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Special Report: Care for Dying Children

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January 2001

New palliative care guidelines ask: What are you doing for dying children?

The ED has a key role in care of terminally ill children, their families

It was one of the worst clinical experiences that **Marcia Levetown**, MD, FAAP, can remember: During her fellowship at Children's National Medical Center in Washington, DC, one winter, two sisters were rushed to the ED after being found in a freezing cold pond.

"They weren't found for a number of hours, so it wasn't clear how long they had been submerged," she recalls. "There was a 2½-hour attempt at reviving the dead children."

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The mother was outside the door of the two crash rooms, the final resting places of her only two children. "She was screaming and wailing and wanted to come in to see her girls, but no one would allow her to," says Levetown, a member of the American Academy of Pediatrics (AAP) Committee on Bioethics.

When the children were finally declared officially dead, the mother was brought into a separate room to be calmed down, without ever having the opportunity to be with the girls or to ask questions of their health care team, says Levetown, "The memory of that still haunts me," she admits. "We could have been much more humane in this case."

New guidelines on palliative care for children from the Elk Grove Village, IL-based AAP call for new approaches to prevent these disturbing scenarios,

EXECUTIVE SUMMARY

New guidelines from the American Academy of Pediatrics on palliative care for children call for new approaches to care for dying children.

- You'll need to collaborate with colleagues who have special training, such as social workers, hospital chaplains, or child life therapists.
- Whenever possible, ask children for input about their care.
- Give family members a private room after the death of a child.

says Levetown. "We need to change our paradigm in the ED when we encounter either children who have been mortally injured or children who are chronically ill with a life-threatening condition, to better meet the needs of children and families."

Of the 53,000 U.S. children who die annually, only 1,500 die of cancer, Levetown notes. "Half of these children die of trauma, which has clear implications for both prevention and preparation in the ED setting."

You're in a key position to advance the use of the guidelines, stresses **Darlene Bradley**, RN, MSN, MAOM, CCRN, CEN, director of emergency/trauma services for University of California-Irvine Medical Center in Orange. "The ED nurse can manage the physical care given and augment this with the psychosocial care that is also needed."

Here are ways to improve palliative care of children and comply with the AAP guidelines:

• **Focus on increasing the child's comfort.**

In the ED, efforts at prolonging and preserving life are the main focus, but avoiding unnecessary pain by using local anesthetics, keeping invasive therapies to a minimum, and aggressively treating discomfort and anxiety should be an equally important priority, encourages Levetown.

"Managing symptoms is an important part of what our goal and mission is," she says. "In the past, it's taken a back seat to our efforts to prolong and preserve life. This weighting of priorities needs to swing to a more balanced approach." **(See related story on pain management, p. 38.)**

• **Ask children for input.**

Giving children even a modicum of control can be helpful in decreasing their anxiety, says Levetown. "While very young children can't make completely autonomous decisions, it is ethically imperative to solicit their preferences and try to honor them."

For example, a seriously ill child may need to have an IV placed, says Levetown. "If the child is still conscious, why not ask them if they want it in their right or left hand? What harm is there in doing that? It will make the child feel important," she says. **(See story with three challenging cases involving terminally ill children, p. 35.)**

• **Collaborate with others to give the best possible care.**

View palliative care and bereavement support as a "team sport," suggests Levetown. "The idea is not for ED staff to be fully responsible for all aspects of care, but rather to be able to diagnose the need for these issues to be addressed."

Levetown recommends calling upon colleagues who have special training, such as social workers, hospital chaplains, or child-life therapists.

The AAP guidelines recommend a more holistic approach that is centered on the patient, the caregivers, and support personnel, Bradley notes. Work with programs that support the mission for caring for children, she urges. Pediatric specialists, chaplains, social service workers, case managers, medical and nursing personnel, child-life specialists, and counselors can be brought together to form a palliative care team, she suggests.

These teams would be most beneficial when they can begin care planning for patients right after the patient comes to the ED, says Bradley. "That care plan developed by the team could then become the treatment plan for all care providers both in the inpatient and outpatient settings," she says.

• **Send a bereavement card.**

At Santa Barbara (CA) Cottage Health Systems' ED, a bereavement policy includes sending a card from the ED staff to the family of any patient who dies in the ED or soon after they are cared for in the ED, says **Denise Huff**, RN, BSN, CEN, director of emergency and trauma services.

Huff checks daily for deaths using the ED log, which has four disposition choices: admit, home, transfer, or died. Huff places a sheet with the demographics and cause of death in a file, and nurses regularly check the file and send the card. **(See sample Bereavement Follow-Up Program policy, inserted in this issue.)**

• **Learn from nurses who excel at helping grieving families.**

Huff says that the staff have grown to realize that some nurses are better at this than others. "We move assignments around sometimes, because we know that the patient or child who will die will have better care," she says. "We learn from watching our peers who excel at this."

Be honest and show emotion, recommends Huff. "Just let them know you care and how sorry you are and help them through this," she says. "Assign someone to them until they physically leave the department."

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COMING IN FUTURE MONTHS

- Create a 'pedi-corner' for kids
- Effective ways of marketing your ED to nurses
- How to educate patients about asthma
- Update on pediatric airway management

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COTTAGE HEALTH SYSTEM

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SUBJECT: Family Witnessed Resuscitation

DEPT.: Emergency POLICY #: ED-38 RECOMMENDED: Denise Huff, SBCH DATE: 6/00
B. Kline, VP SYVCH
Rose Bray, GVCH

ORIGINAL POLICY EFFECTIVE DATE: 2/98 APPROVED BY: Judith Berg, RN MS DATE: 6/00
Sr. VP Nursing

DATE REVISED:

DATE REVIEWED: 5/00

GOAL:

To provide an environment within the Emergency Department that allows family members and/or significant others to be with their loved one during resuscitation or at the time of death.

POLICY:

The Emergency Department will provide guidelines and inservice for offering the option of family/significant other presence during resuscitation efforts in selected cases.

PROCEDURE:

1. The Emergency Department (ED) will participate with Pastoral Care in implementing this option to families. Pastoral Care will continue to be involved in providing a supporting role to critically ill or dying patients whenever possible.

2. ED staff will participate with the ED physician and pastoral care in evaluating each situation and family/significant other regarding the option for family presence during resuscitation.

3. No family member or significant other will be escorted into the treatment room during resuscitation without prior consent of the treating ED physician and ED team.

4. The family member/significant other will enter the treatment room during resuscitation only with the escort of a chaplain or a nurse specifically assigned to support the family member.

5. Before entering the treatment room, the family/significant other will receive an explanation by the support person(chaplain or nurse) of the patient's condition, appearance, and the equipment and treatments that are in use in the room.

6. If the family member in the treatment room becomes faint, hysterical or disruptive, the support person will immediately escort him/her from the room and arrange appropriate care.

7. Families/significant others that participate in this program will receive a bereavement follow-up questionnaire asking for the feedback on their experience. This information, combined with ED staff feedback, will be utilized to determine the success of the program and help determine the value for continued use in the ED.

SBCH AND GVCH EMERGENCY DEPARTMENT ONLY.

ADDENDUM:

GVCH ED: Pastoral care not available on regular basis, each case will be considered on individual basis.

Source: Santa Barbara (CA) Cottage Health System.

SOURCES AND RESOURCES

For more information about palliative care in the ED, contact:

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- **Roxie Foster**, PhD, RN, FAAN, University of Colorado Health Sciences Center, School of Nursing, C288-10, 4200 E. Ninth Ave., Denver, CO 80262. Telephone: (303) 315-6099. Fax: (303) 315-0619. E-mail: Roxie.Foster@UCHSC.edu.
- **Denise Huff**, RN, BSN, CEN, Emergency Department, Santa Barbara Cottage Hospital, Pueblo at Bath Streets, Santa Barbara, CA 93102-0689. Telephone: (805) 569-7879. Fax: (805) 568-8228. E-mail: dhuff@cottagehealthsystem.org.
- **Marcia L. Levetown**, University of Texas Medical Branch at Galveston, 301 University Blvd., Route 0566, Galveston, TX 77555-0566. Telephone: (409) 747-2090. E-mail: mlleveto@utmb.edu.

A copy of the American Academy of Pediatrics (AAP) policy statement, *Palliative Care for Children* (published in the August 2000 issue of *Pediatrics*) is available. AAP policy statements can be downloaded free from the Web site (www.aap.org/policy/re0007.html), or can be purchased for $1.95 each, including shipping and handling. To order materials, contact:

- **AAP Publications Department**, P.O. Box 747, Elk Grove Village, IL 60009-0747. Telephone: (800) 433-9016 Ext. 4086 or (847) 434-4086. Fax: (847) 228-5245.

• **Review patient classifications.**

Caring for the child with terminal illness, lethal congenital conditions, or heritable disorders presents challenges to ED nurses because they require more than just supportive care, Bradley notes.

Because of this, all patient classifications are important to address and review at least periodically in the ED, Bradley advises. "Patients that require palliative treatment could have prolonged stays beyond what is required to do supportive care, because the psychosocial issues of the patient and their family must also be addressed."

Streamlined pathways that assist nurses in addressing needs and expediting care would improve service delivery, she recommends.

• **Give the family privacy.**

Make a private room available for family members to be with the child after death occurs, for as long as they need to be there, Levetown urges. "Give them a place to stay until other family [members] are able to gather. They may want to take molds of the child's hands, bathe the child's body, change them into clean clothes, take pictures, or hold them one last time," she says. "All those things help to bring closure." **(See related story on how to debrief your staff, below, and meet the needs of families, p. 34.)**

However, private space isn't commonly available in the ED, Levetown notes. "Death in the ED is not unusual, so staff may question the need to have that kind of facility available," she says.

Bradley points to her ED's designated "Special Care" unit, which has private rooms in a section that is quieter and has limited access. "Locations such as this are useful to ensure the privacy of these patients and their families," she says. "Family rooms, grief or meditations rooms can also be used to provide privacy for the family."

Providing privacy for families might not be easy in a busy ED, but it's a necessity, Huff emphasizes. "Close doors, anticipate your need for privacy, and provide it," says Huff. "We are experts at setting priorities. This is a priority, and it can be done." ■

Provide debriefing for staff members

Your bereavement program should include critical incident stress debriefing for care providers, says **Darlene Bradley**, RN, MSN, MAOM, CCRN, CEN, director of emergency/trauma services for University of California-Irvine Medical Center in Orange.

"Generally, we don't expect children to die, but when it happens, stress debriefing helps staff come to terms with the death and to review any measure of care that could be bothersome to the provider," she suggests.

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When Bradley was working with a team resuscitating an infant who appeared to be a victim of sudden

(Continued on page 34)

Bereavement Follow-Up Program for Patients Who Expired in the ED

Dear _____,

We, the Emergency Department staff at Santa Barbara Cottage Health System, express our sympathy on the death of your loved one.

Though this time has been difficult for you, we would appreciate your answering a brief questionnaire addressing your impressions and feelings about the staff's interactions with you. Your comments will help us work more effectively with patients, families, and friends during efforts to revive their loved one.

Thank you for your cooperation with our efforts to make sure we offer the best service possible to the people who come to SB Cottage Hospital Emergency Department. Please be assured your responses and your identity will remain confidential. Please feel free to contact me if there are any questions or concerns.

With sincere gratitude,

Denise L. Huff, RN
Nursing Director
Emergency Department

Emergency Department Questionnaire
Family-Witnessed Resuscitation

Please <u>circle</u> the response that represents your feelings.

1. Were you specifically asked by an Emergency Department (ED) staff member if you would care to be present in the room during the resuscitation effort of your relative or friend?
   Yes No Do not recall
2. Do you feel that you were adequately informed in advance of what you would see when you entered the resuscitation room?
   Yes No Do not recall
3. Were you accompanied into the room by a nurse or chaplain?
   Yes No Do not recall
4. Did you touch your relative or friend shortly after entering the room?
   Yes No Do not recall
5. Did you talk to your relative or friend shortly after entering the room?
   Yes No Do not recall

How strongly do you agree or disagree that:	**Strongly disagree**				**Strongly agree**
6. The ED staff were doing all they could have done for your relative or friend:	1	2	3	4	5
7. The ED staff explained what was being done to your relative or friend:	1	2	3	4	5
8. You would choose to participate again in the resuscitation effort:	1	2	3	4	5
9. You would encourage other people to participate in this experience:	1	2	3	4	5
10. This experience, though painful, was helpful for you in adjusting to the death of your loved one:	1	2	3	4	5
11. Your presence was meaningful for your relative or friend:	1	2	3	4	5
12. Your presence was helpful to ease the transition into death for your relative or friend:	1	2	3	4	5

(Continued)

How could the ED staff have been more sensitive to your needs, both during and after resuscitation efforts?

_____
_____
_____
_____
_____

Other comments or suggestions:

_____
_____
_____
_____

Please contact me if you need or want to discuss your experience further. I can be reached at XXX-XXXX. Your responses and identity will be kept in the strictest of confidence.

Thank you for this feedback.

Denise L. Huff, RN
Nursing Director
Emergency Department

Source: Santa Barbara (CA) Cottage Health System.

infant death syndrome, the mother of the baby had just returned that week to work after a prolonged maternity leave. "The mother had done everything right, even leaving the baby in the care of a very competent child caretaker skilled in CPR," she says. "This case affected every nurse in the department."

Long-term accumulations of stress can lead to physical and mental problems as well as burnout, Bradley warns. "Providing the staff a chance to address their fears, concerns, anxieties, or guilt can prevent the disorders seen from chronic stress."

Peer support groups are also helpful, says Bradley. "These programs assist the providers in working through their feelings about loss and death." ■

Here's how to meet needs of families

Are you effectively meeting the needs of families with a terminally ill child in your care? If not, you're not in compliance with new guidelines from the Elk Grove Village, IL-based American Academy of Pediatrics (AAP) on palliative care for children, warns **Marcia Levetown**, MD, FAAP, a member of the AAP's Committee on Bioethics.

Here are ways to ensure you're meeting the needs of family members:

• Consider end-of-life issues for chronically ill children.

Even if a parent who previously negotiated advance care plans for their child calls 911, it might not mean they want lifesaving measures to be done, argues Levetown. "They may want help managing symptoms, anxiety, and fear."

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A family member's exhortation to "do everything" may not mean what you think, Levetown suggests. "'Everything' doesn't always mean putting in a central line and doing CPR," she adds. It might mean doing everything to make the child comfortable, she says. "That means making sure the child and family are together as much as possible, that the patient's breathing is made easier, and that the patient doesn't end up in the ICU with a tube in their throat if that is not desired."

Preserving life and making the patient comfortable are both important goals, says Levetown. "The goal may be to control the symptoms, rather than engage in invasive therapies that may not be of value or interest to the patient and family."

In the ED, survival may be perceived as the only good outcome, says Levetown. "But children do die, sometimes because they were never really meant to live. A child may have a malformation or metabolic defect and won't be able to survive no matter how hard we try."

Sometimes death is prolonged for reasons that are not clear, Levetown argues. "We might need to reconsider what it is that we are doing and what goals we are achieving. Even in the ED, we need to consider the extent of suffering."

There is a difference between a child with neurological devastation with pneumonia and a child with community acquired pneumonia who is normally healthy, Levetown notes. "We do need to get the big picture and discuss with family members. You can bag the child, give an antipyretic, and stabilize. But you may want to ask the family, 'What is it we are hoping to accomplish here?'"

• Ask the family how you can make them as comfortable as possible.

Ask family members if they would like to stay in the hospital or be on a particular floor with familiar nursing personnel, suggests Levetown.

• Allow family members to be present.

A severely ill child is part of a family, Levetown stresses. "By only treating the child, we are missing out on the ongoing support of the child and family. Enabling a family member to be present during procedures is an important part of lessening the discomfort the child experiences."

New guidelines from the Dallas-based American Heart Association (AHA) recommend that family members should be allowed to be present during efforts to resuscitate, reports Levetown. "This ensures that people have peace, knowing that all reasonable efforts were used to assist their child, and that the ED personnel cared." **(For more information on the AHA guidelines and family presence, see *ED Nursing*, November 2000, p. 15.)**

It also gives them a chance to be of help to their child in what could be the final moments of his or her life, Levetown advises. "Ask the family member to stand at the head of bed and talk to the child, to touch the child's cheeks, to hold his or her hand, instead of simply throwing them into a chaotic setting with no defined role."

At Santa Barbara (CA) Cottage Health System's ED, a family witnessed resuscitation policy and procedure was implemented after a consensus was reached at a staff meeting. "We all realized nobody would be able to keep any of us out, so how could we do that to another parent or loved one?" says **Denise Huff**, RN, BSN, CEN, ED director and trauma services. "ED nurses only have to put themselves in the role of a parent of a dying child, and they will change their behaviors." **(See sample Family-Witnessed Resuscitation policy, p. 31.)**

The staff makes every effort to connect patients and families in this situation as soon as possible, but ultimately it is up to the resuscitation team to give the OK, says Huff. "We have never been denied by the team and have been part of some very beautiful end-of-life events."

ED staff have received some training from the pastoral care department on how to be the support person for this role, Huff says. "The importance of the support person cannot be emphasized enough. This person must be aware of the patient's condition, and be able to prepare the family for what they will see and hear."

That individual person also must prepare the family member to interact freely with their loved one, says Huff. "The support person also has to be freed of other responsibilities for a portion of time to stay with the family," she stresses. "The staff has to be supportive of this role and may have to pick up the slack for a time while this is going on."

• Ask for feedback.

After the event, contact family members to ask if you helped them adequately, suggests Huff. "We send a survey to family-witnessed resuscitation families two months later, and we ask them if we met their needs." **(See letter and Emergency Department Questionnaire, pp. 33-34, listed above.)** "Past patients are our best teachers." ■

How would you handle these 3 cases?

The care you give to a child with a life-threatening condition varies on the individual circumstances, says **Marcia Levetown**, MD, FAAP, a member of the Committee on Bioethics for the Elk Grove Village, IL-based American Academy of Pediatrics.

Here are three case studies, with Levetown's suggestions for how to manage each:

Case No. 1: An 8-year-old child is admitted to the ED for fever of three days' duration, increasing cough and

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vomiting, and increased seizure activity. He has a fever of 39, respiratory rate of 35 with flaring and retractions, and a heart rate of 130. He is pale. He has crackles at the right lower lung field posteriorly. He also has flexion contractures in all extremities and is cachetic. He has a G tube. Past medical history includes four admissions this year alone for pneumonia, birth asphyxia, seizure disorder, and inability to speak. He does not recognize his family, even when well. At his best, he seems to smile when music is played. He has a loving mother and two siblings, ages 8 and 4. The parents are divorced, and the mother is on public assistance because of the care needs of this child have caused her to lose several jobs.

You should ask the following questions, says Levetown:

- Is it appropriate to treat the decisions regarding the goals of care for this child the same as for an otherwise healthy child with pneumonia?
- What is the cause of this pneumonia? Is it likely to recur?
- Is this child terminally ill?
- Is he a candidate for palliative care?
- Is it required to intubate him if he deteriorates?
- How does one broach the topic of goals of care with his mother?
- Does she have the ethical and legal right to forgo life-prolonging medical interventions on his behalf?
- What positive things can be offered to her if she chooses this route? Does Child Protective Services or an ethics committee have to be involved?

This child has recurrent aspiration pneumonia, and it is likely to be recurrent and the eventual cause of his death, says Levetown. "Which episode will be his last is unpredictable. Thus, there is a need to institute palliative care before this occurs."

His mother and siblings have sacrificed a lot for this child, but he might not be deriving much benefit from the efforts they are making, says Levetown. "It is a loving and selfless act to allow him to die in peace if it is his time," she says. "This is an ethically supportable decision and is within the law."

Families need permission to feel they are not abandoning their vulnerable children by making such choices, she says. "The positives that can be offered include the willingness to aggressively treat any sensation of shortness of breath and fever and increase the chances that his family will be present when he dies."

Tell teen she has cancer?

Case No. 2: A 13-year-old of normal intelligence with disseminated neuroblastoma has never been told she has cancer, despite the fact that she has been to cancer camp and has been admitted to the oncology ward four times a year on average for three years. Her cancer is progressing. She presents to the ED in a lot of pain from tumor in her pelvis and femur, as well as new onset of abdominal pain. A CT reveals numerous large, centrally necrotic nodes.

She says she knows she has cancer, and she is tired of all the medical treatments. She does not want to engage in any more efforts to prolong her life. She realizes she has been getting rapidly worse, having nose bleeds, etc., and increased bone pain. She does not want to be stuck any more; she wants to be in her bed at home. She is not depressed. She begs you to free her from her pain and assist in getting her mother to understand that she cannot keep doing this.

The nurse's role is to gently educate the mother that the child already knows she has cancer and is dying, and encourage open communication between them, recommends Levetown. "You should also be honest with the child, answering direct questions truthfully and in language the child can understand."

Be an advocate for improved communication between the health care team and the family, says Levetown. "You can also call an ethics consult if there is continued unwillingness on the part of the family to speak with the child about her condition and preferences."[1,2]

15-year-old dies in ED

Case No. 3: A 15-year-old male is brought to the ED with a gunshot wound to the chest. He is not responding to closed chest massage, and he undergoes emergent sternotomy and open-chest massage. His atrium has a back wall blow out and, despite heroic efforts to revive him, he dies shortly thereafter. His parents are waiting in the hall.

After breaking the bad news in a compassionate manner in an appropriate environment, offer to take the parents to a private room to be with their son as long as they like, Levetown advises."Offer to call their chaplain or one from the hospital, get the social worker to help them with calls, and ask child life to assist with the sibling issues."

Levetown also recommends a coordinated program for bereavement follow-up, including a bereavement card.

References

1. AAP Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. *Pediatrics* 1995; 95:314-317.
2. King NMP. Children as decision makers: Guidelines for pediatricians. *J Pediatr* 1989; 115:10-16. ■

Here are ways to make dying children comfortable

New palliative care guidelines from the American Academy of Pediatrics draw attention to aspects of care that are not routinely focused on in the ED, reports **Darlene Bradley**, RN, MSN, MAOM, CCRN, CEN, director of emergency/trauma services for University of California-Irvine Medical Center in Orange.

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"When we care for children, we generally think of injury that is trauma-related and illnesses that are part of growing through the stages of child development," she says. "Our focus for education is generally on injury prevention."

Palliative care provides for the relief of symptoms resulting from the physical ailments and from conditions that might interfere with the child's ability to enjoy life, Bradley explains. There is a lot you can do in the ED to make these children comfortable, she urges. Here are ways to increase comfort of dying children:

• Increase your knowledge of pain management.

You might have misconceptions about the use of opioids for both pain management and dyspnea, warns **Marcia Levetown**, MD, FAAP, a member of the American Academy of Pediatrics Committee on Bioethics. "I exhort nurses to understand that these symptoms can be controlled safely. If you feel you lack knowledge in this area, you need to take every step to remedy that."

One study asked ICU nurses given orders to administer opioids to patients who remained on ventilators whether they felt they were committing euthanasia.[1]

"A huge percentage said yes, when in fact studies have shown that patients are not only more comfortable, but live longer when given opioids,"[2] says Levetown.

The dangers of pain medications are overblown, Levetown emphasizes. "This common exaggeration of the risks may prevent us from giving the humane care that is at our disposal to give, that does not compromise our ethics. By giving medications and alleviating suffering, we have the power to make patients comfortable until the very last moment of their lives."

Sophisticated knowledge of pain management helps to ensure that children will never suffer needlessly, says **Roxie Foster**, PhD, RN, FAAN, associate professor at University of Colorado Health Sciences Center School of Nursing in Denver. "Our goal must be to relieve as much pain as possible."

Comfort is one of the few aspects within our control when caring for a terminally ill child, says Foster. "Parents tell us that it makes a tremendous difference to know their child did not suffer," she says. "Optimal pain management can ease not only the immediate loss but also assists families as they relive the experience in the long process of recovery." **(For information on educating staff, see story, p. 38.)**

• Accept that symptom management is an important goal.

Not every patient benefits from the most aggressive therapies possible, argues Levetown. "We need to consider the context of the whole person and think about whether or not it's reasonable to do our 'normal' things to this patient. We shouldn't use technology simply because it's available."

Whenever a child develops a life-threatening condition, turn your attention to the physical, psychosocial, and spiritual comfort of the child, urges Levetown. "Do this whether the goals of the present moment are life extension or increasing the child's comfort, regardless of the length of life."

Don't automatically use technology

• Use alternatives.

This is an opportune time to utilize alternative therapy concepts such as music therapy and distraction techniques, says Bradley. "In a chaotic ED, I have seen a container of aromatherapy oils put out that had a calming effect on the staff."

Similarly, patients that are tachycardic, anxious, or nervous benefit from music therapy, Bradley notes. "There is music that beats at a rate of 60 per minute, and this musical rate has been documented to lower the patients heart rate and promote relaxation.[3] Some facilities have a central system piped in to patients' rooms that provides music."

Music that is quiet and calming in nature might have positive effects on the staff as well as the patients and family members, Bradley suggests. "Music can also be used as a distraction where children that are chronically ill can be entertained or encouraged to sing along with Disney songs, for example."

There also are many published studies on touch that includes massage, Bradley says. "Chronically ill children seem to be comforted by the touch of the caregiver. There is also a published study demonstrating satisfaction with care when sometime during the care, a gentle touch was given to the patient by the caregiver."

Alternative approaches are sometimes limited by the attitudes and beliefs of parents and professional staff, says Foster. "In high-tech settings, parents may expect high-tech approaches," she explains. "They may need gentle encouragement to see the value in traditional

comfort measures and alternative measures."

Research about alternative therapies can help professional staff decide which measures are most appropriate, Foster suggests. "Parents may be reassured when they know alternative approaches have a research base."

Foster cautions that family beliefs and values are paramount, however. "Ask, 'Are there are pain relief measures you wish to avoid for personal or religious reasons?'" she recommends. "Also ask what comfort measures parents use at home. Then manipulate the environment to allow these mutually comforting activities in the emergent setting."

References

1. Asch DA. The role of critical care nurses in euthanasia and assisted suicide. *N Eng J Med*. 1996; 334:1,374-1,379.
2. Partridge JC, Wall SN. Analgesia for dying infants whose life support is withdrawn or withheld. *Pediatrics* 1997; 99:76-79.
3. Good M, Picot BL, Salen SG, et al. Cultural differences in music chosen for pain relief. *J Holistic Nurs* 2000; 18:245-261. ■

Increase staff knowledge of pain management

With new pain management standards from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, hospitals have been alerted to the need for increased education on this topic, says **Roxie Foster**, PhD, RN, FAAN, associate professor at University of Colorado Health Sciences Center School of Nursing in Denver.

"Thus, it is an excellent time for nurses to let administrators know exactly what education they need," Foster recommends. **(For more information on the new pain management standards, see *ED Nursing*, March 2000, p. 53.)**

The most effective education is evidence-based, ongoing, provides a variety of forums for learning, and establishes a base for expert judgments, she says. "Occasional consultation visits from pain management experts can validate local efforts and open a dialogue about practices in other areas," Foster adds. "Many of these experts have sponsors to offset consultation costs."

Look at literature, conferences

To locate experts, search current literature on pain management, Foster suggests. "The experts are usually well-published, and their contact information is listed with the article," she says. "Also ask co-workers about speakers they have heard at conferences who might make good consultants."

Stay abreast of the current literature in pain management, Foster urges. "Ask the hospital librarian to prepare a monthly update of pain-related articles available within the institution," she says. Selected articles might be collated in a notebook on the unit and the information used for evidence-based practice initiatives, she adds.

Journal clubs are a good way to start a dialogue with physicians and other professionals, suggests Foster. "These usually involve discussing one or more articles of interest that are made available to the group in advance." This provides an opportunity to review sophisticated literature and to discuss its relevance and application for the population of interest, says Foster.

"Interdisciplinary partnership is a prerequisite for optimal pain relief," she says. ■

Short of nurses? Why not 'grow your own'?

(Editor's Note: This is the second of a two-part series on the nursing shortage. In last month's issue, we covered how to retain nursing staff. This month, we cover nurse internship programs and recruiting.)

Is your ED short-staffed due to the nationwide nursing shortage? Are you finding it hard to recruit qualified nurses to your ED? Progressive EDs are thinking ahead and "growing" their own.

At Robert Wood Johnson University Hospital in New Brunswick, NJ, an ED training program was developed in response to a tremendous shortage of ED nurses and expansion of services. "We tried to get experienced nurses to work in the ED, and there was

EXECUTIVE SUMMARY

A growing number of EDs are starting nurse internships to reduce vacancy rates during the nursing shortage.

- Clinical experience and orientation is more thorough with in-house nurse training programs.
- You can influence the work habits that nurses develop.
- Nurses feel a sense of loyalty to the hospital after completing the program.

little response to our recruitment," says **Kathleen Evanovich Zavotsky**, MS, RN, CCRN, CS, CEN, CNS, C, ED clinical nurse specialist. "The responses we did get were from many nurses who did not have ED experience, but had either telemetry experience or prehospital experience."

The program was designed to help develop those nurses into ED nurses, says Zavotsky.

Here are some benefits of ED nurse training programs:

• Less use of agency nurses.

In addition to lower vacancy rates, there is less utilization of temporary help such as agency nurses and traveling nurses, says Zavotsky. This helps to ensure that nurses have an understanding of the hospital's services and operations.

• Nurses are given a chance to change career paths.

Since there is a shortage of experienced nurses for specialized areas, it's necessary to train nurses from other areas, says **Amy Atnip**, RN, MSN, director of emergency services at Medical Center of Plano (TX). "An internship gives them their best start and hopefully result in a successful career transition."

Nurses from areas such as a cardiac or telemetry floor, cardiac cath lab, or other specialty area usually make good ED nurses because they already have a cardiac background and sense of urgency, says **Sandy Vecellio**, RN, BSN, ED clinician at Gwinnett Medical Center in Lawrenceville, GA. "The biggest asset that an ED nurse must have is organization and knowing that certain things need to be done first."

• Vacancy rates are reduced.

Currently, the internship program is assisting in filling vacant positions, Atnip reports. "However, ED nursing is still in a state of change in which many long-term nurses are leaving the field completely, and enrollment in nursing schools is down."

Unfortunately, for each nurse hired, sometimes one is lost, says Atnip. "However, with the continuation of an internship, programs will continue to become better known with more nurses wanting to gain ED experience, and also allow for the training of nurses without emergency nursing experience," she adds.

The interns also feel a sense of belonging to the hospital, so they are more likely to stay, says Vecellio. "They also sign a two-year contract with us, so we know they usually will stay or they have to pay the hospital back a certain amount of money," she says.

Last year, six interns filled holes in the nursing staff, says Vecellio. "This helped, since at the end of the summer we actually had 14 nursing vacancies," she reports. "So with the six new interns, that almost cut that vacancy in half."

The cost of the internship is significant, since the ED pays the nurse candidates' 12 weeks of salary, in addition to salaries of instructors and preceptors, says Vecellio. "But with them signing a two-year commitment with us, it helps with our vacancy rates. So the money spent on them to do this was well worth it."

• Nurses receive a better orientation.

An internship program allows for an extended clinical orientation period ensuring that the new nurse receives enough training, says Atnip. "The ED does not always allow for a smooth orientation process due to patient load," she explains. "This way, we are assured that the new nurses are better prepared for their own patient assignment when released from orientation."

• Clinical experience is improved.

If you take two nurses who have never worked in an ED before and place one in an internship program with classroom time and extended orientation and place the other nurse directly into the clinical area for orientation only, the nurse who went through the formal internship program is much more likely to succeed, says Atnip. **(See story on course material in three ED internship programs, p. 41; and sample course objectives for the ED, p. 40.)**

Classes that are taught by practicing ED nurses, physicians, and ancillary staff are much better able to relate lecture materials to real-life situations and give those needed "pearls" about watching out for potential problems in certain situations, says Atnip. "This type

(Continued on page 41)

SOURCES

For more information about ED nurse internship programs, contact:

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Emergency Department Specific Objectives

- **Assessment/Reassessment of Emergency Patients**
  To standardize the nursing assessment in the ED.
  Define how to incorporate the nursing process with each assessment.
  Define policies regarding assessment of the ED patient at GHS.
  Define process of reassessment of the ED patient.
- **Eye, Ear, Nose, and Throat**
  Identify emergencies related to the eye, ear, nose, and throat.
  Identify the major structures of the eye, ear, nose, and throat.
  Describe nursing care of the patient with eye, ear, nose, and throat emergency.
- **Chest Pain in the ED**
  Identify what an MI is.
  Describe clinical presentation of a patient presenting to the ED with chest pain.
  Define what tPA is and how it is administered.
  Define what the ASSENT III study is and what drugs are used.
  Identify different anticoagulant therapies used with patients with chest pain.
- **Musculoskeletal Emergencies**
  Describe signs and symptoms to look for on a patient with musculoskeletal injury.
  Identify types of musculoskeletal injuries seen in the ED and treatment of each.
  Describe and perform proper splint application.
- **Pulmonary Emergencies, Asthma, Pneumonia, PE**
  Identify types of respiratory emergencies presenting to the ED.
  Define assessment and treatment of various respiratory emergencies.
- **Environmental Emergencies**
  Identify types of environmental emergencies seen in the ED.
  Describe the process of reporting environmental emergencies in the ED.
- **Disaster Preparedness**
  Identify types of disasters and what your role would be.
- **Pediatric Assessment**
  Describe nursing assessment of the pediatric patient in the ED.
- **Pediatric Medical Emergencies**
  Identify types of pediatric medical emergencies in the ED and care of each.
- **Surface Trauma Burns**
  Identify types of burns in the ED and assessment and care for each.
  Identify complications in the burn patient.
- **Legal and Ethical Considerations**
  Identify terms related to legal and ethical issues seen in the ED.
- **Abuse: Elderly, Child, Domestic**
  Identify types of abuse seen in the ED.
  Describe legal process taken for patients in the ED who present with abuse or suspected abuse.
- **Psychiatric Emergencies**
  Define types of psychiatric emergencies seen in the ED.
  Describe process of 10-13, 20-13, and legal implications.
- **Abdominal Pain**
  Describe assessment of patient presenting to ED with abdominal pain.
  Identify labs and protocols used for patients presenting to ED with abdominal pain.
- **Trauma**
  Identify roles of resuscitation of the trauma patient in the ED.
  Describe assessment and treatments of the trauma patient in the ED.
- **Pediatric Trauma**
  Identify assessment of the pediatric trauma patient in the ED.

Source: Promina Gwinnett Hospital System, Lawrenceville, GA.

of practical knowledge is more reality based, and can benefit the new nurse much more." ■

Sample internship course outlines

What you teach nurses in an internship program can make or break your chances for success, stresses **Hollie Gehring**, RN, CEN, ED nurse clinician at Medical Center of Plano (TX).

In the ED's internship program, classroom lectures are focused on specific emergency situations, says Gehring. "This ensures that nurses obtain the knowledge base needed to make appropriate decisions in the clinical area."

In the ED, decisions often must be made rapidly and independently, says Gehring. "Classroom time provides each nurse with the fundamentals needed to make appropriate clinical decisions in the ED."

Hospital uses weeklong course

Here are summaries of the content of three successful ED nurse internship programs:

At Robert Wood Johnson University Hospital in New Brunswick, NJ, the hospital and ED nursing leadership worked together to develop a weeklong didactic course to prepare the nurses to work in an adult ED, says **Kathleen Evanovich Zavotsky**, MS, RN, CCRN, CS, CEN, CNS, C, ED clinical nurse specialist. The course content is based on the common problems of the ED patient, such as neurological and abdominal emergencies, as well as the Emergency Nurses Core Curriculum.

"After the curriculum development, we then looked at the clinical piece of the training program," she explains. "We looked very closely at the orientation manual that we had for the ED with the experienced preceptors and made the necessary changes."

For example, a competency checklist for assessing fetal heart tones was added, says Zavotsky. "Being a Level 1 Trauma Center, we were seeing an increase in pregnant trauma patients," she says. "So the preceptors wanted to include this as a basic competency during orientation."

Nurses taught to be preceptors

A preceptor workshop was held for experienced nurses to help prepare them for the new nurses. "We estimated that most of the new nurses would need about 10 weeks of clinical orientation in addition to the weeklong didactic session," says Zavotsky.

The first program was offered to five in-house transfer candidates, so issues could be identified and necessary improvements made before outside candidates were contacted. "We then opened the program to outside candidates and advertised through the nursing journals, conferences, and the Internet," Zavotsky reports.

At Medical Center of Plano, the internship is a 13-week course in which 15 eight-hour class days are front-loaded and the rest of the time is spent in clinical applying newly acquired knowledge to specific patient situations, explains **Amy Atnip**, RN, MSN, director of emergency services.

Managers reserve space for nurses

Each ED manager is responsible for the hiring of general nurses or inexperienced nurses and then reserving a space for them in the internship program. There are identified preceptors at each facility to assist each new hire with their clinical orientation. The process in which clinical orientation is accomplished is up to each individual facility, Atnip explains.

At the end of the 15 class days, a test is given to establish baseline competency coming out of the program and also to identify areas in which the orientee may need special attention at the clinical site, says Atnip. "Some managers have chosen to have the orientee repeat the test at the end of their clinical rotation in hopes to show improvement," she explains.

At Promina Gwinnett Health System, managers at the five EDs in the hospital system select interns, says **Sandy Vecellio**, RN, BSN, ED clinician at Gwinnett Medical Center in Lawrenceville, GA. "The managers look at their vacancies and then determine how many they can put in each area. This past year, we had six interns in the program, all new graduates."

The 12-week program includes two classes per week and two to three days of clinical to make 40 hours. "In the ED rotation, they have to go through all five EDs. At the end, the decision is made which ER

SOURCE

For more information on nurse internships, contact:
- **Hollie Gehring**, RN, CEN, Emergency Department, Medical Center of Plano, 3901 W. 15th St., Plano, TX 75075. Telephone: (972) 519-1505. E-mail: hollieg@airmail.net.

department they will go to, and they have input into this, also," she says.

Last four weeks cover ED

The classes are specifically geared toward the ED during the last four weeks, covering cardiac emergencies, trauma, shock, and orthopedic emergencies. "The students have a test after each system and must make a score of 80. If they do not make this score, they are given a case study to do on their own and return," says Vecellio.

Nurses cannot fail more than three tests or they are out of the program, says Vecellio. "There are also expectations for the clinical time as far as being on time and not absent, and getting back good evaluations from their preceptors. If we find that at the end of the internship that someone still is not quite ready to be on their own, we can work with them and give them more orientation time up to a point." ■

Get your degree on the Internet

Are Internet-based nursing degrees the wave of the future? The University of California at Los Angeles School of Nursing will offer students the option of getting a master's degree on-line. The Internet-based degree-granting program is one of the first in the country offered by a large research-oriented university.

Beginning in fall 2001, the program will allow students working toward a master's degree in nursing administration to satisfy course requirements on-line. Students will be allowed to attend the program's 11 courses, plus take any of four electives on the Internet. There also is the option of attending some classes in person and others on-line.

The on-line courses will cost an additional $30-$150 per course and will include 24-hour access to technology assistance. Participating students will be required to attend regular chat room sessions with their instructor, in addition to "attending" lectures on-line.

For more information about the master's degree program, contact Mary Anne Schultz, PhD, MBA, RN, Director of On-line Educational Development, UCLA School of Nursing, 700 Tiverton Ave., Box 951702, Los Angeles, CA 90095-1702. Telephone: (310) 825-8609. Fax: (310) 206-7433. E-mail: mschultz@sonnet.ucla.edu. Web site: www.nursing. uclaonline.org. ■

Chen ZM, Sandercock P, Counsell C, et al. **Indications for early aspirin use in acute ischemic stroke.** *Stroke* 2000; 31:1,240.

You should give all patients with suspected stroke aspirin on arrival to the ED, according to this study, which combines results of the Chinese Acute Stroke Trial and the International Stroke Trial. Giving aspirin to stroke patients can reduce the risk of recurrent strokes, say the researchers.

Starting daily aspirin promptly in patients with suspected acute ischemic stroke reduces the immediate risk of further stroke or death in the hospital and decreases the overall risk of death, says the study.

Two large randomized trials with 20,000 patients each were used. Data from 40,000 patients were analyzed and confirmed that early aspirin benefits a wide range of patients.

The study shows that aspirin provides an immediate prevention benefit in the days and weeks following the stroke.

Clinicians might have been reluctant to give aspirin immediately to stroke patients because of concern that it might cause bleeding in the brain, suggest the researchers. The study found that aspirin was much safer than initially anticipated, with the benefits outweighing the risk for all types of patients studied.

Here are key findings:

• Consider aspirin for all patients who present with signs and symptoms of acute ischemic stroke, provided that no strong contraindications are apparent, and that hemorrhagic stroke can be excluded with reasonable probability.

• The urgency of other treatments for ischemic stroke, such as fibrinolytic therapy, might cause aspirin to be overlooked.

• Because aspirin has been shown to be effective in the long-term secondary prevention of stroke after hospital discharge, you should administer aspirin promptly even to patients who present more than 48 hours after onset of symptoms.

• The ability of aspirin to prevent recurrent ischemic stroke is about as great for patients with atrial fibrillation as those without.

For maximum benefit, aspirin should be started promptly after the onset of suspected ischemic stroke and continued indefinitely, say the researchers. ▼

Singer AJ, Stark, MJ. **Pretreatment of lacerations with lidocaine, epinephrine, and tetracaine at triage: A randomized double-blind trial.** *Acad Emerg Med* 2000; 7:751-756.

Triage nurses should apply topical anesthetics to simple lacerations, according to this study from the State University of New York at Stony Brook. Researchers looked at 43 patients, 22 of whom received LET (lidocaine 2%, epinephrine 1:1000, tetracaine 2%) at triage and 21 placebo. Lacerations in the LET group were more often adequately anesthetized, and LET patients had less pain from injection than the placebo group, according to the study's findings.

Topical application of an anesthetic solution such as LET to lacerations by triage nurses is both feasible and effective in reducing the pain of subsequent lidocaine injection, say the researchers.

CE objectives

After reading this issue of *ED Nursing*, the CE participant should be able to:

1. Identify clinical, regulatory, or social issues relating to ED nursing. (See *New palliative care guidelines ask: What are you doing for dying children*? p. 29; *Here are ways to make dying children comfortable*, p. 37; and *Journal Reviews*, pp. 42-44 in this issue.)
2. Describe how those issues affect nursing service delivery.
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. ■

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Editorial Questions

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This method also might have the potential to reduce the patient's ED length of stay, they suggest. "It seems likely that having lacerations ready for injection when the emergency practitioner first evaluates them would indeed save time," they write.

They says the alternatives would be for the emergency practitioner to apply a topical anesthetic and then wait for an additional 15-30 minutes before onset of action, or proceed with lidocaine injection and wound closure without the benefit of topical anesthesia.

The researchers suggest the following:

• having triage nurses apply a topical anesthetic as soon as the patient presents to the ED;

• having triage nurses identify lacerations that necessitate some form of primary closure;

• carefully instructing nurses on the appropriate indications and contraindications for the use of LET;

• using LET instead of other topical anesthetics.

"The advantages of LET over TAC [tetracaine, adrenaline, and cocaine] and EMLA [eutectic mixture of local anesthetics] are its low cost, safety, and lack of administration issues associated with use of a controlled substance," say the researchers. ▼

Meischke H, Mitchell P, Zapka J. **The emergency department experience of chest pain patients and their intention to delay care seeking for acute myocardial infarction**. *Progress in Cardiac Nursing* 2000; 15:50-57.

Reassure chest pain patients who are sent home that they did the right thing to come to the ED for their symptoms, according to this study, which was part of the Rapid Early Action for Coronary Treatment (REACT) research. The study was designed to test the effects of a community education program on reducing prehospital delays in patients with heart attack symptoms.

A telephone survey was conducted for 426 ED patients with a chief complaint of chest pain who were released from the ED. The patients were asked about their satisfaction with ED staff communication and their intention to delay prompt action for acute myocardial infarction (AMI) symptoms in the future.

The results showed that the less education patients had, the less sure they felt that going to the ED had been "the right thing to do," the greater their embarrassment, and the greater their intention to delay action for future symptoms. Conversely, patients who were reassured by ED staff that they did the right thing to come to the ED were less likely to report intentions to delay seeking care in the future. The researchers recommend the following:

• giving counseling to ED patients with chest pain who are sent home about the importance of seeking care for chest pain, even if it turns out not to be life-threatening;

• being sensitive to feelings of embarrassment and trying to mitigate these feelings;

• improving ED staff communication;

• targeting patients with lower education levels about the importance of fast action to seek care for AMI.

Because about half of all chest patients are sent home from the ED, many patients are at risk for not responding promptly for a future chest pain event, say the researchers.

"It is critical that ED staff, including emergency medical services staff, praise chest pain patients for their actions and communicate to patients that AMI symptoms are ambiguous and require evaluation by a physician, and that fast action is the only appropriate course of action," they say. ■

Distribution Code: 2 Section: Psych Emergency Dept. Page: 9

COTTAGE HEALTH SYSTEM

Page 1 of

SUBJECT: Bereavement Follow-up Program for Patients Who Expired in the Emergency Dept. SBCH ONLY

DEPT.:	Emergency Dept.	POLICY #:	ED-7	RECOMMENDED:	Denise Huff, RN	DATE:	5/00
ORIGINAL POLICY EFFECTIVE DATE:	5/98			APPROVED BY:	Judith Berg, RN MS Sr. VP Nursing	DATE:	5/00
DATE REVISED:							
DATE REVIEWED:	4/00						

GOAL:

To assist the families of patients who expire in the Emergency Department (ED) through the grieving process by sending a card expressing our sympathies. To provide feedback to the ED staff on a death experience in the ED so we can make improvements.

POLICY:

The ED will send a bereavement card to the family or significant others of any patient who expires in the ED 2 - 3 weeks following the death. This responsibility will be shared by 2 designated Clinical Resource Nurse (CRN) within the department. In the event that the family participated in the family witnessed resuscitation program, a feedback survey will be included.

PROCEDURES:

1. The ED log will be checked daily by the Nursing Director or her designee, and a face sheet will be printed and placed in the bereavement follow-up file kept in the nursing station file. Any staff member may pull the gold copy of the chart and place it in the file as well.

2. The CRN's assigned to the program will check the file regularly and determine if a bereavement card is appropriate to send. They will have a system created for sending the card 2-3 weeks later.

3. If the family was involved in the Family witnessed Resuscitation Program, a feedback survey will be included. When returned, these will be filed by the Nursing Director and used to evaluate the FWR program on a regular basis.

F:\ED-7

Source: Santa Barbara (CA) Cottage Health System.