses give a mandatory 4-hour update on safe response to all ED staff, this 4-hour education is not sufficient to address the in-depth education associated with this specialized field. Once implemented, the EBH nurses’ workstation proved too small to fit all necessary equipment (e.g., fax machine, copier, and supplies), and the addition of a door on the front of the workstation to signal to patients that the space was off limits made the area seem even smaller.

Future directions

Implementation of the EBH occurred at one of LVHHN’s three EDs; however, this team effort and the extension of the shared governance model integrated representatives from various departments throughout the network. A committee that started as a group of individuals has since...
evolved into what is now known as the EBH Council. This council now includes staff from our other two sites and, ultimately, has enabled us to standardize policies and procedures related to the care of the behavioral health patient in the ED.

Acknowledgement
The authors would like to acknowledge Brian Nester, DO, Senior Vice President, Physician Practice and Network Development, for his role in the creation of the Emergency Behavioral Health Unit and his continuous advocacy for the clinical staff. The authors would like to acknowledge Rosanne Teders, LCSW, Director of Psychiatric Evaluation Services, for her role in developing the standards of practice for the Emergency Behavioral Health Unit and her ongoing dedication to the success of the unit.

REFERENCES
A 4-year-old Boy With Pulmonary Hemosiderosis and Respiratory Distress Requiring Use of a Cuffed Endotracheal Tube

4-year, 11-month-old boy was brought to our community emergency department because he had difficulty breathing since awakening 5 hours earlier. He had been feeling tired for approximately 1 month but otherwise was well until that day. When the child presented to triage, he was pale and tachypneic with a frequent nonproductive cough. The triage nurse immediately brought him to the treatment area.

The child’s vital signs were as follows: temperature, 37.1°C (98.8°F); heart rate, 142 beats/minute in a sinus tachycardia; respiratory rate, 42 breaths/minute; blood pressure, 97/63 mm Hg; and an SpO2 of 82% on room air. The patient’s history was remarkable only for pulmonary hemosiderosis (PH), a rare condition that causes hemorrhage in the lungs and subsequent severe, symptomatic anemia. He had no known medication allergies, but the child’s father noted that dairy products “set off” the hemosiderosis. The child did not take any medications.

On physical examination, the child was awake, alert, oriented, and in moderate respiratory distress with 5- to 6-word dyspnea. He had increased respiratory effort and mild retractions, but his breath sounds were clear and equal bilaterally with no evidence of stridor.

Our initial management included initiating oxygen therapy with a simple face mask at 4 L/minute. While receiving nebulized albuterol, 2.5 mg, and ipratropium, 0.5 mg, the patient’s SpO2 decreased to 89%. After the treatment, the respiratory therapist reapplied the simple face mask at 3 L/minute and the patient’s SpO2 increased to 98%. Because the child had no signs of heart failure, we initiated an intravenous line and administered a bolus of 320 mL of 0.9% normal saline solution (20 mL/kg).
After having a chest radiograph completed, the child returned to the emergency department in increased respiratory distress with marked hemoptysis; he was unable to speak. His respiratory rate was 50 to 60 breaths per minute and his SpO2 was ≤50%, despite administration of high-flow oxygen at 12 L/minute. His breath sounds were coarse throughout.

The emergency physician decided to orally intubate the child with a 5.0 uncuffed endotracheal tube. Initially the respiratory therapist set the ventilator with a pressure-control at 32 breaths per minute, fraction of inspired oxygen of 100%, a tidal volume of 200 mL, and 5 cm H2O of positive end-expiratory pressure (PEEP) with an additional 3 cm H2O pressure support (PS). An air leak and consistently low SpO2 (<80%) improved when the child was reintubated with a 5.5 uncuffed endotracheal tube. Although our patient maintained an SpO2 of 95% to 100%, we needed to provide frequent endotracheal suctioning for copious bright red hemoptysis. The respiratory therapist gradually increased PEEP to 7 cm H2O because of increasing airway pressure from the bleeding.

After use of the ventilator was implemented, the patient’s arterial blood gas results were as follows: pH, 6.99 (normal, 7.35-7.45); pCO2, 51 mm Hg (normal, 35-45 mm Hg); HCO3, 12.3 mEq/L (normal, 24-28 mEq/L); and SaO2, 75.9% (normal, ≥95%). The hemoglobin level on this blood sample was 4.2 g/L (normal for 1- to 6-year-olds, 9.5-14.1 g/L). One hour earlier the patient’s hemoglobin had been 6.2 g/L, and his hematocrit was 22% (normal for 1- to 6-year-olds, 30% to 40%).

To restore blood volume, we administered divided transfusions of packed red blood cells (PRBCs); our patient received 387 mL over 80 minutes. We also administered sodium bicarbonate, 16 mEq intravenously, for the marked acidosis. Blood drawn for arterial blood gas analysis after these interventions demonstrated improvement in the patient’s condition: pH, 7.38; pCO2, 30 mm Hg; HCO3, 67 mEq/L; and SaO2, 89%.

We kept the patient sedated with a midazolam infusion at 2 mg per hour and maintained paralysis with periodic doses of 2 to 3 mg of intravenous vecuronium. We also administered ceftriaxone, 800 mg intravenously, because the chest radiograph demonstrated bilateral, diffuse, patchy parenchymal densities throughout the lung fields; we could not rule out pulmonary infiltrates. The child still required frequent endotracheal suctioning to remove bright red blood from his airway. During a 5-hour period, he received a total of 700 mL PRBCs.

The patient continued to have episodes of desaturation (SpO2 ≤60%) despite aggressive airway maintenance and manipulation of ventilator settings, including greater PS, and PEEP up to 8 cm H2O. The emergency physician decided to reintubate the child with a 5.5 cuffed endotracheal tube because he needed the pressure support the cuff would provide. PEEP was gradually increased to 10 cm H2O. This ultimately provided the best ventilation for our patient, and after these interventions, he maintained a consistent SpO2 of 97% to 98%. The child remained relatively stable as he was transported to the ICU at a regional pediatric center for further evaluation and management.

Despite the cuffed tube, higher volumes of PEEP (ie, 5-20 cm H2O) or PS (ie, 2-20 cm H2O) may be required in the presence of pulmonary hemorrhage to increase the mean airway pressure.

Discussion

With PH, recurrent alveolar hemorrhage results in an abnormal pleural accumulation of hemosiderin, an iron-containing hemoglobin pigment produced from red blood cell breakdown that may cause permanent lung damage. Our patient’s clinical presentation included the classic PH triad of hemoptysis, iron deficiency anemia, and diffuse pulmonary infiltrates on chest radiography.

PH affects children in 80% of cases.1 The cause is unknown, but it is suspected to be an autoimmune disorder.2 Our patient had Heiner Syndrome, a form of the disease that is characterized by hypersensitivity to cow’s milk. Of note, however, is the fact that this child had not ingested dairy products before the onset of his symptoms.

Our patient required intubation with a cuffed endotracheal tube. Generally, pediatric guidelines recommend uncuffed endotracheal tubes in children 8 years of age or younger, but they recognize that cuffed endotracheal tubes
may be needed in children like our patient who have high airway resistance requiring higher ventilatory pressures. Some of the advantages of using a cuffed endotracheal tube in these children include reduced air leak, fewer laryngoscopies to change a poorly fitting tube, decreased risk of aspiration, and decreased use of larger uncuffed tubes, the main cause of subglottic mucosal damage. To avoid complications, some persons have suggested inflating the endotracheal tube cuff in pediatric patients only when it is necessary. Despite the cuffed tube, higher volumes of PEEP (ie, 5-20 cm H₂O) or PS (ie, 2-20 cm H₂O) may be required in the presence of pulmonary hemorrhage to increase the mean airway pressure. Our patient received 10 cm H₂O PEEP in addition to 3 cm H₂O PS to maintain effective ventilation.

Our patient’s clinical presentation included the classic PH triad of hemoptysis, iron deficiency anemia, and diffuse pulmonary infiltrates on chest radiography.

Patients with exacerbations of PH require supportive therapy with aggressive ventilatory and circulatory support. We administered a total of 1400 mL of intravenous 0.9% saline solution and multiple transfusions of PRBCs to maintain sufficient vascular volume. Steroid therapy, a treatment option for patients with PH, was initiated at the tertiary center. The child was weaned from the ventilator after 13 days and was eventually discharged home in stable condition.

REFERENCES
Knowledge Assessment and Preparation for the Certified Emergency Nurses Examination

With the current emphasis on credentialing in nursing, many nurses have committed to taking the CEN examination. The following questions have been developed to assist in emergency nursing knowledge assessment and in preparation for the CEN examination. Questions, rationale for the correct answers, and references are provided here for your self-evaluation. ENA has developed educational materials that can be used as further resources for CEN preparation: Emergency Nursing Core Curriculum and CEN Review Manual. For further information on educational review materials, please contact the ENA Association Services Team at (800) 243-8362.

REFERENCES

1. Which of the following assessment findings in a 2-year-old child with diarrhea is consistent with moderate dehydration?
A. Alert, restless
B. Dry skin and mucous membranes
C. Absent tears
D. Decreased skin elasticity

2. A patient presenting with cardiogenic pulmonary edema and a systolic blood pressure above 100 mm Hg has nitroglycerin and furosemide prescribed. The expected outcome after administration of furosemide is:
A. increase in afterload.
B. increase in preload.
C. increase in venous capacitance.
D. increase in left ventricular filling pressure.

3. A patient is brought to the emergency department after being struck by lightning while working outdoors. The patient is conscious. Which of the following would be a usual or expected finding in this patient?
A. Full-thickness burns
B. Retrograde amnesia
C. Fractured extremity
D. Ruptured tympanic membrane

4. A 35-year-old man who presented to the emergency department after an 8-foot fall from a ladder is diagnosed with a calcaneus fracture of the left foot. Which of the following injuries is often associated with calcaneus fracture?
A. Femur fracture
B. Lumbar vertebral fracture
C. Pelvic fracture
D. Cervical spine fracture
5. A critically ill patient on mechanical ventilation is awaiting transfer to the ICU. Which of the following nursing measures, if not contraindicated, has been associated with a reduction in the risk of ventilator-associated nosocomial pneumonia?

A. Placing the patient in a supine position
B. Placing the patient in a left lateral position
C. Placing the patient in reverse Trendelenburg position
D. Elevating the head of the bed to a 45-degree angle

ANSWERS

1. Correct Answer: B
   Children with moderate dehydration (60 mL/kg body fluid loss) have dry skin and mucous membranes, tenting, reduced tears, deep-set eyes, increased heart rate, decreased urine output, and are restless to lethargic. Children with mild dehydration (30 mL/kg body fluid loss) are alert, restless (A), with decreased skin elasticity (D), have tears, slightly dry mucous membranes, and normal to slightly elevated pulse rate. Children with severe dehydration have parched/cracked mucous membranes, absent tears (C), absent skin turgor, significantly increased heart rate, decreased urine output, and are lethargic to comatose. Wade,1 306.

2. Correct Answer: C
   Furosemide, a diuretic, increases venous capacitance and decreases left ventricular filling pressure. Nitroglycerin works by decreasing both preload and afterload. Other drugs that may be given include morphine, brain-type natriuretic peptide, phosphodiesterase inhibitors such as milrinone, and angiotensin-converting enzyme inhibitors. Bixby,2 58.

3. Correct Answer: D
   More than half of all victims have at least one ruptured tympanic membrane. Burns from lightening are usually superficial because of the flash over phenomenon (A). Antero-grade amnesia is more common (C), and fractures of the extremities are rare (D), but should be considered if the patient fell or was thrown by the shock wave from a nearby lightening strike. Nunnelee,3 46.

4. Correct Answer: B
   Calcaneus fractures are associated with landing on the feet after a fall from a height. Other injuries associated with this mechanism of injury are thoracolumbar vertebral fractures resulting from the force of impact being transmitted upward to the spinal column. If the patient falls forward onto outstretched hands on impact, wrist fractures may result. Emergency Nurses Association,4 190.

5. Correct Answer: D
   In a study examining supine position versus 45 degrees, nosocomial infections occurred less frequently in patients with the head of the bed elevated to 45 degrees. Other measures found to be associated with reduced risk of nosocomial pneumonia are rinsing the mouth with chlorhexidine, suctioning subglottic secretions, and maintaining proper endotracheal tube cuff pressure to prevent aspiration of oropharyngeal secretions. Lingren and Ames,5 52-3.
Do not resuscitate (DNR), do not intubate (DNI), and comfort measures only (CMO) are among many terms that are all too familiar to health care professionals. Quite often, these terms are frightening for families who do not fully understand what they mean. It is not uncommon to hear family members say they do not want their loved one to have DNR status because they interpret that as meaning nothing will be done for the patient. Health care workers know that interpretation is not true but find it difficult to explain what DNR means under such circumstances.

An alternative to DNR was introduced in 2000 by Reverend Chuck Meyer, a nationally recognized expert on the ethics and issues surrounding death and dying. According to Meyer, “Allow Natural Death” (AND) is meant to ensure that only comfort measures are provided. By using the term AND, clinicians are acknowledging that the person is dying and that everything is being done for the patient, including the withdrawal of nutrition and hydration, that would allow the dying process to occur as comfortably as possible. AND prevents unintentional pain and simply allows a natural death. Although AND status is not really different from DNR status, it is presented in a language that is more suitable for patients and families.

AND orders may help families make more appropriate end-of-life decisions. To date there have been no empirical studies of its effect and no sustained analyses of its ethical implications. According to Meyer, AND initially was presented to approximately 100 hospitals in the United States, as well as many hospices and nursing homes. The AND movement seemed to slow after Reverend Meyer’s death in November 2000.
In 2004, Baptist Hospital East in Louisville, Kentucky, officially adopted the “allow natural death” language, and the Ethics Committee at the University of Louisville currently is reviewing the information, with the support of our chaplaincy. A limited number of ED nurses in the Kentuckiana area were familiar with the term AND when the hospital began this process. Interestingly, based on information gathered from a number of phone calls made to area chaplains, other hospitals in the Kentucky and southern Indiana area also are considering using the term but have not yet formally presented the concept to their staff.

Baptist Hospital East in Louisville, Kentucky, has not only added the use of the AND language but also has expanded on the basics so that patients and families understand it better. According to Diane Huber, RN, the Critical Care Resource Team at Baptist Hospital East articulates 3 levels of care: (1) Full Support, which includes CPR, defibrillation, and chest compressions if necessary; (2) Conditional Support and AND, which allows the patient, family, and doctor to determine which interventions will be used to restore or maintain functions as the patient’s needs change; and (3) Comfort Support and AND, in which no CPR or chest compression will be performed if the patient experiences cardiac or respiratory arrest and health care workers will allow the patient to die naturally while providing comfort and support to both the patient and family (personal communication, Diane Huber, May 29, 2005). Huber believes that working with the “allow natural death” language has been easier and more effective and that patients seem to understand it better. Every nurse I have spoken to at Baptist Hospital East who has worked with this new wording seems to agree.

The patient’s family will spend a lifetime remembering or regretting the conversations and decisions of that day.

As with everything in health care, end-of-life care terminology is changing. Frank Chessa points out in his paper “A Rose by Any Other Name” that bad connotations have been applied to various terms throughout history and terms that are now considered not politically correct once were, in fact, quite politically correct. Chessa argues that AND eventually may be viewed as negatively as DNR. However, we (CK and JV) are both experienced ED nurses who have had to discuss or clarify DNR issues and have found that the AND terminology makes it easier for families to discuss end-of-life care. We believe that the change from DNR to AND is worth the effort. The terminology may change yet again, but AND may be the best conceptual description we have to offer at this point, the best way of helping those with difficult end-of-life decisions to feel a little more comfortable with the process.

Emergency nurses spend a relatively brief amount of time giving explanations to families on a given day. However, the patient’s family will spend a lifetime remembering or regretting the conversations and decisions of that day. They need to be at peace with the decisions they make. The families, not the health care provider, will carry the guilt or other emotions evoked by the death of a loved one. We believe it is our duty to help ease their suffering along with the suffering of the patients, and the AND advance directive helps to do just that. Our sense is that this concept will become more common, and we believe that emergency nurses should embrace it.

REFERENCES
A Percutaneous Coronary
Intervention Kit and Program Kit: Reducing
Door-to-Cath Lab Time

In November 2003, North Shore Medical Center implemented a Percutaneous Coronary Intervention (PCI) program to ensure a door-to-cath lab time of less than 40 minutes. At the start of the program, our time averaged 70 minutes. Nurses had to access separate drawers or bins in our automated medication dispenser for each medication, and it took nurses an average of 3 to 5 minutes to obtain all the medications, depending on their knowledge of the PCI protocol and their familiarity with the dispenser machine.

After implementing the PCI kit, we found it took an average of 20 seconds [as opposed to 3-5 minutes] to obtain the [...] medications] kit from the automated medication dispenser.

The ED Nurse Manager and Clinical Leader approached the pharmacy with a proposal for a PCI kit that contained all the necessary drugs. The pharmacy staff had reservations about introducing yet another kit into the hospital system, but they agreed to develop it in response to our enthusiasm and persistence. We now store all the medications in a simple container that was originally designed to hold art supplies. The kit is kept in the refrigerated section of our automated medication dispenser and is restocked from the dispenser by the primary nurse after use. The drug outdate is posted on the outside of the container.

Kit Contents:
- Heparin: 5 2-mL vials, 1000 U/mL
- Metoprolol (Lopressor): 3 filtered straws (ie, a needle-safe system for drawing up medication from an ampule) B. Braun Medical, Inc, Bethlehem, PA
Nitroglycerin: bottle of 0.4 mg SL tablets and bottle of premixed nitroglycerin for intravenous infusion

Eptifibatide (Integrilin): 2 10-mL vials, 2 mg/mL for bolus, and 1 100-mL vial, 0.75 mg/mL for infusion plus the Integrilin dosing chart

Baby aspirin: 4 tablets, 81 mg

Syringes: 2 10-mL, 3 5-mL

Calculator

Alcohol swabs: 6

PCI Order Sheet, PCI Consent Form, and Performance Improvement Form (for documenting time of arrival, time of EKG, time of physician assessment, time of medication administration, time of arrival in cath lab, etc)

Note: Morphine is excluded from the kit because it is a controlled substance and is subject to narcotic count.

To further minimize [the door-to-cath lab] time, we have implemented a process whereby the ED physician can call in the cath lab team (if they are not in the hospital) rather than waiting for the cardiologist to see the patient and then calling the team.

After implementing the PCI kit, we found it took an average of 20 seconds to obtain the kit from the automated medication dispenser. Now our door-to-cath lab time averages 40 minutes, though, of course, many variables beside medication access affect this time. Whether the cath lab is open or the team has to be called in, whether the patient developed EKG changes during the ED visit or had them on arrival, and whether the nurse is experienced with the medication dispenser machine and the PCI protocol all factor into the door-to-cath lab time. To further minimize this time, we have implemented a process whereby the ED physician can call in the cath lab team (if they are not in the hospital) rather than waiting for the cardiologist to see the patient and then calling the team. Because we know “Time is Muscle,” every minute saved promotes a better outcome for the patient.
The Aftermath of Workplace Violence: One Person’s Account

This article was adapted from an article entitled “Emergency room violence growing concern for nurses,” first published in the “Salem (Massachusetts) Evening News” on Nov. 8, 2004, and later in the April 2005 issue of the “MassNurse,” the Massachusetts Nurses Association’s newsletter, with permissions.

In March 2003, the author, a nurse at a New England Hospital, was assaulted by a 50-year-old man from a neighboring town while the author was working in the emergency department. He was eventually convicted of indecent assault and battery and sentenced to 18 months in jail. This assailant served a portion of this sentence and is currently released and is on probation for 2 years. The following first-person account is from that nurse.

More than 4000 hospital employees working in emergency settings were the victims of violence in 2002 according to the Bureau of Labor Statistics. I never thought too much about the fact that I could become a statistic. I never thought that I would have to fight for my life at my place of employment, but I learned that it can happen to you.

I suffered an “indecent assault” at the hands of a male patient who I had taken care of for several hours prior to his attack. In retrospect, this patient, much bigger and stronger than I, had probably intended to do harm. Over 2 years later, just thinking about that 90-second vicious attack still makes my skin crawl and it is difficult to talk about the specifics. Since it was reported, in the newspaper, as well as to the police, I have been overwhelmed by the public response. A local Assistant District Attorney said, emphatically, “No one should have to tolerate such horrible behavior.”
People wonder how it has affected me, personally and professionally.

Since then, I have given a great deal of thought to how to even begin to answer these difficult questions. Most times, I find myself unable to describe the turmoil this has caused in my life. Working as an ED nurse was always a dream for me. Although it is a stressful career, I welcomed each new day and enjoyed the challenge that came with the specialty for many years. As ED nurses, we must be skilled and ready for anything to happen on a moment’s notice, but I never dreamed at what would occur to ME with no notice at all.

Unfortunately, our job also includes taking care of violent, assaultive patients. There are people who present to the ED for legitimate help with their illnesses and I have always felt more than up to the task. I now feel that some people present to the ED with the primary intention of being disruptive, and maybe even violent to the ED staff and other patients or visitors. I am very aware that nurses are out on the front line, without adequate support and resources to keep safe.

This incident has been completely life-altering for me. I no longer work in the Emergency Department, my first love. I now work in the post-anesthesia care unit, which has opened a new door for me and given me time to heal.

It has left my husband married to a completely different person. He describes me as “not being a whole person anymore.” This is emotionally distressing because I know that he is right.

I have feelings about this incident that I am unable to convey, even to him. How do you tell the most important person in your life that you feel destroyed by one 90-second violent incident? It is especially hard since he works in law enforcement and prides himself on putting such criminals away, where they belong.

I guess the bottom line is that admitting to my peers how much this hurt me was more than I could bear.

**Aftermath**

Since this incident, I have to “kick-start” myself daily, where previously I was a happy, energetic person. I fight daily to find the “pre-incident me” as I continue in my multiple roles as nurse, wife, mother, daughter, grandmother, and friend.

It is grueling to rise daily and look in the mirror only to see myself as “his victim.” Friendships become altered when friends simply lack any basic understanding of a post-traumatic response that is quite normal. An incident like this is haunting and causes sleepless nights, restlessness, a heightened “startle” reflex, and generalized feelings of insecurity.

This incident has helped me to better understand many things. I now completely understand why sexual assault victims decide not to go forward with the process of prosecuting their assailant. The legal process is lengthy and exhausting.

I have yet to understand the thinking of a few, that it is reasonable for nurses to be abused in any way by patients or visitors. We are there to help them. This present mentality insinuates that if this occurs while we are on the job, “it is OK” on some level. They are the “customer” and our choice of occupation somehow makes us a second-class citizen.

I rise daily to ask myself this same question: How did this whole incident become about anything else except me being a victim to a brutal felony crime? How can I be judged by some who actually believe that this was OK or “comes with the territory,” because of my choice of occupation?

This incident has opened my eyes to the reality of normal post-traumatic response and the effect that an inadequate response can have on the victim. I now realize that without the proper support systems in place, a victim’s recovery from the incident can be prolonged. Luckily, I have great friends that I have been able to lean on during this most difficult time.

I finally decided to share my story through activities sponsored by our state nurses’ association. Now, I am speaking out to let other nurses know that it hurts intensely when the victim of violence does not receive the support that they need after such a critical incident. Every word said to the victim post-incident is critical since any negative comment will reintroduce trauma and re-victimize the victim. Most days, just when I think that I have cried my last tears over this issue, I am surprised at how I become re-victimized and the pain is as fresh as just after the incident when someone says something out of ignorance.

In my case, I know how crucial the support of a co-worker is. It can make or break you.
All nurses need to reach out and support their colleagues who are victims of assault. My state nurses’ association has been extremely supportive and has filed legislation to make it mandatory that every hospital have a plan in place to prevent workplace violence from occurring, to educate all employees about the issue, and to offer a system of support and counseling for those who are victimized. I feel these kinds of laws are important.

This life-altering incident has completely changed my life yet has shaped my future. I recently obtained certification in legal nurse consulting and I am proactive in pursuing legislation to make nurses safe. This endless drive in pursuit for change to make nurses safe is what sustains me as a survivor. My mission is to educate and support nurses who are victims of violence in the workplace. I am committed to seeing my hospital change and seeing that conditions are made as safe as possible for all of us. My mission is not about assigning blame, but rather working for solutions that ensure that hospitals make every effort to keep us safe and provide us with the best support if the worst happens.

Fortunately, in the grand scheme of things, I feel that I have accomplished something. My assailant received the maximum penalty of 18 months of which he served the majority of for the crime of indecent assault and battery. He is now a registered level 2 sex offender and a permanent “stay away” order was granted on my behalf by the Judge. He has never shown any remorse.

But justice prevails, and so does the truth.

—Name withheld per Journal policy

**Advice for other victims**

Nurses, we are on the front lines so my advice is to take care of yourself, but also each other! Stress the importance of a zero-tolerance policy for workplace violence to your employer. If you are assaulted, get help, call the police, and press charges. Insist on immediate debriefing for the emotional trauma.
An Informal Discussion of Emergency Nurses’ Current Clinical Practice: What’s New and What Works

Susan McDaniel Hohenhaus, RN, MS, Wellsboro, Pa

“Handoffs” During ED Patient Transport Within the Institution

Screening for and Treating Sepsis in Infants

One of the 2006 Joint Commission on Accreditation of Healthcare Organizations Patient Safety Goals concerns the process of “handoffs” in clinical care. In the emergency department, these handoffs occur not only when we change shifts but also when we turn over care, no matter how briefly, to others who will care for the patient, such as in the radiology or computed tomography departments. Deciding what types of information to share during this short-term transfer of care can be daunting. Tricia Kassab, RN, MS, CPHQ, assistant vice president of clinical quality at St Joseph Health System in Orange, Calif, offers a novel approach to the challenge. Experts at Northern California’s St Joseph Health System have developed a way to share patient information in a standardized, succinct manner when the patient is being transported. A brief form called “Ticket to Ride” consists of the patient’s essential demographics and information that is critical to care regardless of where or how the patient is being transported. Questions to be answered for patient transport include: Is the patient oriented? Does the patient need medications, or has the patient recently been medicated? Does this patient have infection control issues such as methicillin-resistant Staphylococcus aureus, vancomycin-resistant Enterococci, or tuberculosis? How does this patient ambulate? Does this patient have spinal precautions or any other special needs? Does this patient have multiple examinations in Imaging today? Does the patient have “Do Not Resuscitate” status? By using something that is standardized to communicate about the transported ED patient, the information is always readily available and easy to check.
The treatment of febrile infants is one of the most common and highly debated issues in pediatric emergency care. A search at www.PubMed.com using the key words “emergency care febrile infant” dated July 8, 2005, yielded 198 recent articles, many of which come to little to no general consensus on screening tools and treatment.

For the safety of children seen in the emergency care setting, it is important to consider coming to consensus and standardizing practice for their care, particularly within the same clinical institution. Practice variability may cause harm to our most vulnerable patients, and when multiple approaches are used to guide care for similar clinical challenges, especially in low-volume, high-risk patient populations, there can be confusion among caregivers. When clinical pathways are written and decisions are made, emergency nurses with interest and expertise should be represented at the table. This does not necessarily mean the nurse manager; local safety teams, that is, a group of bedside or “front line” clinicians familiar with the safety issues in a single or like clinical unit, can assist in developing strategies and creating solutions.

Pamela Smith, BSN, RN, a pediatric emergency nurse leader at Medical University of South Carolina, recently observed that in her pediatric emergency department, staff collect blood, urine, and spinal fluid for each febrile infant younger than 60 days. All infants younger than 30 days are automatically admitted. She also says that infants who “look good” are discharged home if they are 30 days of age or older and the laboratory reports feature no warning signs. Antibiotics are administered to the infants who are admitted, but antibiotics usually are not given if the infant is discharged and sent home. At Smith’s institution, antibiotics administered to these infants are considered high-alert medications.

A significant challenge for emergency nurses is the recognition of seriously ill infants. Remember, not all infants will be febrile when they have an infectious disease because their thermoregulatory systems are still developing. Thus, however the medical staff decide to treat infants with fever or possible sepsis, emergency nurses should be prepared for continued reassessment and vigilant attention to oxygenation, ventilation, and perfusion.

The following resources will assist nurses in the recognition, treatment, and disposition of these infants:

- The new Emergency Service Index (ESI) version 4 guidelines for febrile infants state that for infants 1 to 28 days of age, ESI acuity level 2 is assigned if the temperature at triage is >38°C (100.4°F). For infants 1 to 3 months of age, consider assigning ESI 2 if the temperature at triage is >38°C; if the infant is aged 3 months to 3 years, consider at least ESI 3 if the temperature is >39°C (102.2°F) or if the child has incomplete immunizations or no obvious source of fever. For more information, see http://www.ahrq.gov/research/esi/
- Reducing Medical Error Through Systems Improvement: The Management of Febrile Infants (http://pediatrics.aappublications.org/cgi/content/full/105/6/1330/a)
- An excellent (and entertaining!) PowerPoint presentation on the management of the febrile infant by Dr Steve Krug, one of our pediatric emergency medicine colleagues from the American Academy of Pediatrics, can be found at http://researchinpem.homestead.com/files/Febril~2.ppt#1

Clinical questions from nurses are welcome, as are names and addresses of clinicians who are interested in answering questions. Submit to:

Susan McDaniel Hohenhaus, RN, MS
6 Willard Terrace, Wellsboro, PA 16901
570 724-1715 • shohenha@ptd.net
Look-Alike and Sound-Alike Drugs: Errors Just Waiting to Happen

In 2004, an ED patient died after receiving a 10-mg dose of hydromorphone when 10 mg of morphine was ordered. As the ED nurse reached into the cabinet to select the narcotic, she recalled seeing “morph 10” on the box. She was temporarily distracted as she made the selection because another of her patients (an elderly gentleman) was attempting to climb off the end of a stretcher. She placed the 1 mL ampul in her pocket and proceeded to prevent the second patient from falling. She returned to the medication station to obtain a syringe and draw up the drug but did not stop at that time to complete the narcotic reconciliation record (thus eliminating the possibility of catching her mistake with a check of the remaining narcotic count). As a seasoned ED nurse, she never anticipated this possible drug package confusion. Concentrated hydromorphone, 10 mg/mL, typically was not stored in the emergency department. Only after the error was it discovered that an entire box of hydromorphone had been brought to the emergency department months earlier for an oncology patient. The extra drug had never been returned to the pharmacy. Given that these 2 drugs were in look-alike packaging from the same manufacturer, it was only a matter of time before a selection mistake like this would happen. Unfortunately, this error was complicated by the fact that this emergency department did not have specified monitoring guidelines in place for the care of patients after they received narcotics, and as such, the patient was discharged without reassessment. The pressure to free up beds to avoid ambulance diversion may have contributed to the decision to discharge the patient shortly after the drug was administered. On the way home, the patient experienced respiratory arrest in the family car and could not be resuscitated.
In a case like this, it is easy to be a Monday-morning quarterback and say “The nurse should have read the label more carefully,” yet we all have been the victim of a similar human slip called “confirmation bias” when we look at something (like a drug label or an order) but our brain sees what it thinks it should. (Have you ever gotten home from the grocery store with regular cola, when you swear you bought diet cola?) This human factors element, coupled with the look-alike packaging and distractions in the workplace, all helped to contribute to this fatal error.1

How do errors happen?

Emergency departments are prime locations for mix-ups with look-alike and sound-alike drug names and packaging. Frequent verbal orders, automated dispensing cabinets, access to stock medications (often without pharmacy review), crowded storage spaces, and the need for rapid administration of medications all contribute to errors. When patients take numerous prescription medications and/or receive care from multiple health care providers, medication history information may be less reliable and more difficult to verify. Add to these factors the sheer number of look-alike and sound-alike drug names, available overlapping dosages and concentrations, and similar-looking packaging, and you have a recipe for disaster (Figure 1).

Opioids, lipid-based products, and newer insulin mixtures are among the drug classes in which medication names are commonly confused. Such products include specific look-alike and sound-alike drug name pairs (eg, ephedrine–epinephrine, morphine–hydromorphone, Zantac–Zyrtec, and Celebrex–Celexa). Mix-ups involving any drug are problematic but are even the more frightening when the confusion involves high-alert medications, as was illustrated in the opening error example.

Sound-alike names for insulin (also a high-alert drug) can create serious problems. Prior to admission, one patient told a physician he was taking Novolog Mix 70/30, which the physician ordered. The patient, however, received Novolin 70/30 for 2 days before a nurse discovered the error. Ironically, the hospital did not have Novolog Mix 70/30 on the formulary and Novolin was entered into the profile in error, possibly due to sound-alike confirmation bias and the look-alike dose concentration of “70/30.” Trying to correct the situation, the pharmacist called the physician and suggested the use of Humalog Mix 75/25, which was on the formulary. The physician, however, insisted that the regimen remain the same as at home. The pharmacist then asked the patient’s family to bring in the patient’s insulin. Upon inspection, the insulin from home was actually Novolin 70/30, which the patient had been getting all along.2

What is being done to prevent these errors?

The Institute for Safe Medication Practices (ISMP) has created its “List of Confused Drug Names” (http://www.ismp.org/tools/confuseddrugnames.pdf) to help raise awareness about the multitude of drug names that have been mixed up with one another. ISMP works continuously with drug manufacturers to improve the safety of drug naming and packaging procedures.

Additionally, using a modified Delphi Process, the ISMP assisted the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in creating its lists of look-alike and sound-alike drugs by rating the severity of the consequences of a mix-up and the likelihood of confusion in the clinical setting. This listing may be reviewed at the following Web site: http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/lasa.pdf. As of January 2005, as part of the JCAHO’s National Patient Safety Goals, organizations have been asked to “identify
and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.” Participating organizations’ lists of look-alike drug name pairs should contain a minimum of 10 name pairs.3

What can you do?

While awareness of look-alike and sound-alike products is a basic step in improving medication safety in the emergency department, reliance on human memory is not effective. It is necessary to employ system-based strategies rather than depending on individuals alone to prevent these errors. Use the following strategies to reduce your risk of error with look-alike and sound-alike medications.

Verbal orders. Because of the nature of the ED work flow, it may not be possible to totally eliminate the use of verbal/telephone orders. However, when verbal orders must be used, it is important to “read back” the order, spelling the name aloud. State the understood purpose of the medication, the brand, and the generic name of the drug.

Employ system-based strategies rather than depending on individuals alone to prevent these errors.

Storage. Do not store look-alike medications side-by-side or alphabetically. Remove problematic, infrequently used, look-alike medications like U-500 insulin or concentrated forms of narcotics. If you catch yourself selecting the wrong look-alike drug, discuss changing the location of that drug with your manager and pharmacy. Be sure to post a sign that lets others know when something has been moved and that guides them to the new location.

Reminders and alerts. Find out about placing alerts for look-alike and sound-alike products on automatic dispensing cabinet screens or on electronic medication administration records (eg, “this is epinephrine [Adrenaline]” or “this is Novolog [rapid-acting insulin]”).

Differentiate. Ask the pharmacy to apply “name alert” labels to look-alike products. Use tactile clues for certain products (eg, regular insulin) that could be confused with other products. Use bright colored highlighters to draw out names. Use “tall man” lettering (eg, hydrOXYzine, hydrALAzine) to call attention to the different letters in look-alike names.

Redundancies. Use independent double checks with a second practitioner to avoid confirmation bias (where we “see” what we are expecting to find). The use of bed-side bar-code scanning is another form of an effective double check.

Patients. Upon discharge, provide patients with written information about their drugs, including the brand and generic names. Let patients know the name of the drug you are administering and show them the packaging at the bedside before administration. Further investigate all patients’ questions prior to drug administration. Teach patients about drug names similar to those they are taking to alert them to the possibility of a mix-up, even when they pick up their prescriptions at a community pharmacy.2

Report. If you find drug names or packages with the potential for error, report them. Chances are, if you catch yourself choosing the wrong medication, someone else will do the same thing, only they may not catch it. By reporting the situation, you could prevent the same error from reaching a patient. Do not limit your reporting to just your institution, however. Inform your colleagues across the United States by reporting all errors to ISMP (USP-ISMP Medication Error Reporting Program) at www.ismp.org. ISMP can then use the information to effect change.2

REFERENCES
Motorcycle Crash With Multiple Pelvic Injuries

This image demonstrates multiple pelvic fractures, as well as bilateral subtrochanteric femur fractures. The patient, a 21-year-old man, was ejected during a high-speed motorcycle crash and struck a tree. He also suffered right comminuted tibia and fibula fractures. On arrival to the emergency department, his vital signs were as follows: blood pressure, 70/40 mm Hg; heart rate, 135 beats/min; respirations, 14 breaths/min; and SpO₂, 94%. He lost consciousness, even though wearing a helmet, and was assessed with a Glasgow coma scale of 6. He was intubated and aggressively resuscitated. The ultrasound examination in the trauma bay documented free fluid in the abdomen. A T pod device was secured on the patient to stabilize free-floating pelvic bones and provide a tamponade effect and he was taken quickly to computerized tomography, enroute to the operating room.

Subsequent diagnostics revealed a ureteral rupture and a disruption of the external iliac vessel from the femoral artery, resulting in an ischemic right leg.

Over the next 48 hours, the patient underwent an amputation of a nonviable right leg at the hip, as well as placement of a suprapubic catheter and colostomy. After a 64-day hospitalization and remarkable recovery, he was transferred to rehabilitation.

Pelvic fractures are caused by extreme force. Forty percent of them will have associated abdominal injury. Pelvic injury coupled with hypotension on admission is an ominous sign and calls for rapid diagnostics to determine the source of hemorrhage. This is difficult owing to the vescera and vascularity of the pelvic ring. Our patient suffered a transection of the iliac vessel, which is rare but carries 85% mortality.
Nursing includes rigorous monitoring of vital signs, fluid resuscitation, oxygenation, and pelvic stabilization. This was a true pelvic emergency with a high probability of death.

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Contributions for this column are welcomed and encouraged. Submissions should be sent to:

Gail Pisarcik Lenehan, RN, EdD, FAAN
c/o Managing Editor, 77 Rolling Ridge Rd, Amherst, MA 01002
800 900-9659, ext 4044 • awbkelley@comcast.net

FIGURE
Catastrophic pelvic injury.
I recently had the opportunity and privilege of attending a rally in Washington, DC, on the West Lawn of the US Capitol. More than 3500 emergency physicians and nurses rallied, urging Congress to “Save our emergency departments” so our patients can continue to have access to care. The American College of Emergency Physicians asked for the support of the Emergency Nurses Association (ENA) and invited our president, Patricia (Patti) Kunz Howard, PhD, RN, CEN, to speak on the dais. Attendees were requested to wear their uniforms—scrubs and/or white coats. ENA distributed large purple buttons reading “Emergency Nurse, ENA.” We were also given huge purple placards reading, “No one should wait for emergency care.” The emergency physicians had their own placards reading, “Vote to save emergency care.” The physicians were having their annual meeting at the Washington Convention Center, so many arrived by bus. We all met at the entrance to the Botanical Gardens to pick up our signs and pins, and to walk together to the rally. We could feel the excitement in the air, and we wondered how many would attend. ENA Board members were up front by the dais so we could support Patti as she spoke. At 9:30 am, while everyone waited for the rally to officially begin, physicians from across the country approached the microphone to speak. Their remarks were their own and personal, many sharing stories about lives saved, and occasionally, sharing a story of heartache because the system did not work. They gave examples of crowding and diversion in their institutions, and it was the same story over and over. As much as we are different—urban, rural, or community—we are the same. We share similar circumstances, similar triumphs, similar challenges, and similar heartaches. And, now here we were, telling the
world what is happening to our emergency departments. It was energizing and exciting.

Ten am quickly arrived and the official rally began. Frederick C. Blum, MD, FACEP, president of the American College of Emergency Physicians, began by saying that our health care system is collapsing and nowhere is it more apparent than in our emergency departments. He noted Hurricane Katrina’s aftermath made it clear that we need to expand the “surge” capacity of our nation’s hospitals. An emergency physician who stayed to care for the patients in Charity Hospital during the hurricane and her aftermath made the trip from New Orleans to be on the stage. With heartfelt comments he told of being unable to care for the increasing numbers of uninsured and underinsured patients. Patti said, “Today we are moving to protect the rights of our patients and colleagues by urging our legislators to partner with us to secure the future of emergency patient care by endorsing initiatives that alleviate crowding and support emergency care as an essential public service.” She received a resounding round of applause. I turned to see how large the crowd had become, but couldn’t really see beyond the placards.

Maura Tierney, from the TV show “ER,” was on the dais to speak in our support. She said no matter how the show strives to depict emergency medicine, it does not compare to what emergency nurses and physicians do every day. “They’re heroes to millions of Americans.” She then told a personal story of a family member who was “saved” by emergency care. Many tributes were voiced and my tears fell as one after another speaker praised our efforts in caring for our patients. Diane Salvatore, Editor-in-Chief of Ladies Home Journal, described the 14 million, primarily women, readers as gatekeepers for their family’s health. She is sure Journal readers will put their full support behind our efforts to help save America’s endangered emergency departments.

Throughout the rally, much applause, waving of placards, and cheering took place. And I saw many in the audience taking photos of this historic event. More importantly, I saw emergency physicians and nurses reunited. Nurses and nurses, nurses and physicians—ones who had once worked together, but then traveled different roads—were hugging and happy to see one another. They were united in their support of a single cause on the West Lawn of the Capitol.

As the rally finished, the crowd was asked to walk up the hill behind the dais for photographs with the Capitol in
the background. Then I was able to see the crowd gathered behind me on the lawn; it was, literally, a sea of white coats and scrubs. It gave me chills to see that so many had taken time from busy schedules to join this effort.

Although the rally was exciting and a newsworthy item, the true work is only just beginning. The ENA Board and a few of the members then met with Kathy Ream, our legislative person in Washington, to learn the dos and don’ts of visiting our Congressmen. Her staff had made appointments for each of us with our Senators and Congressman, and gave us prepared information packets to leave for them. She outlined talking points for us and, although I was nervous, I was also excited about this opportunity. I had appointments with the health aides from the offices of Senators Kennedy and Kerry of Massachusetts. I was surprised they were so knowledgeable about health care, and they were very interested to hear from nurses on the front line—our personal stories and our descriptions of providing patient care in our challenging environment. They were not just polite; they were interested, animated, and sincere. It was actually much easier to talk with them than I had expected. My last appointment of the day was with Congressman Delahunt from my district in Massachusetts. He was genuinely interested, and asked pointed questions about emergency care, long patients waits, and creative solutions. He, as many before, related a personal story about going to an emergency department for care.

I am grateful to have had this opportunity. Several ENA State Councils sponsor a “Day on the Hill” in their states. I encourage each and every one of you to make an appointment to meet with your district Congressman and Senators. They will never know the real story of emergency care until we tell them, and we will never get the support we need for our patients without their help.

Such a visit is a little intimidating, but so worthwhile. ENA has resources to help emergency nurses know what to say and how to say it. Visit the website, www.ENA.org, and click on “Government and Advocacy.” So much information is available, and you can put in your zip code and find the legislators in your area. Currently, ENA is supporting two issues. The first, Title VIII Nurse Education Program, asks for additional funding for nurse faculty for our schools. The other pending legislation is the Trauma Care Systems Planning and Development Act. You live the challenges of emergency care every day. Sharing our stories with our legislators helps them learn from the experts—us—about the issues we are facing.

Contributions for this column are welcome and encouraged. Submissions should be sent to:

Gail Pisarcik Lenehan, RN, EdD, FAAN
c/o Managing Editor, 77 Rolling Ridge Rd, Amherst, MA 01002
800 900-9659, ext 4044 • awbkelley@comcast.net
B ALAD, Iraq - The first rule of war is that young men and women die. The second rule of war is that surgeons cannot change the first rule.

We had already done around a dozen surgical cases in the morning and the early afternoon. The entire medical staff had a professional meeting to discuss the business of the hospital and the care and treatment of burns.

It is not boastful or arrogant when I tell you that some of the best surgeons in the world were present—I have been to many institutions, and I have been all around the world, and at this point in time, with this level of experience, the best in the world were assembled here at Balad.

LTC Dave S., the Trauma Czar, and a real American hero was present. He has saved more people out here than anyone can imagine. The cast of characters included two Air Force Academy graduates, Col(s). Joe W. and Maj. Max L. When you watch ER on television, the guys on the show are trying to be like Max: cool, methodical, and professional. Max never misses anything on a trauma case because he sees everything on a patient and notes it the same way the great NFL running backs see the entire playing field when they are carrying the ball.

Joe is an ENT surgeon who is tenacious, bright, and technically correct every single time—I mean every single time. The guy has a lower tolerance for variance than NASA. LTC(s). Chris C. was the Surgeon of the Day (SOD), and I was the back-up SOD. Everyone else was there and available; as I said, the best in the world.

As the meeting was breaking up, the call came in.

An American soldier had been injured in an improvised explosive device (IED) blast north of here, and he was in a bad way with head trauma. The specifics were fuzzy, but after 3 months here, what would need to be
done was perfectly clear—the 332nd Expeditionary Medical Group readied for battle. All of the surgeons started to gravitate toward the PLX, which is the surgeons’ ready room and centrally located midway to the ER, OR, and radiology.

The lab personnel checked precious units of blood, and the pharmacy made ready all the medications and drugs we would need for the upcoming fight. An operating room was cleared, and surgical instruments were laid out, the anesthesia circuits were switched over, and the gasses were checked and rechecked. An anesthesiologist and two nurse anesthetists went over the plan of action as the OR supervisor made the personnel assignments.

In the ER, bags of IV fluids were carefully hung, battery packs were checked, and the ER nursing supervisor looked over the equipment to make sure all was in working order and the back-ups were ready just in case the primaries failed. The radiology techs moved forward in their lead gowns, bringing their portable machines like artillery men of old wheeling their cannon into place. Respiratory therapy set the mechanical ventilator and double-checked the oxygen. Gowns, gloves, boots, and masks were donned by those who would be directly in the battle.

All of the resources that America can bring to the war—medical, mechanical, and technological—were in place and ready, along with the best skill and talent from techs to surgeons.

The plan was for me and the ER folks to assess, treat, and stabilize the patient as rapidly as possible to get the guy into the hands of the neurosurgeons. The intel was that the man was injured in an IED blast, which rarely come with a single, isolated injury. It makes no sense to save the guy’s brain if you have not saved the heart pump that brings the oxygenated blood to the brain. With this kind of trauma, you must be deliberate and methodical, and you must be deliberate and methodical in a pretty damn big hurry.

All was ready, and we did not have to wait very long. The approaching rotors of a Blackhawk were heard, and Chris and I moved forward to the ER, followed by several sets of surgeons’ eyes as we went. We have also learned not to clog up the ER with surgeons giving orders. One guy runs the code, and the rest follow his instructions or stay out the way until they are needed.

They wheeled the soldier into the ER on a NATO gurney shortly after the chopper touched down. One look at the PJs’ faces told me that the situation was grim. Their young faces were drawn and tight, and they moved with a sense of directed urgency. They did not even need to speak because the look in their eyes was pleading with us: hurry. And we did.

In a flurry of activity that would seem like chaos to the uninitiated, many things happened simultaneously. Max and I received the patient as Chris watched over the shoulder to pick out anything that might be missed. An initial survey indicated a young soldier with a wound to the head, and several other obvious lacerations on the extremities.

Max called out the injuries as they were found, and one of the techs wrote them down. The C-collar was checked, and the chest was auscultated as the ET tube was switched to the ventilator. Chris took the history from the PJs because the patient was not conscious. All the wounds were examined and the dressings were removed except for the one on the head.

The patient was rolled on to his side while his neck was stabilized by my hands, and Max examined the backside from the toes to the head. When we rolled the patient back over, it was onto an x-ray plate that would allow us to take the chest x-ray immediately. The first set of vitals revealed a low blood pressure; fluid would need to be given, and it appeared as though the peripheral vascular system was on the verge of collapse.

I called the move as experienced hands rolled him again for the final survey of the back and flanks, and the x-ray plate was removed and sent for development. As we positioned him for the next part of the trauma examination, I noted that the hands that were laid on this young man were Black, White, Hispanic, Asian, American Indian, Australian, Army, Air Force, Marine, Man, Woman, Young, and Older: a true cross-section of our effort here in Iraq, but there was not much time to reflect.

The patient needed fluid resuscitation fast, and there were other things yet to be done. Chris watched the initial survey and the secondary survey with a situational awareness that comes from competence and experience. Chris is never flustered, never out of ideas, and his pulse is never above fifty.

With a steady, calm, and reassuring voice, he directed the next steps to be taken. I moved down to the chest to start a central line, Max began an ultrasonic evaluation of the abdomen and pelvis. The x-rays and ultrasound
examination were reviewed as I sewed the line in place, and it was clear to Chris that the young soldier’s head was the only apparent life-threatening injury.

The two neurosurgeons came forward and removed the gauze covering the soldier’s wounded head, and everyone’s heart sank as we saw the blossom of red blood spreading out from shredded white and grey matter of the brain. Experience told all the surgeons present that there was no way to survive the injury, and this was one battle the Medical Group was going to lose. But he was American, and it was not time to quit, yet.

Gentle pressure was applied over the wound, and the patient went directly to the CT scanner as drugs and fluids were pumped into the line to keep his heart and lungs functioning in a fading hope to restore the brain. The time elapsed from his arrival in the ER to the time he was in the CT scanner was 5 minutes.

The CT scan confirmed what we had feared. The wounds to the brain were horrific and mortal, and there was no way on earth to replace the volume of tissue that had been blasted away by the explosion. The neurosurgeons looked at the scan, they looked at the scan a second time, and then they re-examined the patient to confirm once again.

The OR crew waited anxiously outside the doors of radiology in the hope they would be utilized, but Chris, LTCs. A. and S., and Maj. W. all agreed. There was no brain activity whatsoever. The chaplain came to pray, and, reluctantly, the vent was turned from full mechanical ventilation to flow by. He had no hint of respiratory activity, his heart that had beat so strongly early in the day ceased to beat forever, and he was pronounced dead.

The pumps were turned off, the machines were stopped, and the IVs were discontinued. Respectful quiet remained, and it was time to get ready for the next round of casualties. The techs and nurses gently moved the body over to the back of the ER to await mortuary services. And everyone agreed there was nothing more we could have done.

When it was quiet, there was time to really look at the young soldier and see him as he was. Young, probably in his late teens, with not an ounce of fat anywhere. His muscles were powerful and well defined, and, in death, his face was pleasant and calm.

I am always surprised that anyone still has tears to shed here at Balad, but thank God they still do. The nurses and techs continued to care for him and do what they could. Not all the tubes and catheters could be removed because there is always a forensic investigation to be done at Dover AFB, but the nurses took out the lines they could. Fresh bandages were placed over the wounds, and the blood clots were washed from his hair as his wound was covered once more. His hands and feet were washed with care. A broken toenail was trimmed, and he was silently placed in the body bag when mortuary services arrived, as gently as if they were tucking him into bed.

Later that night was Patriot Detail—our last goodbye for an American hero. All the volunteers gathered at Base Ops after midnight under a three-quarter moon that was partially hidden by high, thin clouds. There was only silence as the chief master sergeant gave the Detail its instructions. Soldiers, Airmen, Marines, colonels, privates, sergeants, pilots, gunners, mechanics, surgeons, and clerks all marched out side-by-side to the back of the waiting transport, and, presently, the flag-draped coffin was carried through the cordon as military salutes were rendered.

The Detail marched back from the flight line, and the doors of the big transport were secured slowly. The chaplain offered prayers for anyone who wanted to participate, and then the group broke up as the people started to move away into the darkness. The big engines on the transport fired up, and the ground rumbled for miles as they took the runway. His duty was done: he had given the last full measure, and he was on his way home.

The first rule of war is that young men and women die. The second rule of war is that surgeons cannot change the first rule. I think the third rule of war should be that those who have given their all for our freedom are never forgotten, and they are always honored.
At 4:12 in the afternoon of January 13, 1999, an ambulance was summoned to the home of a 59-year-old male. The medics noted a severe occipital headache accompanied by nausea and vomiting, with an onset time of 2:30 PM. The patient’s blood pressure was 148/90. He was taken to the emergency department (ED) and the ambulance call report (ACR) noted his hospital arrival time of 5:06 PM.

At 7:17 PM, the patient’s triage note read, “Brought in by ambulance, + vomiting, nausea, dizziness, 2:30 PM, shortness of breath, + headache.” The blood pressure was noted to be 180/100. At 7:30 PM, the ED attending physician examined the patient and noted complaints of nausea, vomiting, dizziness, vertigo, nystagmus, and headache for the previous 5 hours. He noted that the patient was alert and oriented and diagnosed the patient with labyrinthitis, hypertension, and viral syndrome.

Based upon the physician’s diagnoses (of labyrinthitis, hypertension, and viral syndrome) and no suspicion of a neurological problem, the patient was treated with Compazine, Antivert, and Pepcid. At 7:00 AM after the patient spent the night in the holding area, nursing noted “Patient dizzy, hold discharge, M.D. aware, to be reevaluated.” On January 14, 1999, at 10:00 AM, a nursing entry read, “Patient reevaluated by MD and discharged.”

By 4:25 PM later that same day, the patient was brought back to the ED, responsive only to painful stimuli. His pupils were nonreactive. Dolls eyes were exhibited. There was no right corneal reflex. Extraocular muscles were uncoordinated. Because of respiratory compromise, he required intubation and mechanical ventilation. No gag reflex was elicited during the intubation. Additionally, decerebrate posturing was observed.
A head computed tomography was interpreted as demonstrating a posterior fossa subarachnoid hemorrhage with compression of the fourth ventricle and obstructive hydrocephalus, as well as cerebral edema with effacement of the cerebral sulci. He was transferred to another facility for surgical intervention.

At the receiving facility, a magnetic resonance imaging demonstrated bilateral cerebellar infarcts with involvement of the entire right posterior inferior left cerebellum. Severe hydrocephalus was noted, with transependymal spread of cerebrospinal fluid. Finally, tonsillar herniation was evident, along with compression of the fourth ventricle by mass effect. The patient underwent a right posterior fossa craniectomy with decompression of a right hemisphere cerebellar infarct. Acute ischemic changes were found in the resected tissue.

Despite the surgical intervention, the patient sustained permanent, severe brain damage. His claims included memory loss, speech impairments, walking difficulty, the loss of second language skills, headaches, depression, loss of balance causing falls, double vision, and the inability to drive.

This neurological devastation was not the result of a suddenly occurring stroke. It was not the result of an asymptomatic event. It was not the result of the patient’s failure to seek treatment. Finally, it was not the result of his arriving to the hospital too late for intervention. So, in the end, the question was whether this was an unpredictable stroke in a patient who had previously presented with signs and symptoms consistent with the physician’s diagnosis and discharged after appropriate work up and observation? Or, was it the result of a premature ED discharge following a failure to properly assess the patient and obtain neurological diagnostics and consult?

A civil lawsuit commenced, with the complaint claiming the latter. It was up to the defense to establish the former. Some of the actions and documentation of the nursing staff contributed to the difficulties for the lawyers defending the hospital and staff.

Starting with the nursing triage documentation, the plaintiff’s counsel asked the emergency physician questions that illustrate some troublesome testimony in this case:

Q: Sir, when a plus sign is used, that means it’s a positive finding, right?
A: Yes.

Q: And the positive finding indicates that the patient actually has the condition that you are naming; is that right?
A: I cannot say, because I did not document it.

Q: When the person writes a plus sign, that means they are writing that the patient has the condition? Positively means they do have it?
A: Yes.

Q: So, if a patient reports a history which is positive for nausea, that means they did have nausea?
A: Yes.

The Court: That means that the nurse determined that the patient was nauseous and wrote it down?

A: Yes.

Q: And the nurse determined that the patient had vomited since 2:30 PM?
A: Yes.

Q: Did she say how often?
A: No.

One obvious problem with this testimony is the physician’s lack of knowledge regarding the significance of the nursing triage documentation. The jury has been told that the nurse determined that the patient had been vomiting for more than 5 hours, without determining how often the vomiting occurred. In fact, the triage nurse was documenting the patient’s history as told to her, not her own observations. The note, however, left itself open to this interpretation.

Lesson one from this case: Triage notes must clearly differentiate patient-provided information and clinical observations. A sign is what a provider observes. A symptom is what the patient identifies. The triage documentation must distinguish signs from symptoms. Use quotes and identify the source of the information.

The ACR documented an arrival time of 5:06 PM. The triage nursing entry was timed at 7:17 PM—more than 2 hours after the patient’s arrival to the ED. There was no explanation for this. The ACR did not note the time the ambulance went back into service. Did the patient really wait that long to be triaged when brought in by ambulance? Most probably not. We know the medics would not be out of service this long. But in the absence of an alternative explanation, it is difficult to dispute.

Lesson two from this case: When accepting report from the medics, note the time of receipt on the ambulance report. Check the arrival time for accuracy.
The plaintiff’s counsel cross-examined the defense expert regarding the patient’s overnight stay in holding:

Q: Doctor, you said there is nothing in the chart to say that there was any further problem neurologically with [the patient] arriving overnight but was there anything further in the chart to say these rechecks that we heard every two or three hours were adequate and turned up nothing?
A: There is no documentation that there are complete examinations every two or three hours, no, not in the record.

Lesson three from this case: Neurological evaluations must be documented frequently with patients presenting with neurological complaints. Any patient in a holding area requires ongoing evaluation. Documentation must reflect the patient’s condition and notation of clinical changes or the absence of clinical changes. Had the nurses documented the patient’s neurological status with frequent Glasgow Coma scales, the plaintiff would have a much more difficult time convincing the jury that an acute neurological event was occurring during his time in the holding area.

Continuing with trial testimony, the defense expert was cross-examined by the plaintiff’s counsel:

Q: Is there anywhere in the chart where it states that [the patient’s] gait was actually evaluated in the emergency room?
A: I don’t see any reference to walking in the chart.
Q: Do you know how he left this emergency room?
A: I don’t.

Lesson four from this case: A nursing discharge note must include an assessment of the patient related to the presenting triage complaints. How did this patient go home? Was he ambulatory? Did he leave by wheelchair? His presenting complaints included dizziness and vertigo. His gait is certainly important information. An entry that the patient’s gait was steady would have supported the decision to discharge the patient. Because no neurological observations were made at discharge, the question was left for the jury to decide.

Notes such as “MD aware,” “Discharged by MD,” etc., provide no information as to the actual physician notified or making the discharge decision. Any provider must be identified by name. Nursing note must specify which MD was aware of something and which MD discharged a patient.

Finally, defense attorneys spend a great deal of time preparing a defendant for testimony. One thing that they particularly stress is that a yes or no question should be responded to with a simple yes or no answer. The purpose of this advice is to avoid giving your adversary more information to use against you. The following answer, taken from the plaintiff’s examination of one of the physician defendants illustrates how much more helpful an answer like “no” would have been.

Q: Have you ever been convicted of a crime?
A: Not yet.

Finally, an alarm bell should go off whenever a patient re-presents to the ED after having been recently discharged. Pull the previous record to correlate findings and discover differing clinical pictures. Obtain previous diagnostics and reassess the patient thoroughly. A claim of missed diagnosis in the ED can be difficult to defend if the missed diagnosis causes patient harm.

The Court granted the defendant’s motion for a directed verdict. This means the defense attorneys were able to convince the judge that the plaintiff had not successfully established questions of fact for a jury to decide. As such, the jury was directed to find in favor of the defense without deliberating. The defense lawyers’ jobs, however, would have been much easier with a few changes in nursing practice and documentation.

REFERENCE
1. 16004/00 Supreme Court of the State of New York, County of Kings.
How are other emergency departments handling the assessment of a patient’s risk of falling?

**Answer 1:**
We have a statement in our corporate policies and procedures that all ED patients are considered at risk for falls. This statement eliminates the need to do individual patient screening. As a safety precaution, we place all patients on stretchers with 1 or 2 side rails up (depending on the patient’s age and current condition) and have the call light within reach.

—Sylvie Simpson, RN, BSN, ED Nurse Clinician, Orlando Regional Medical Center, Orlando, Fla; E-mail: sylvies@orhs.org

**Answer 2:**
We have used the Morse Fall Risk Assessment tool for approximately 6 months. It has about 6 screening areas regarding the history of falls, secondary diagnosis, ambulatory/mobility aid/equipment, intravenous line/heparin lock, gait/transferring, and mental status. The score indicates if a patient is at no risk, low risk, or high risk. A CD program is available for training in how to use the tool and interpret the results. For a sample form, go to [www.patientsafety.gov/SafetyTopics/falltoolkit/media/morse_falls_pocket_card.pdf](http://www.patientsafety.gov/SafetyTopics/falltoolkit/media/morse_falls_pocket_card.pdf).

If the score is more than 50 (high risk), additional preventive interventions are used. These interventions include having the patient wear a bright pink “Fall Risk” armband and providing nonslip booties/slippers. Now the first question asked when a patient is getting out of bed is, “Do they have the armband on?” We are planning to incorporate the Morse Fall Risk Assessment checklist in our next chart revision.

—Bev Beard, RN, ED Staff Nurse, Providence Everett Medical Center, Everett, Wash; E-mail: angelbev@juno.com
Answer 3:
We have a custom-added mandatory drop-down list on our computerized charting program that is completed for all patients by either the triage nurse or the primary nurse. The assessment risk criteria include “elderly and frail,” “poor balance at baseline,” “sedating medications administered,” “requires walking aid device at baseline,” “non-ambulatory at baseline,” “weakness from acute illness,” or “other” (with free text space provided). As a result of the assessment, the nurse indicates that the patient is either at no increased risk of falling, has baseline risk for falling, or has an acute problem exacerbating the risk for falling.

If the patient is at risk, the chart is stamped “AT RISK FOR FALL” in red ink. We also use red Fall Precautions bracelets that are placed on the same extremity as the patient ID bracelet so that any caregiver (eg, from radiology or respiratory therapy) is aware of the need to take precautions. We order the Fall Risk bracelets from Cardinal Health (800-964-5227; www.cardinal.com).

A nurse can perform and document a new assessment at any time during the ED visit. We obtained a lot of the information to include in our assessment from the ENA GENE course. The policy has worked well for us.

—Molly Grismore, RN, Nurse Manager, Emergency Department, Northwestern Medical Center, St Albans, Vt; E-mail: MGRISMORE@nmcinc.org

Answer 4:
We have screened patients for the risk of falls as part of our full triage initial assessment for about 2 years. A patient determined to be at risk for a fall is assigned fall prevention status, and an order is generated automatically on the basis of this initial fall risk assessment. The order is sent to the patient tracking board every 2 hours for reassessment and documentation of the patient and his or her fall prevention safety needs. Since initiating the fall screening and fall prevention documentation, the incidence of falls in our system’s 4 adult emergency departments has decreased steadily during the past 2 years, and we have had no injuries resulting from falls to date in 2005.

—Debbie Dafferner, RN, BSN, CNO, E-mail: DaffernD@Methodisthealth.org, and Charlene R. Wooten, RN, BSN, Clinical System Analyst, Nursing Information Systems, Methodist Le Bonheur Healthcare, Memphis, Tenn; E-mail: wootenc@Methodisthealth.org

Answer 5:
We have doors on all of our ED rooms and use the Hendrich Fall Risk Assessment. A score greater than 5 means the patient is at risk. We then place a fall precautions sign at the bedside and a purple dot on the patient’s ID band. The purple dot has been helpful to ancillary staff in identifying patients at risk because everyone uses the armband for patient identification.

If the patient is confused or considered at a high risk, a red eye is posted on the patient’s door. It is a reminder to everyone who walks by that room to check that the patient and the environment are safe.

—Glenn Carlson, RN, MSN, CCRN, Clinical Nurse Specialist, Bronson Methodist Hospital, Kalamazoo, Mich; E-mail: carlsong@bronsonmh.org

Answer 6:
We added a Fall Risk Assessment at the time of triage or initial assessment by a registered nurse (RN). The evaluation assesses and scores patients as follows:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of fall in past 3 months</td>
<td>2 points</td>
</tr>
<tr>
<td>Impaired judgment/lack of safety awareness</td>
<td>3 points</td>
</tr>
<tr>
<td>Impaired gait</td>
<td>1 point</td>
</tr>
<tr>
<td>Agitation</td>
<td>2 points</td>
</tr>
<tr>
<td>Difficulty getting to bathroom in time</td>
<td>1 point</td>
</tr>
<tr>
<td>Dizziness/vertigo</td>
<td>1 point</td>
</tr>
</tbody>
</table>

A score greater than or equal to 2 identifies patients as being at a high risk for falls.

General safety interventions are implemented for all ED patients. These interventions include placing the bed in the low position (except during care), ensuring the bed wheels are locked, having the 2 side rails up when the patient is unattended (unless otherwise ordered), locking wheels during a patient transfer, eliminating environmental hazards, and answering call lights promptly.

Additional interventions are implemented for patients who are determined to be at high risk for falls, either by score or nursing judgment. These interventions include alerting all staff of the patient’s status, placing a green dot on the identification band, and instructing the patient and family to call for assistance when the patient wishes to get up.
Our policy also includes patient/family education, the definition of a “fall” (eg, the patient, family, or staff says a fall has occurred, a person is found on the floor, a patient lowers himself or herself or is lowered to the floor by staff, or an infant is dropped), and the procedure for managing a patient who has sustained a fall.

—Rita Johnson, RN, Nurse Manager, Emergency Department, Jane Phillips Medical Center, Bartlesville, Okla; E-mail: RJohnson@JPMC.ORG

RESPONSE TEAMS

I am hearing that some hospitals are setting up response teams. How do response teams work?

Answer 1:
Medical Emergency Teams (METs) are designed to respond to inpatient emergencies, short of a cardiac arrest or typical “code” team responses. As I observe teams developing in response to the Institute for Healthcare Improvement 1,000,000 Lives initiative, I typically see the team consist of an ICU nurse, a respiratory therapist, and a physician or physician assistant. The literature, initially out of Australia, supports the use of METs. Team composition should be carefully assessed, and recommendations from the evidence-based projects should be noted. A MET is not intended to be activated by the emergency department, because, by definition, we always are a MET.

I have several concerns about this trend that I hope will be addressed in the future:

• A trend toward the attitude of “not my patient, not my team.” Because we comprise clinicians who are often trained at many different places, it might be helpful to conduct human factors team training to enhance communication and teamwork in our highly complex specialty (www.healthcareteamtraining.com).
• The lack of emergency nurses involved in the planning and implementation of these teams. ED nurses are often members of code teams; MET is certainly something our specialty does every day.
• There is a need for evidence-based practice recommendations on the MET approach with pediatric patients.

As is typical of many safety strategies, one size does not fit all.
—Sue Hohenhaus, RN, MA, Safety and Quality Consultant, Patient Safety Office, Duke University Medical Center, and Editor, PEMSoft, Clinical Decision Making Pediatric Software, Wellsboro, Pa; E-mail: shohenha@ptd.net

Answer 2:
This team responds throughout the hospital as patients begin to deteriorate. A response team is like a precursor to a code team and is not designed for critical care areas or the emergency department. Response teams work in teaching and nonteaching hospitals and have been shown to decrease the incidence of codes. One 750-bed facility has seen a 23% reduction in their overall code rate per 1000 discharges (http://www.ihi.org/NR/rdonlyres/9134B60C-BB05-4735-8DF4-D96D09CC9EAB/0/RRTHowtoGuideFinal620.pdf).

We are instituting a team composed of a critical care RN and a respiratory therapist. They will respond whenever a patient’s vital signs fall outside of the standards or whenever the RN’s “gut feeling” indicates a problem.
—Robert G. Flade, RN, BS, Director, Emergency Department, New Britain General Hospital, New Britain, Conn; E-mail: RGFlade@nbgh.org

Answer 3:
Our hospital is in the process of developing a rapid medical response team. It is seen as a support, especially for newer medical-surgical nurses. Our hospital also is offering a course to support senior nurses who are assuming this new role.
—Joanne Liptock, RN, EMT-P, CEN, CCRN, CLNC, Director of Emergency Services, Monongalia General Hospital, Morgantown, WV; E-mail: LiptockJ@Monhealthsys.org

Answer 4:
We have a cadre of clinical resource nurses who are experienced in critical care. Their role is solely to serve in a float capacity, and they move from unit to unit on a given shift to help manage critical patients. They are never dedicated to any unit exclusively for that shift and can
be redeployed to a unit with more pressing needs at the discretion of the house supervisor.

We use clinical resource nurses in the emergency department mainly if we are busy and have a patient who has undergone conscious sedation or an intubated patient awaiting transfer to an ICU. We find the system works well.

—Larry Torrey, RN, EMT-P, Staff Nurse, Emergency Department, Tufts-New England Medical Center, Boston, Mass; E-mail: Ltorrey@maine.rr.com

—Diane Marsh, RN, BSN, CEN, Operations, Director, Emergency Services, Lakeside Hospital, Omaha, Neb; E-mail: DMarsh@alegent.org

I have heard that some emergency departments do not have a waiting room but immediately put all patients in a treatment bed. How does that process work?

Answer:
We opened a brand-new facility in August 2004 with 32 inpatient beds and 18 ED beds for our approximately 18,000 per year (and increasing) census. All patients are immediately put into a bed in one of our multi-use rooms until all the rooms are full. A quick registration is sufficient to generate labels and numbers. Full registration and the nursing history and assessment are done at the bedside. Our electronic tracking system allows the ED physician to see immediately where a patient has been placed. Our eventual goal is to be paperless.

If all of the rooms are full, patients remain in our “family waiting or gathering area” (no longer called a “waiting room”), and the traditional triage room is then used to obtain a nursing history, vital signs, and traditional triage prioritization. We call this ongoing process “monitoring” rather than “triage.” The need to add this “monitoring” usually happens only on weekends, and we have had to add a traditional triage nurse position for that time period.

This whole change in process is part of the entire hospital’s culture of excellent patient and family-centered service. We make hiring decisions based as much on a person’s attitude as on their skills.

Overall, following this policy has been a great patient satisifier. Our hospital is in an affluent part of town, and this type of treatment tends to be expected by our patients, yet also still appreciated by them. I compare it to how pleased we all feel when we go to a restaurant and get seated immediately rather than waiting in the lounge for a table.

—Mary Martin, RN, CEN, Nurse Manager, Emergency Department, MedCentral Health System/Shelby Hospital, Shelby, Ohio; E-mail: Mmartin@medcentral.org

As a new manager, I am struggling to decide what to give the ED staff for a holiday gift. In the past, some of the gifts went over like a lead balloon. What ideas have other managers used?

Answer 1:
I believe it is important to do something, no matter the scope of the gift, to give the staff some recognition. I have sent cards to their families. I have given gift certificates for Starbucks (all nurses drink something!). Consider a gift certificate for the hospital’s coffee cart/snack bar if you have one: it is sort of like letting the staff member take a break on you.

—Abby Purvis, RN, ED Director, Iroquois Memorial Hospital, Watseka, Ill; E-mail: agpurvis@iroquoismemorial.com

Answer 2:
I gave car wash tickets one year, which was very well liked by both male and female staff. (Those candles have a limited popularity with the guys.) One year I gave license plate frames to the nurses that stated, “Emergency Nursing, Excellence in Action.” I purchased them at an ENA convention.

—Abby Purvis, RN, ED Director, Iroquois Memorial Hospital, Watseka, Ill; E-mail: agpurvis@iroquoismemorial.com

Answer 3:
I find giving gifts a problem because I appreciate and respect my staff so much that I always feel whatever I do is not enough. They do so much for me and their patients all year, I just want to keep giving and giving. However, I have 91 staff members, so there are limits.

This year I bought the Fast Track staff a coffee pot, the nurse staff 3 new textbooks, and the support staff hand cream and multi-tool little kits to carry in their pockets. I also donate to the Educational Fund.
In past years I have purchased a microwave oven, radios, foot massagers, fruit, fruit cakes, and popcorn, provided a dinner in the conference room that all could attend, and provided catered meals. I also have donated to one of the elderly from the Christmas Angel tree in the staff’s name.

I give an individual gift such as a necklace, pen, or Livestrong bracelet (for the guys) to each charge nurse (8) and to my secretary.

—Dorothy (Dotty) Kuell, RN, BSN, CEN, ED Nurse Manager, FirstHealth Moore Regional Hospital, Pinehurst, NC; E-mail: dkuell@firsthealth.org

Answer 4:
We celebrate the 12 days of Christmas. We start on December 14 with an empty Christmas stocking for everyone. There are about 112 total stockings to fill, so each of our clinical council leaders (5) takes a day, the ED physicians have massage therapists come in for one of the days, and I handle the other 6 days. This year, the gifts were: the stocking, a tea lite candle, chocolate chip cookies, massage day, a Christmas ornament, a Christmas pencil, a Christmas bendy figure, a coal ornament with poem, a candy cane, jingle bells, Hershey hugs and kisses candy, and champagne bubbles.

I have done this type of thing for the past 8 years in 2 different facilities; it is something everyone enjoys and is a conversation starter with patients as well.

—AnnMarie Papa, MSN, RN, CEN, Director, Emergency Services, Doylestown Hospital, Doylestown, Pa; E-mail: apapa@dh.org; ampapa109@hotmail.com

Answer 5:
I always teach managers, new and seasoned alike, that the holidays need not make you feel like you have to purchase something for everyone. Some ideas I share:

- Send a letter home to their family thanking the family for supporting their loved one’s time away from home to care for ED patients.
- Send a donation in their name to a worthwhile charity and post a notice about it.
- Place an ad in the community newspaper honoring the staff with this donation.
- Connect with your local Red Cross or military recruiter to obtain contact information for ED nurses serving overseas. Send them some personal hygiene kits.

The idea is to show that you, as the manager, are giving of yourself to better others. It sends a message about who you are. What better role model is there for staff than this?

—Shelley Cohen, RN, BS, CEN, Health Resources Unlimited, Hohenwald, Tenn; Web site: www.bru.net, E-mail: educate@bru.net

Answer 6:
We recently had a pediatric death caused by child abuse, which is rare in our geographic region. The patient had a surviving sibling who also was severely abused. The staff put up a notice asking for donations to buy presents and make it a Christmas the young survivor would never forget. Rather than buying individual staff gifts, I donated what I would have spent on them to the child’s Christmas fund on behalf of the department. Some staff members thanked me for doing that gesture, which emphasized the true intention of the holiday.

—Vivian Rebel, RN, Director, Emergency and Trauma Services, Henry Mayo Newhall Memorial Hospital, Valencia, Calif; E-mail: rebelvl@henrymayo.com; Rebel-Zinn@socal.rr.com

### SHARPS DISPOSAL

We are having difficulty with a few physicians who expect the nurses to dispose of their contaminated sharps. Recently a nurse was nicked by a contaminated blade wrapped inside the sterile towel by the physician. How have others brought about a change in behavior?

Answer 1:
I would approach this as an ownership issue that includes practical, ethical, and moral responsibility. Simply stated, whoever uses a sharp is responsible for its safe disposal. Life and health safety is too important for anyone to be “too busy” to do that. At the very least, discuss this issue with repeat offenders and make it a part of a “collaborative practice” committee project.

I suggest creating a well-crafted policy statement. It could include specifics, such as any sharp left to be
removed by another will be done so by mutual agreement before the physician leaves the room and/or will be placed in a Styrofoam block in the kit, etc. Correctly worded, this policy could mean that the physician or other offending users could be held in tort liability for the consequences of this negligent act or omission.

—Tom Trimble, RN, BA, ASN, AA, CEN, Staff ED Nurse, University of California–San Francisco Medical Center, San Francisco, Calif; List Administrator, “Em-Nsg-L: The Emergency Nursing List”; E-mail: Tom@ENW.org

Answer 2:
We have a department policy that the user (eg, an ED physician or primary care nurse) must dispose of his or her own sharps. Initially some consulting physicians resisted, stating that they were “too busy.” I responded that the nurses were “too busy to get Hepatitis C or other blood-borne pathogens.” We reported some offenders to the Executive Committee, and the individuals are now compliant.

—Darlene Glover, RN, MSN, CEN, Nurse Manager, Emergency Services and ICU, Stephens Memorial Hospital, Norway, Maine; E-mail: Gloverd@wmhcc.org

GUARANTEEING THAT PATIENTS ARE SEEN WITHIN A CERTAIN TIME FRAME

We are considering offering a time guarantee for ED patients as a marketing tool. How has this policy worked for other emergency departments?

Answer:
More than a year ago we started to market a guarantee that each patient’s care would be initiated within 33 minutes of arrival; this guarantee is interpreted as the patient being triaged and placed in a room but not necessarily examined by a physician. There is an exception clause in case of a community mass disaster.

We chose this marketing technique because we were a new facility in a community that already had 3 other hospitals with very busy emergency departments, with anecdotal stories of up to 2-hour waits. Our time studies showed that we already were consistently doing better than the proposed 33 minutes. We believed that emphasizing the time issue was a distinction the public would understand and want, compared with advertising “all board-certified physicians” or a “level II trauma center.” The “33 or it’s free” was selected because it was symbolic of the uniqueness of care provided at Aurora BayCare.

The intention was never to draw in patients with minor complaints for primary care purposes. In fact, we also offer this guarantee at our Urgent Care centers and provide ongoing public education to help the public choose the most appropriate facility.

Within the first 6 months, the census increased from 3% to 40% at all of our facilities. In the first 20,000 patient visits, there were fewer than 15 “failures” to meet our guarantee, and only 2 were in the 22-bed level II trauma center with approximately 1800 patients per month. Meeting the guarantee is more of a challenge for urgent care facilities because they have fewer staff members and less space and have more arrival “peaks.” The facility and physician fees are waived for “failures,” but the patient is still responsible for any diagnostic tests, consultant fees, or hospitalization.

The key to our success has been the staff. They are all dedicated to providing quality care in a timely manner and own the need to watch the times on the tracking board.

—Roy Cline, RN, Critical Care Services Manager, Janice Norman, RN, CEN, ED Supervisor, and Jay Faherty, Director of Public Relations, Aurora BayCare Medical Center, Breen Bay, Wis; E-mail: roy.cline@aurorabaycare.com

CONVERTING TO THE 5-LEVEL ESI TRIAGE SYSTEM

We are planning to convert to use of the 5-level Emergency Severity Index (ESI) triage system from a 3-level triage system. What lessons have others learned from going through this conversion process?

Answer:
Our hospital system converted to the 5-level ESI system almost 2 years ago. I was responsible for training at the 3 sites. In addition to site-specific differences (2 of the hospitals are suburban and one is an inner-city teaching/specialty hospital), some of the things I found included the following:

• The nurses still needed to “diagnose” in triage to determine the number of resources needed. Is that abdominal pain probably just constipation, suspicious for a ruptured ectopic with peritonitis, or a leaking aortic
aneurysm? If the nurse in triage does not have the ability to perform appreciative inquiry (skill at interviewing the patient, discriminating what information is important, and identifying and sorting through potential diagnoses), then all patients become “3’s” or “2’s” because some nurses identify all conditions as the “worse case scenario.” We do not assign new ED nurses or nurses who have “floated” to the emergency department to the triage role.

- The general guideline that all “4’s” and “5’s” could go to fast track had to be revised when we realized that our hospital’s fast track often is staffed with licensed practical nurses (LPNs). Hospital policy does not allow an LPN to start intravenous lines or give intravenous push medications. A patient needing simple hydration for vomiting or a saline solution lock with intravenous medication could be a “4” but would not be appropriate for this fast track department. On the other hand, a patient with a simple laceration that needed sutures and an x-ray is a “3” but could easily be treated in this fast track department. Nursing leaders in this department adjusted the parameters accordingly.

- Physician and regional differences were noted to affect the triage category. In the ESI training manual, some patients with example diagnoses were triaged to their ESI level based on therapies that differed from the standard therapy in this area. For example, many of our physicians treat migraines with either the migraine protocol, which consists of up to 8 medications (in a specific order), or with intravenous fluids and ketorolac (Toradol). Either way, the patient would be a “3” versus a “4” if treated with an injection. Similarly, patients with potential pelvic inflammatory disease typically are given an intramuscular and oral dose of antibiotics instead of intravenous antibiotics. Nurses had to base their triage decision on our local list versus going by the ESI manual.

- Nurses were noted to be making acuity decisions based on a particular physician’s ordering habits versus what was essential to make the diagnosis. Nurses would ask, “Which doc is working?” and vary the triage level assigned based on that information. We had to remind the nurses that the “resources” are those things needed to make the diagnosis or treat the patient versus ruling out all other potential diagnoses.

- Policies and procedures needed to be changed to reflect the new ESI 5-level triage system. Many policies and procedures were no longer supportive or described what triage actually was. In addition, the standing orders (eg, guidelines of care) were updated to facilitate the triage nurse implementation.

- The need for quick, readily accessible aids. I created triage desk “place mats,” that is, 12 × 20 laminated sheets that lie flat and are inconspicuous. They provide critical information, including the algorithm, vital sign parameters, assessment pneumonics, and examples of resources and problems that would fit into each category.

Another minor glitch was that the nurses had some trouble with the “acuity” triage number not being the same as our “charge” number for level of care. It too is 1 to 5, but in reverse order. One nurse developed an interesting variation to help look at issues like staffing. She went back and changed the acuity level after the patient was discharged to reflect the accurate number of resources that were used.

The revised ESI version 4 is now available. The updated version 4 handbook, as well as the training DVD and accompanying materials, are available free of charge at the Agency for Healthcare Research and Quality (AHRQ) Web site (http://www.ahrq.gov/research/esi/index.html).

—Joanie Somes, RN, MSN, PhD, CEN, NREMT-P, FAEN, ED Staff RN/Department Educator, St Joseph’s Hospital Emergency Department, EMS Coordinator, Regions EMS, Independent Consultant, St Paul, Minn; E-mail: jmsomes@healtheast.org; somes@black-hole.com

**WHEELCHAIR AVAILABILITY**

We never seem to have a working, complete, clean wheelchair in the department when we need one. How do others handle this problem?

**Answer:**

We had a plan in which we would order and monitor our own wheelchairs. Our engineering services department made the necessary physical repairs, and the maintenance
department was responsible for cleaning the wheelchairs. However, there still was a “black hole” that swallowed up the wheelchairs’ legs and arms. They managed to disappear even when we ordered wheelchairs with non-removable parts!

As a result of this organization-wide frustration, we developed a central equipment depot that has worked well for several years. Depot staff order, track, and maintain a “par level” in each hospital department and also provide ongoing maintenance. Depot staff round through the emergency department 4 times a day to handle these needs. Overall, with this system, it appears that we “lose” fewer wheelchairs and have one when we need it.

—Linda Gillespie, RN, ED Assistant Nurse Manager, St Alphonsus RMC, Boise, Idaho; E-mail: LindGILL@sarmc.org

AVOIDING HOLDING AND OVERCROWDING FOR PSYCHIATRIC PATIENTS

When a patient needs a psychiatric admission but a bed in an inpatient psychiatric facility is not available, how do other emergency departments prevent the patient from becoming an ED “hold”?

Answer 1:
Three major factors have helped us reduce our holding of patients who need a psychiatric inpatient bed.

- **Web-based diversion log for the local region.** Organized by the American Hospital Resource Association (AHRA), a Web-based diversion log gives us around-the-clock awareness of which hospitals are on bypass status and for what type of cases. Consulting the log saves us the time it takes to notify others when we go on bypass status or to check on other hospitals’ status related to our needs.

- **Consolidation of services.** The area’s 3 largest hospitals, represented by the Akron Regional Hospital Association, have agreed to consolidate certain services, even though we are not in the same network. For instance, our hospital is known as the cardiac hospital, another institution handles trauma, and the third one handles psychiatric needs.

- **Efficient streamlined flow sheet with the process for patients who present with signs or symptoms that necessitate a psychiatric consultation.** We use a Psychiatric Evaluation Resource service, through which a psychiatrist is always available to initially evaluate patients. If the psychiatrist determines that the patient needs a psychiatric hospitalization and the local psychiatric facilities are full, the algorithm indicates other resources to contact, including facilities up to 50 miles away. All of these psychiatric patients are transferred with complete ED records via an ambulance service that is waiting on our tarmac 24 hours a day, 7 days a week. The goal is to transfer the patients as soon as possible, but an individual can remain in our emergency department overnight (if he or she is not disruptive) if pending discharges are known to create an available bed in a closer facility.

—Sandra R. Cox, RN, BSN, Manager, Emergency Department, Summa Akron City Hospital, Akron, Ohio; E-mail: coss@summa-health.org

CONTRACTING YOUR POSITION

I have heard that some nurse specialists contract their position. How does that process work?

Answer:
I negotiated 2-year employee contracts with my employing hospital for the past 4 years. I negotiated these contracts because I wanted certain atypical concessions. For instance, I wanted permission to fulfill my frequent outside speaking commitments, and I wanted the authority, as well as the responsibility, for the education of all levels of health care providers (eg, physicians, nurses, and technicians) within the department. I believe it is essential to have a universal understanding and consistency of practice within an area rather than having some providers who are updated and others who are not updated.

In addition, I use the contract negotiation time to consider changes in responsibility, such as eliminating or adding some additional departments. My pay range remains similar to the other nurse practitioners within the Surgical Critical Care Division.

—Leanna R. Miller, RN, MN, CCRN, CEN, NP, Education Specialist, Trauma & Burn Patient Care Center, Vanderbilt University Medical Center, Nashville, Tenn; E-mail: leanna.miller@vanderbilt.edu
Physicians wanted to know why their patients were “held” in the emergency department, so the ED nurses documented factual reasons, such as “waiting for ICU staffing” or “waiting for an available bed.” Some administrators are now objecting to this documentation. What do others do in this situation?

Answer 1:
In an emergency department, timely intervention(s) can be key for a good outcome. If there is a delay in implementing the plan of care, such as the admission of the patient to the ICU, the factual reason for the delay is important if the patient eventually has a bad outcome. It will be central in determining whether the individual providers practiced in accordance with the standard of care.

As in any case, documentation is a necessary tool in shielding the emergency nurse from liability. It is the facts surrounding the clinical interactions that often are at the core of the legal dispute.

Of course, nurses should not “point fingers” in the medical record, but that does not mean that essential facts ought to be omitted due to a concern that such facts might raise potential issues. A distinction can be drawn between documenting the occurrence of certain objective facts related to the care of a patient versus conclusions that are subjective in nature that implicate another provider. Generally speaking, if there is a factual reason for a delay in effecting care that can be objectively identified (such as no available bed), that fact should be documented.

—Kevin Giordiano, JD, Defense Attorney and Speaker, Keyes and Donnellan, Springfield, Mass; E-mail: kgiordiano@keyesanddonnellan.com

Answer 2:
We document the reason given for the delay on the ED flow sheet. Reasons have included “An attempt was made to call report and the nurse was _____ (at lunch, in an isolation room, or off the floor)” or “Bed unavailable awaiting environmental service.”

We have started using a tracking tool at both of our emergency departments to gather data about the given reasons. This tool allows the ED managers to take factual data to the inpatient managers about reasons for our backlogs.

Our hospitals also have added “manager bed huddles” twice a day, and there are plans to extend this practice into the evening and weekend shifts. In Shared Leadership, we are working on improving interdepartmental understanding of each other’s patient care environments.

As a result, we have seen an improvement. We receive fewer excuses, and the emergency department can understand if an area is being heavily hit with direct admits, postoperative patients, or unforeseen circumstances.

—Gail McWilliams, RN, MS, CCRN, CEN, Clinical Nurse Specialist—ED/Critical Care, Shore Health System, Cambridge, Md; E-mail: gmcwilliams@shorehealth.org

Answer 3:
We have an admission book in which the unit secretary documents the related information, including the time the bed was called for, time received, time the patient left the unit, and any reason for delay (eg, admitting physician here, code on floor, or nurse unavailable for report). This process allows me to gather pertinent information and respond appropriately to questions regarding delays. The managers and directors of the involved departments also received the information. It is very easy to see which units (and even which shifts) are the worst offenders. The admission book has been very useful.

This information was also very useful in a CMS inquiry regarding our left-without-being-seen data and why anyone might have to wait for extended periods. The documentation showed that it had been identified as a problem and a process was in place to make improvements.

—Rhonda K. Davis, RN, CEN, Nurse Manager, Emergency Department, Lovelace Emergency Department, Albuquerque, NM; E-mail: rhonda.davis@lovelacesandia.com
Capnography: Clinical Aspects.

Have you ever had a question about capnography? This book will probably answer it. Studies have shown that capnography, a method of monitoring exhaled carbon dioxide (CO₂) quantitatively, is emerging as a way to improve patient outcomes in emergency departments. The purpose of Capnography: Clinical Aspects is to provide the reader with a good knowledge base of the clinical applications and technical aspects of capnography.

The book is made up of 4 sections. The first section is titled “Clinical Perspectives.” Different applications of capnography, as well as studies that support its use in each area, are discussed. This section also discusses the results of studies that compare the effectiveness of capnography with other methods of monitoring patients’ ventilatory status.

The second section, entitled “Physiological Perspectives,” discusses physiologic concepts of CO₂ monitoring as they pertain to clinical application. It includes chapters that discuss CO₂ pathophysiology, acid-base balance, and ventilation-perfusion abnormalities. The third section provides the reader with a historical perspective of capnography from a few of those who had a hand in pioneering its introduction and application. The final section discusses the technologic perspectives of capnography.

The book is well organized, and each aspect of capnography is explained thoroughly. In addition, references to studies are listed at the end of each chapter. Clinicians who have limited experience with this technology may find some of the reading that refers to research studies or technical aspects overwhelming, but overall, this

Reviews of Books, Videos, CDs, Audiotapes, Web Sites, and More, Written by Emergency Nurses
text will serve as a great resource for any clinician who is considering implementing this technology in his or her emergency department.—Maija Anderson, RN, DNP


Triage Nursing Secrets

Let me begin by saying that the Massachusetts ENA State Council recently purchased 74 copies of this incredible triage resource book as its annual Emergency Nurses Week gift to every emergency department in the state. In the tradition of the “Nursing Secrets” series, “Triage Nursing Secrets” poses questions and gives answers. The format is one that is easy to read, is easy to understand, and cuts right to the chase. Whether you are a novice triage nurse or a seasoned ED nurse, you will learn from this collection of wisdom written by very familiar names in emergency nursing literature.

The book begins with 82 “Top Secrets” of triage (perform a quick check for adequate oxygenation and perfusion with “30-2-CAN DO”) and ends with suggestions on how to transition from 3-level triage to 5-level triage. In between, you will find information about everything you might encounter at triage; from pediatrics to geriatrics, from orthopedic injuries to headaches. Learn how to deal with “heavy users” (perhaps better known as “Frequent Flyers”), as well as how to take care of yourself (“Discuss the effects of fatigue,” followed by “Can’t someone overcome this with coffee?” and “Anything to help beside limiting an individual nurse’s hours?”).

Included in each chapter are key points, internet resources, and a bibliography. One section of the book addresses symptoms patients commonly present with at triage. The chapter on “Headaches” asks such questions as “When should I be the most concerned about a headache?” and “List some questions I could ask in assessing the headache.”

Managers will be interested in the sections “Regulatory and Systems Issues” and “Triage Personnel Issues.” Those EDs looking for more information about triage protocols will find a chapter with examples currently in use in EDs across the country. One of my favorite chapters is “Decision-making and Prioritization Principles.” Critical thinking skills are so important when you are in the “hot seat” at triage. Nurses have innate intuition and triage showcases that more than anywhere else. How many of us have said, “I just don’t have a good feeling about this one!” only to have that patient quickly decompensate.

I encourage you to purchase this triage “encyclopedia.” There are answers for all your questions and more. It is a concise and thorough delivery of important emergency nursing triage information. I really love this book. I could reveal more “secrets,” but suffice it to say that this is one of the best books on emergency nursing that I have ever read and I know you will think so as well.—Robin Walsh, RN, BSN

Understanding the Assessment and Treatment of Caustic Ingestions and the Resulting Burns

A 35-year-old woman arrives in your emergency department one night just after having ingested a cup of alkaline drain cleaner in a suicidal gesture. She is drooling and says she cannot swallow. You immediately clean her mouth and check for burns to the oral mucosa. You do not give her anything to drink. She ultimately is admitted to medicine for an endoscopy and is treated for esophageal and gastric burns.

Background

Drain cleaners contain “caustics,” substances that have the ability to cause tissue injury. Although there are exceptions, we typically classify caustics as either acids or alkalis. Acids with a pH of 2 or below and alkalis with a pH of 12 or above are most commonly associated with tissue injury. In addition to pH, other factors influencing the extent of injury include the duration of contact, volume ingested, and the concentration of the caustic. Acidic agents will cause injury by coagulation necrosis, a process by which the proteins of superficial tissues are damaged; this results in the formation of an eschar, which actually can help limit ongoing tissue injury. Alkalis, on the other hand, cause severe liquefaction necrosis; they penetrate more easily than acids and will cause deeper burns. Although acid and alkali injuries are histologically different, the clinical pattern of injury may not be all that different.

Some strong caustics commonly found in the home include toilet bowl cleaners, drain cleaners (which can be either alkaline or acidic), automatic dishwasher detergents, certain bleaches, and hair relaxers. Industrial-use products typically are stronger than what is found in the home and will be expected to be quite caustic. Sometimes employees
bring industrial-strength cleaners home from work, and the cleaners then typically are transferred to a different container, often an empty drinking bottle. Unfortunately, there are reports of many children, as well as adults, ingesting these strong caustics from an improper container.

**Symptoms**

When a patient is seen in the emergency room with a history of a caustic ingestion, be alert for specific signs and symptoms. There may be burns to the lips, tongue, and oral mucosa. There may be burns to the face as well if the liquid splashed during the ingestion. Drooling may indicate an inability to handle one’s own secretions because of pharyngeal injury. There may be dysphagia, vomiting, or a refusal to drink. The patient may speak in a muffled voice or complain of chest or abdominal pain. In more serious cases there may be acute airway compromise, evidenced by stridor, tachypnea, or hyperpnea. Vomiting increases the risk of aspiration, so be especially sure to assess the respiratory status of patients in these instances. Bloody vomitus in particular can indicate a more serious burn. Severely burned patients may become hemodynamically unstable as a result of vascular perforation, and shock may develop. Never assume that a patient without oropharyngeal burns has no tissue damage. A patient with any of the aforementioned symptoms, with or without oropharyngeal findings, most likely has a significant burn. If the patient has no signs or symptoms following a period of observation, there likely is no, or minimal, tissue injury.³

**Laboratory testing**

Depending on the patient’s history and clinical findings, the initial workup may include obtaining the pulse oximetry, determining electrolyte and arterial blood gas status, as well as getting a chest radiograph.²

**Treatment**

Try to obtain the container of the ingested product; knowing the ingredients and their concentration will help guide medical management. If the concentration is not listed, the product should be labeled according to the U.S. Consumer Product Safety Commission Labeling Recommendations. This indicates the risk of injury: “Caution—weak irritant; Warning—strong irritant; Danger—corrosive.”²

The initial treatment of a patient who has ingested a caustic should be dilution. Dilution with small amounts of water or milk is allowed only in those patients who have no respiratory symptoms, no vomiting, and no complaints of nausea, and who are alert and able to speak. If a patient is refusing to swallow, do not force the dilution. Next remove the caustic from the mouth. If, for example, a granular automatic dishwasher detergent was ingested, check the entire oral cavity for residual that may be trapped. For liquid ingestions, have the patient swish and spit to clean the mouth. Dilution with small amounts of water or milk is allowed only in patients who have no respiratory symptoms, no vomiting, no complaints of nausea, and who are alert and able to speak. If a patient is refusing to swallow, do not force the dilution.

Never assume that a patient without oropharyngeal burns has no tissue damage.

Never administer activated charcoal. Acids and alkalis typically do not adsorb to it, and furthermore, the charcoal will certainly impair any endoscopic evaluation that may be required. Do not try to neutralize the caustic. These attempts may cause an exothermic reaction that produces heat and may actually increase tissue injury.⁴

Patients who have unintentionally ingested small amounts of a caustic and remain asymptomatic can be safely discharged and return home after a few hours of observation.⁵ Otherwise, an endoscopic evaluation may be indicated to determine the extent of tissue injury. Although there are no definitive rules, persons who exhibit at least 2 or more symptoms of injury and those with intentional ingestions typically require endoscopic examination. Intentional ingestions are best assumed to be severe because of the probable large amount ingested. Patients found to have endoscopic tissue damage will be treated according to the extent of the injury. Treatment options with varying amounts of documented success include soft diets, corticosteroids,
antibiotics, surgery, and stent placements. In the event of stricture formation of the esophagus, repeated dilations may be required. These patients also are at risk for the future development of esophageal carcinomas.\textsuperscript{4}

**Special considerations**

Several caustics have unique properties that mandate medical intervention different from what has been described. These agents include Clinitest tabs, phenols, button batteries, and hydrofluoric acid.\textsuperscript{4} Their management is not discussed here. For a good understanding of the treatment of these special cases, refer to *Toxicologic Emergencies* by Lewis Goldfrank.\textsuperscript{4}

*Never administer activated charcoal. Acids and alkalis typically do not adsorb to it, and furthermore, the charcoal will certainly impair any endoscopic evaluation that may be required. Do not try to neutralize the caustic. These attempts may cause an exothermic reaction that produces heat and may actually increase tissue injury.*

**Prevention**

Instruct families to keep caustics in their original containers, and make sure they are safely out of reach of children and pets.

**Acknowledgment**

I thank Diane Calello, MD, for her critical review of this article.

**REFERENCES**


**Submissions** to this column are welcomed and encouraged. Submissions may be sent to:

Allison A. Muller, PharmD, CSPI
The Children’s Hospital of Philadelphia, 34th and Civic Center Blvd, Philadelphia, Pa 19104
215 590-2004 • mullera@email.chop.edu

**Correction**

The author’s email address was inadvertently omitted from the Policy Perspectives article *Transgender Patients: Implications for Emergency Department Policy and Practice* on page 405 of the August 2005 issue of the Journal. The author is Nancy Shaffer, RN, MS, CCRN, Petaluma, Calif, and her email address is nancs@sonic.net.
Epistaxis Following an Assault: Practical Considerations in Stopping the Bleeding

A 52-year-old man who was struck in the face with a full bottle of wine sustained significant facial trauma to the left side of his face. On arrival at the emergency department, he had swelling about his left eye and zygoma, and his mid face was freely mobile. His maxillofacial computed tomography scan showed extensive facial bone fractures, including bilateral orbit walls, turbinates, nasal septum, maxillary wall, and sinuses (Figure 1).

While lying supine, the patient did not appreciate any bleeding, but upon sitting up, he began to have some active bleeding from both nares. Holding direct pressure on his nose did not help. Soon he also was spitting blood from his mouth. The team attempted to pack his nares with cocaine-soaked gauze, but this procedure did not staunch the bleeding. To protect his airway, he was electively intubated. The team then placed 2 No. 14 Foley catheters into the nares, inflated the balloons, and pulled the catheters forward to seat them firmly against the nasopharynx (Figure 2). This maneuver was successful. The patient was admitted into the ICU. Two days later, the ear, nose and throat (ENT) surgeons took the patient to the operating room for repair of his facial fractures. He went on to have an uneventful recovery.

During our review of this patient, we discussed what we would have done if the patient had other major injuries. What if the epistaxis was but one of many injuries competing for your attention?

Let’s start with some background. Epistaxis, or nasal hemorrhage, can be distressing for both the patient and the medical team. The nose has a rich and complex vascular supply, and gaining control of brisk bleeding can be challenging. The bleeding can be caused by a wide variety
of factors, including trauma, allergic rhinitis, mucosal drying from low humidity, and nose picking, among others. Epistaxis is classified as either posterior or anterior bleeding, an important distinction that helps us direct our management decisions. The sphenopalatine artery, emerging from a foramen posterior to the middle turbinate, is the most common site of posterior epistaxis. The most common site of anterior epistaxis is within the area called Kiesselbach’s plexus.

One of the hallmarks of treating epistaxis is to identify the bleeding source. Typically, this requires the patient to sit up and assume a “sniffing” position, with the head slightly extended and the neck flexed so that a nasal speculum examination of the nares can be done. During the initial resuscitation of a trauma patient, this examination clearly will not be possible.

If you get some advance warning that an incoming trauma patient has epistaxis, the first step to take is to marshal your resources. If you have an epistaxis tray in your emergency department, get it out and ready. Roberts and Hedges provide a detailed listing of equipment and supplies for a dedicated epistaxis tray. If you have an ENT surgeon on call, it may be prudent to alert him or her. Ensuring a patent airway certainly could be an issue, so have your suction and airway equipment ready. Everybody in the room should wear coveralls and shoe covers, along with masks and eye protection.

When the patient arrives, following the standard Advanced Trauma Life Support guidelines is critical. If the patient requires intubation, have suction ready to clear away any blood or clots. Assess and reassess the patient’s hemodynamic stability and intervene accordingly. The goal of epistaxis treatment during the initial trauma resuscitation is to control the nasal bleeding while the workup is ongoing. To do that, the first step is to apply direct compression of the nostrils at the septal area. This procedure will take one team member out of commission, so it is important to decide in advance who this person will be.

Packing the nostrils with soaked gauze may help tamponade the bleeding and allow you to complete a secondary survey. This procedure will be effective only if the bleeding is anterior. The gauze or pledgets are soaked in anesthetic or a vasoconstricting substance, such as cocaine or lidocaine, and the excess fluid is squeezed out of the pledget. Again, compression is held manually to the septal area and the team member is out of commission.

FIGURE 1
A 3-dimensional reconstructed computed tomography scan shows multiple facial fractures.

FIGURE 2
Staff holding directed pressure and Foley balloons in place.

When the patient arrives, following the standard Advanced Trauma Life Support guidelines is critical. If the patient requires intubation, have suction ready to clear away any blood or clots. Assess and reassess the patient’s hemodynamic stability and intervene accordingly. The goal of epistaxis treatment during the initial trauma resuscitation is to control the nasal bleeding while the workup is ongoing. To do that, the first step is to apply direct compression of the nostrils at the septal area. This procedure will take one team member out of commission, so it is important to decide in advance who this person will be.

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As with any medication, it is important to know the total amount of drug being administered and to stay within recommendations for the maximum safe dosage.

If the patient has posterior bleeding, direct pressure and anterior packing will not tamponade the bleeding. Maneuvers to apply compression to the sphenopalatine artery will be necessary. One option is to use an intranasal balloon. Commercial products are available, or Foley catheters can be used.

**With any trauma patient with skull fractures, there is the very real risk of entering the cranial vault when you pass a catheter via the nose. Once the risk and benefits have been analyzed, if the decision to place a Foley catheter is made, the procedure must be done very carefully.**

It takes at least 2 staff members to insert the intranasal Foley catheter. To start, insert a 12 French or 14 French Foley catheter through the bleeding nares into the posterior pharynx and partially inflate the balloon. Slowly pull the Foley catheter into the posterior nasopharynx and snug it against the posterior aspect of the middle turbinate. Once secure, finish inflating the balloon. The reason for inflating the balloon in a 2-step fashion is to ensure that the balloon moves into the correct position. If the balloon is fully inflated initially, it can rest too posterior in the nasopharynx to effectively tamponade the bleeding from the sphenopalatine artery.

One team member will apply gentle tension on the Foley catheter, while another packs the patient’s nares using layered petroleum-impregnated gauze. Both nares are packed to prevent septal deviation. Finally, the Foley catheters are secured close to the nares, taking care to not exert too much pressure on the nasal alar and cause necrosis.

Other maneuvers to stop posterior nasal bleeding include surgical ligation of the artery or endoscopic cautery. These two options will require an ENT consult. With any trauma patient with skull fractures, there is the very real risk of entering the cranial vault when you pass a catheter via the nose. Once the risk and benefits have been analyzed, if the decision to place a Foley catheter is made, the procedure must be done very carefully.

Epistaxis in a patient with multiple other injuries adds a layer of complexity to the care of the injured patient. One team member may be unavailable during the resuscitation because of the task of holding direct pressure. An epistaxis tray brought to the bedside can help ensure all the necessary equipment is present. Being prepared can help you make the best of a difficult situation.

**REFERENCE**


**Contributions** for this column are welcomed and encouraged. Submissions should be sent to:

Maureen Harrahill, RN, MS, ACNP-CS
1404 SE Malden, Portland, OR 97202
503 494-6007 • harrahim@ohsu.edu
It Takes More Than String to Fly a Kite: 5-Level Acuity Scales Are Effective, but Education, Clinical Expertise, and Compassion Are Still Essential

What is the number one cause of mistriage?

1. Using a 3-level rather than a 5-level triage acuity scale
2. Using the wrong 5-level triage acuity scale
3. Lack of education, triage nurse inexperience, and empathy burnout

Because of the recent emphasis on 5-level acuity scales in the United States, we have heard from many persons who believe that using a 5-level acuity scale, or using the “right” 5-level acuity scale, is the most important ingredient at triage. However, based on our 8 years of consulting and educating emergency nurses across the United States on the topic of triage, we at Triage First, Inc. have found that education, experience, and empathy (answer 3) are still the most important factors at triage, no matter what triage scale is used.

Yes, problems are inherent in the existing 3-level acuity scales, and yes, data from a 5-level scale promise to more easily quantify ED data. In light of the promise of the 5-level scales, ENA joined forces with the American College of Emergency Physicians to review literature regarding acuity scales, asserting our common belief that the “quality of patient care would benefit from implementing a standardized... triage scale and acuity categorization process.”1 In July 2004 this work group concluded that both the Canadian Triage Acuity Scale (CTAS) and the Emergency Severity Index (ESI) had been shown to be reliable 5-level acuity scale options.1 As a result, many emergency departments across the United States are embracing this transition to a 5-level triage acuity scale. As a member of this task force and someone who has championed a standardization to 5-level triage, I applaud such a move, but the question becomes, “Is it enough?”
Adoption of a standardized 5-level acuity scale:
Is it enough?

In a 1999 article entitled “What’s Wrong With Triage,” Edwards noted, “The process of allocating patients to categories has come to be seen as the sole purpose and end point of triage. This static and narrow perspective separates the responsibility for decisions on urgency from the responsibility to act on those decisions.” As desirable as the adoption of a standardized 5-level triage acuity scale is, it is not the definitive answer to many of the problems we hear about that are associated with triage as a point-of-entry process. In itself, the scale fails to address the other components of an effective triage system.

Contributing to the confusion may be that many persons use the terms acuity scale and triage system interchangeably. An acuity scale is only one of the many aspects of a comprehensive triage system. A system must also address “factors influencing access to health care and patient flow through the emergency care system.”

Another cause of confusion regarding standardized 5-level acuity scales may arise from a flawed interpretation of articles and studies reporting the effectiveness of both CTAS and ESI. Readers are told of improvements in the departments in which they were implemented, but some of the reports do not discuss the comprehensive approaches to triage education that each of these facilities took before or during implementation of the 5-level scale. At Triage First it has been our experience that emergency nurses who have read the reports have incorrectly concluded that all an emergency department needs to do is to implement the correct acuity scale and all will be well at triage. It is likely that even persons who support the use of these scales would not want to give that impression.

In a 1999 article, Gerdtz and Bucknall comment, “Triage scales are not a panacea for all triage decision-making.” Triage scales do not always indicate the need for prompt emergency nursing care, particularly for less urgent and nonurgent patients. The triage nurse must rely on education and experience to know which nursing measures must be taken immediately for each presentation, such as advocating for pain relief or administering medications.

By itself, the adoption of a 5-level acuity scale often is not enough, for example, to guide the patient interview in the appropriate direction. That skill requires a knowledgeable triage nurse. One large study looked at hundreds of charts from approximately 30 different hospital emergency departments and found triage documentation to be inconsistent, incomplete, and inaccurate, often doing little more than simply quoting patients or their family members. In many cases the triage nurse noted the chief complaint but neglected to use a systematic approach to explore other possible implications or the patient’s related medical history.

Regardless of the acuity system used, a systematic approach is needed. Mistriage usually does not occur with patients who obviously are very ill or badly injured; it occurs with patients who do not seem to be very sick. Mistriage of this sort is generally the result of certain remediable inadequacies in the triage nurse: lack of education, lack of experience, or lack of empathy.

Education

As we at Triage First have consulted with and educated thousands of emergency nurses and hundreds of physicians, we have discovered that most of them have not received formal education regarding the triage acuity scale in use at their own facilities. It also has been our experience that “MOST of the problems associated with a consistent triage performance and outcomes are due to lack of education regarding same.”

We have found that a good number of emergency nurses are unable to describe their acuity scale with any clarity beyond saying, “It’s in a policy book somewhere.” We also have found that certain discriminators such as “pain,” “immunocompromised states,” and “risk factors,” although well described in hospital policy, were not familiar terms for all of the registered nurses (RNs) performing triage. Thus, we have found that such discriminators are not always considered when assigning an acuity level to the patient or deciding on immediate action.

The scope of knowledge needed for the efficient operation and daily functioning of a triage system is broader than just acuity determination. Historically, ENA has supported a wide clinical and conceptual knowledge base for the triage nurse role. Comprehensive triage education, therefore, must address a wide variety of issues, including systematic assessment (both rapid and comprehensive), critical thinking skills, documentation skills and...
tools, knowledge of federal and hospital mandates, how to address violence and hostility, and understanding and having a clinical knowledge base for various populations, for example, pediatric, geriatric, psychiatric, and intimate-partner violence populations.

Of course, triage nurses cannot possibly know everything about every possible presentation or scenario; that is why the ability to think critically is even more fundamental to the avoidance of mistriage than an acuity scale. Gerdz and Bucknall\(^4\) note, “Critical thinking in nursing involves rational, linear problem-solving. Its logic involves reflective thinking, intuition, and imaginative thought processes about nursing problems that defy a single solution.” It considers the big picture and asks the right questions. The triage nurse must be the “detective” at the front door; it is not the patient’s job to tell the nurse what is wrong, it is the nurse’s job to find it out.

Critical thinkers must be inquisitive, systematic, analytical, truth-seeking, open-minded, self-confident, and mature.\(^7\) How is a nurse to gain all these traits? In addition to reading journals and gleaning knowledge from more experienced colleagues, I believe that comprehensive triage education with scenario-based training can be invaluable.

**Experience**

An ENA position statement on requirements for triage nurses includes the requirement of being an RN with at least 6 months of ED experience. Some facilities require nurses to have as much as 2 years of ED experience before working at triage. Furthermore, although comprehensive triage education can be invaluable, certain things can only be learned through years of experience.

*The triage nurse must be the “detective” at the front door; it is not the patient’s job to tell the nurse what is wrong, it is the nurse’s job to find it out.*

If years of experience are the cornerstone of triage nursing, that experience does not guarantee consistent best practice or no mistriage. In fact, experience also can lead to cynicism and “empathy burnout.” As the saying goes, 10 years of experience for some persons may really be just 1 year of experience repeated 9 times for other persons.

**Empathy**

In a 1999 article, Edwards\(^8\) comments, “Triage is not merely a gateway to care but one which brings therapeutic gains in its own right and acts as the critical first phase in the total process of care.” Regardless of the acuity scale in use, cynical nurses may not be able to provide the best care and may therefore allow their biases and prejudices to influence their triage decisions. Edwards\(^8\) also says, “Nurses operate on the basis of concern as well as clinical acumen. If triage is to be nurse-led, these concerns should be seen as equally legitimate as those based on pathology.”

To assist nurses in maintaining this caring ethic, hospital emergency departments must implement policies, procedures, and practical training to help emergency nurses avoid “empathy burnout” and the resulting impact on patient safety. In our experience at Triage First, Inc., these measures can include the following:

- Triage nurses have safe and efficient workplaces conducive to best triage practice.
- Triage nurses recognize their “trigger groups” (ie, the types of patients who may trigger an inappropriate verbal or nonverbal response) and have a plan for how to establish rapport and treat such patients with compassion.
- Triage nurses recognize and treat the anger and verbal attacks of patients as symptoms not to be taken personally or retaliated against.
- Triage nurses should feel free to ask for a break from the triage position. This self-awareness should not be considered a sign of weakness.
- Managers should learn to recognize signs of compassion fatigue and encourage staff members to take some time off, rotate to a less stressful department for a while, or get some other support.
- Managers need to cultivate the habit of expressing appreciation to their staff. Triage nurses have told us that a few kind words or even a simple “thank you” makes a world of difference.

**The real solution**

Reducing the incidence of mistriage will have a positive impact on patient satisfaction, patient safety, and, ultimately, the bottom line. To accomplish this goal, we obviously need a proven acuity scale, but we also need
efficient processes, appropriate physical layouts, and supportive administrators. However, in our experience at Triage First, the most important key to alleviating the problem of mistriage is to have experienced, triage-educated, compassionate RNs assigned to triage.

REFERENCES

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Submissions to this column are welcomed and encouraged. Submissions may be sent to:
Diane Gurney, RN, MS, CEN
261 Bishops Terrace, Hyannis, MA 02601
508 862-5970 • dgurney@capecodhealth.org

December 2005 31:6 JOURNAL OF EMERGENCY NURSING 603
CE Earn up to 8 Contact Hours by Reading the Designated Articles and Taking These Post Tests

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To provide registered professional nurses with information to increase their knowledge about current issues affecting emergency nursing practice.

LEARNING OBJECTIVE—RESEARCH (CONTACT HOURS 1.5; FEE $12.95)

After reading this article and taking this test, you will be able to:
1. Discuss the literature review and results of this descriptive study on the perceptions of workplace violence and safety strategies in a Level 1 trauma center.

LEARNING OBJECTIVES—CLINICAL (CONTACT HOURS 4.5; FEE $30.00)

After reading these articles and taking this test, you will be able to:
1. Outline the etiology and treatment of epistaxis.
2. Describe the implementation and associated outcomes of a percutaneous coronary intervention kit and program.
3. Describe factors affecting triage and recommendations to improve triage.
4. Discuss the need for safe handoffs in clinical care and explain how to assign acuity levels for infants with sepsis.
5. Outline the common clinical findings, treatment, and prevention of caustic ingestion.
6. Identify look-alike, sound-alike drugs and strategies to prevent medication errors.

LEARNING OBJECTIVE—PROFESSIONAL/ADMINISTRATIVE (CONTACT HOURS 2.0; FEE $14.95)

After reading this article and taking this test, you will be able to:
1. Discuss the implications of creating a behavioral health unit as part of an emergency department at Lehigh Valley Hospital and Health Network in Pennsylvania.

*In accordance with Iowa Board of Nursing administrative rules governing grievances, a copy of your evaluation of the CE offering may be submitted directly to the Iowa Board of Nursing.
RESEARCH TEST QUESTIONS

A Descriptive Study of the Perceptions of Workplace Violence and Safety Strategies of Nurses Working in Level 1 Trauma Centers (pp. 519-25)

1. According to Simonowitz (1995), the type of workplace violence that nurses are most likely to experience is
   A. Type I.
   B. Type II.
   C. Type III.
   D. Type IV.

2. A study by Mahoney (1991), which investigated the extent, nature, and response of victimization of emergency nurses in Pennsylvania, revealed that
   A. 45.3% of nurses who experienced workplace violence terminated employment in the emergency department within 6 months.
   B. 60% of nurses were victims of aggression primarily because of the lack of police protection in the emergency department.
   C. 75% of nurses who experienced workplace violence worked in a community hospital during the night shift.
   D. 97.7% of nurses reported experiencing some type of aggression at work during their nursing careers.

3. One of the reoccurring themes revealed in this study was
   A. inadequate safety measures.
   B. inadequate support following a violent attack.
   C. the lack of awareness of potential danger.
   D. the lack of an adequate hospital orientation.

4. Participants in this study reported that
   A. physical threats were the most common type of aggression exhibited by family members.
   B. nurses need to take more responsibility in assessing risk factors for violence.
   C. control of access to the emergency department was a primary issue of concern.
   D. violent behavior was greatly decreased when metal detectors were used at the emergency entrance.

CLINICAL TEST QUESTIONS

Epistaxis Following an Assault: Practical Considerations in Stopping the Bleeding (pp. 597-9)

1. The most common site of posterior epistaxis is the
   A. columellar artery.
   B. dorsal nasal artery.
   C. lateral nasal artery.
   D. sphenopalatine artery.

2. What is the most common site of anterior epistaxis?
   A. Maxillary artery.
   B. Pharyngeal artery.
   C. Kiesselbach’s plexus.
   D. Fossa of Rosenmüller.

3. A patient presents with epistaxis but with no cervical spine injury to the emergency department. In order to identify the bleeding source, you should place the patient in which position?
   A. Lateral recumbent.
   B. Reverse trendelenberg.
   C. With the head slightly extended and the neck flexed.
   D. With the head slightly flexed and the neck extended.

4. What is the first step in epistaxis treatment?
   A. Applying direct compression of the nostrils at the septal area.
   B. Administering Vitamin K via the intramuscular route.
   C. Decreasing the patient’s mean arterial blood pressure.
   D. Placing an ice pack over the nasofrontal suture line.

5. Which of the following statements about packing the nostrils with soaked gauze is accurate?
   A. The gauze is soaked in normal saline prior to insertion.
   B. The use of this treatment is limited to epistaxis caused by anterior bleeding.
   C. This should not be attempted until after the secondary survey is completed.
   D. This technique should not be used in patients who take prescribed anticoagulants.
6. Which of the following is used to treat epistaxis caused by a posterior bleed?
   A. Surgical ligation.
   B. Intranasal packing.
   C. Direct external pressure.
   D. Compression of the ethmoid artery.

7. Which of the following statements about intranasal foley catheter insertion is correct?
   A. A 12 to 14 French catheter is commonly used.
   B. Conscious sedation should be provided prior to insertion.
   C. The catheter should be inserted into the unaffected nares.
   D. The foley catheter should be secured close to the nasal alar.

8. Which of the following medications is excluded from the percutaneous coronary intervention (PCI) kit?
   A. Heparin.
   B. Morphine.
   C. Metoprolol (Lopressor).
   D. Eptifibatide (Integrilin).

9. Implementation of the PCI kit resulted in which of these outcomes?
   A. A door-to-cath time of 70 minutes.
   B. A 25% increase in patient survival rate.
   C. A medication retrieval time of 20 seconds.
   D. A 30% decrease in hospital length of stay.

10. Which of the following strategies was implemented to minimize door-to-cath lab time?
    A. The triage nurse contacts the cardiologist upon patient arrival.
    B. The emergency department physician has the authority to call in the cath lab team.
    C. A hospital-wide “Code Cath” is announced upon arrival of a patient having a myocardial infarction.
    D. The emergency department nurse obtains the patient’s signature for cardiac catheterization immediately following the initial assessment.

11. According to the author, the most important factor(s) at triage is/are
    A. education, experience, and empathy.
    B. use of a three-level triage acuity scale.
    C. staffing, census and patient arrival time.
    D. use of the Canadian Triage Acuity Scale (CTAS).

12. An ENA position statement on requirements for triage nurses includes
    A. certification as an emergency nurse.
    B. preparation at the baccalaureate level.
    C. at least 6 months of emergency nursing experience.
    D. a minimum of 2 years of experience as a registered nurse.

13. A study by Berger and Gillespey (2002), which looked at hundreds of charts from approximately 30 different hospital emergency departments, found that
    A. emergency departments with more than 50,000 visits per year performed the most accurate triage assessments.
    B. those certified as emergency nurses were more likely to use a systematic approach when triaging patients.
    C. the most effective triage documentation included quotes from patients.
    D. triage documentation was inconsistent, incomplete, and inaccurate.

14. Which of the following statements about the process of “handoffs” in clinical care is correct?
    A. It is one of the 2006 JCAHO Patient Safety Goals.
    B. It was recently the subject of an ENA position statement.
    C. It is limited to the period of time during the change of shift.
    D. It has been considered the period of time when medications errors are most likely to occur.
15. Which of the following reflects an accurate use of the ESI version 4 guidelines when treating a febrile infant?
   A. Assigning a 12-month-old child with a temperature of 40°C (104°F) as ESI acuity level 5.
   B. Assigning a 2-month-old infant with a temperature of 39°C (102.2°F) as ESI acuity level 3.
   C. Assigning a 28-day-old infant with a temperature of 37.5°C (99.5°F) as ESI acuity level 2.
   D. Assigning a 14-day-old infant with a temperature of 38.2°C (100.8°F) as ESI acuity level 2.

16. A 2-year-old child is brought to the emergency department with a fever of 39.5°C (103.1°F). Immunizations are not up-to-date. Using the ESI version 4 guidelines, this infant should be assigned at least to
   A. ESI 1.
   B. ESI 2.
   C. ESI 3.
   D. ESI 4.

17. Tissue injury is most commonly associated with ingestion of
   A. acids with a pH of 4.
   B. alkalis with a pH of 6.
   C. acids with a pH of 2 or below.
   D. alkalis with a pH of 8 or below.

18. Which of the following statements about acidic and alkali injuries is correct?
   A. The clinical pattern of injury is very different.
   B. Acid injuries are more difficult to treat.
   C. They are histologically the same.
   D. Alkalis will cause deeper burns.

19. You should suspect pharyngeal injury in a patient who ingested a caustic agent and
   A. is drooling.
   B. is vomiting.
   C. has burns to the face.
   D. has complaints of chest pain.

20. What is the initial treatment of a patient who has ingested a caustic?
   A. Insertion of an oral airway.
   B. Neutralization of the caustic.
   C. Administration of activated charcoal.
   D. Removal of the caustic from the mouth.

21. An endoscopic examination usually is performed in a patient who ingested a caustic agent and
   A. is under the age of 5 years.
   B. is over the age of 65 years.
   C. does not know the name of the agent.
   D. reports that the ingestion was intentional.

22. To prevent caustic ingestion, you should teach families to
   A. give ipecac within 10 minutes of ingestion of a caustic agent.
   B. keep caustics in their original container.
   C. avoid using milk as a mouth rinse following caustic ingestion.
   D. keep caustic agents in a cabinet above waist level.

23. According to the author, which of these is a drug class in which drug names are commonly confused?
   A. Antituberculars.
   B. Opioid analgesics.
   C. Electrolyte modifiers.
   D. Neuromuscular blocking agents.

24. Which of these strategies is recommended to help prevent medication errors?
   A. Committing drug names to memory.
   B. Using bar-code scanning at the bedside.
   C. Storing look-alike medications alphabetically.
   D. Completely eliminating the use of verbal orders in the emergency department.

25. Which of these is a recommended strategy for differentiating medications?
   A. Writing hydralazine as Apresoline.
   B. Writing hydroxyzine as hydrOXYzine.
   C. Relabeling each medication prior to administration.
   D. Referring to each medication by its generic name.
1. Which of these factors generated a greater need for specialized behavioral health care in the Lehigh Valley Hospital and Health Network (LVHHN) emergency department?
   A. The nationwide shortage of inpatient behavioral health beds.
   B. The decrease in availability of psychiatric social workers.
   C. The decrease in reimbursement for DSM IV diagnoses.
   D. The rapid expansion in the regional population.

2. Which of the following occurred as a result of increasing the number of LVHHN’s licensed inpatient behavioral health beds?
   A. A decrease in patient satisfaction survey results.
   B. A decrease in billable services provided by the hospital.
   C. An increase in consistency among staff practice patterns.
   D. An increase in behavioral health admissions by approximately 50%.

3. The Emergency Behavioral Health (EBH) unit is staffed by
   A. a registered nurse and a physician’s assistant.
   B. a licensed practical nurse and a non-licensed technical partner.
   C. a psychiatric clinical nurse specialist.
   D. a psychiatric nurse practitioner.

4. An emergency department staff survey conducted after implementation of the EBH revealed
   A. elimination of the use of restraints.
   B. a stabilization of patient wait times.
   C. a decrease in patient frustration witnessed by staff.
   D. improved in-patient placement of behavioral health patients.

5. Which of the following is a challenge faced by the EBH unit?
   A. Staff turnover.
   B. Staff–patient ratio.
   C. Education of emergency department staff.
   D. Number of critical elopements resulting in a negative outcome.

6. One criteria for direct admission to the EBH unit is met if the patient
   A. is less than 65 years of age.
   B. is currently receiving treatment for schizophrenia.
   C. has consumed alcohol within the past 8 hours.
   D. has developed a new onset of hallucinations.

7. Which of the following is a visitor policy for the EBH unit?
   A. Patients who are 13–21 years of age are limited to one sibling visitor at a time.
   B. Parents may be asked to stay with a patient who is younger than 13 years of age.
   C. Visitors may bring the patient preferred food from home.
   D. Each patient is limited to two visitors at a time.
CE ENROLLMENT FORM

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FEES AND CONTACT HOURS LISTED ABOVE
Celebrating Nursing: Quilt Begun by ED Staff Mushrooms to Successful Hospital-wide Project

Last summer I suggested to my emergency nursing peers at Mary Lane Hospital in Ware, Massachusetts, that we make a quilt in honor of Nurses Week. In the past we had made crib-size, cross-stitch quilts for staff expecting a baby. I thought that making a quilt for Nurses Week would be a way for us to demonstrate our pride in nursing and also would be a fun group project. Each one of our ED nurses committed to completing a block, as did our manager, 4 of our MAs, and one of our ED physicians.

Word of our quilt project quickly spread throughout the hospital, and I was approached by staff from most departments who asked to be part of our effort. Participants included our director of nursing, the hospital executive vice president, nurse managers, a case manager, a nursing supervisor, a CNA, laboratory, radiology, cardiology, and registration personnel, and staff nurses from every nursing department. I was overwhelmed by the response. What started as an ED project soon became one that was hospital-wide.

I thought that making a quilt for Nurses Week would be a way for us to demonstrate our pride in nursing and also would be a fun group project.

The quilt contains 52 blocks related to nursing in all shapes and sizes. We have traditional squares, such as the Nightingale Pledge, the Nurse’s Prayer, a portrait of a nurse, and a nurse’s cape.

Jean M. Comeau, RN, BSN, Ware, Mass.
For correspondence, write: Jean M. Comeau, Mary Lane Hospital, 85 South St, Ware, MA 01082; E-mail: Jean.Comeau@bhs.org.
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We have blocks representing nursing specialties—geriatric, orthopedic, surgical, delivery room, and pediatric. We have whimsical blocks, such as a Hello Kitty nurse and a Betty Boop nurse, and some very clever personal interpretations—for example, the word nurse in 5 languages, laughter is the best medicine, and celebrate nursing. We have blocks featuring a male nurse, an advanced practice nurse, and a research nurse. It is beautiful!

I am very proud of this project; a small group of ED nurses brought a hospital together to demonstrate pride in their nurses, in this era of low morale and nursing shortages.

My ED pals and I assembled the quilt, and we had an exciting and well-attended unveiling ceremony in May 2005 (Figures 1 and 2). The hospital has given us a permanent location to display it in a beautiful oak case built by the engineering department. I approached our medical group, and they agreed to pay for the glass to enclose and preserve our efforts.

I am very proud of this project; a small group of ED nurses brought a hospital together to demonstrate pride in their nurses, in this era of low morale and nursing shortages.
Coming Meetings

FEBRUARY 2006

21st Annual National Conference on Wilderness Medicine
February 11-15, 2006; Yellowstone Convention Center, Big Sky, Montana
Sponsors: American College Of Emergency Physicians (ACEP, CAL/ACEP) and Wilderness and Travel Medical Seminars. Contact: Mountain Destinations, 1822 W. Lincoln, Bozeman, MT 59715. Phone: (888)995-3088, (406)522-9038; Fax (406)587-2541; E-mail: info@mountaindestinations.com; Web-site: www.mountaindestinations.com.

■ 2006 ENA Leadership Challenge
February 23-26, 2006, Austin, Texas
Sponsor: Emergency Nurses Association. Contact: Emergency Nurses Association, 915 Lee St, Des Plaines, IL 60016. Phone: (800) 243-8362; Fax: (847)460-4001; E-mail: enainfo@ena.org.

MARCH 2006

21st Annual National Conference on Wilderness Medicine
March 4-8, 2006; Westin Resort & Spa, Whistler, BC, Canada
Sponsors: American College of Emergency Physicians (ACEP, CAL/ACEP) and Wilderness and Travel Medical Seminars. Contact: Mountain Destinations, 1822 W. Lincoln, Bozeman, MT 59715. Phone: (888)995-3088, (406)522-9038; Fax (406)587-2541; E-mail: info@mountaindestinations.com; Web-site: www.mountaindestinations.com.

JUNE 2006

Washington State Council Cruise
June 16-23, 2006; Summer Cruise from Seattle to Alaska

SEPTEMBER 2006

■ 2006 ENA Annual Meeting
September 13-16 2006, Henry B. Gonzalez Convention Center, San Antonio, Texas
Sponsor: Emergency Nurses Association. Contact: Emergency Nurses Association, 915 Lee St, Des Plaines, IL 60016. Phone: (800)243-8362; fax: (847)460-4001; E-mail: enainfo@ena.org.

FEBRUARY 2007

■ 2007 ENA Leadership Challenge
February 28-March 2, 2008, Honolulu, Hawaii
Sponsor: Emergency Nurses Association. Contact: Emergency Nurses Association, 915 Lee St, Des Plaines, IL 60016. Phone: (800)243-8362; fax: (847)460-4001; E-mail: enainfo@ena.org.

SEPTEMBER 2007

■ 2007 ENA Annual Meeting
September 26-29, 2007, Salt Palace Convention Center, Salt Lake City, Utah
Sponsor: Emergency Nurses Association. Contact: Emergency Nurses Association, 915 Lee St, Des Plaines, IL 60016. Phone: (800)243-8362; fax: (847)460-4001; E-mail: enainfo@ena.org.

FEBRUARY 2008

■ 2008 ENA Leadership Challenge
February 28-March 2, 2008, Honolulu, Hawaii
Sponsor: Emergency Nurses Association. Contact: Emergency Nurses Association, 915 Lee St, Des Plaines, IL 60016. Phone: (800)243-8362; fax: (847)460-4001; E-mail: enainfo@ena.org.

SEPTEMBER 2008

■ 2008 ENA Annual Meeting
September 24-27 2008, Annual Meeting Minneapolis Convention Center, Minneapolis, Minnesota
Sponsor: Emergency Nurses Association. Contact: Emergency Nurses Association, 915 Lee St, Des Plaines, IL 60016. Phone: (800)243-8362; fax: (847)460-4001; E-mail: enainfo@ena.org.

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