AMERICAN HEALTH CONSULTANTS®

ED NURSING™

Bioterrorism Watch enclosed in this issue

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Inside

November 2001

ED nurses cope with emotions after terrorist attacks: Here are strategies

Approaches range from formal debriefings to acupuncture

When you imagine a large-scale disaster, you probably envision treating scores of injured patients. For ED nurses in New York City and Washington, DC, the opposite was true after the Sept. 11 terrorist attacks: There was a chilling silence as nurses waited for patients who never came.

Immediately after the terrorist attacks occurred, the well-practiced disaster plans of New York City EDs went into effect. Nurses who were stuck in roadblocks managed to find a way to work somehow and were ready to do whatever was needed to save lives.

But after an initial rush of patients, EDs suddenly became eerily quiet. "Everyone looked at each other, but no one was saying anything. Finally I said what everyone was thinking: 'I think there are not many survivors,'" says **Anna Chin**, RN, an ED nurse at New York Presbyterian Hospital-Weill

Disaster Planning Audio Conference

The unimaginable has happened in New York City. At Saint Vincents Hospital, less than three miles from the site of the World Trade Center attack, the disaster plan was put to the test as dedicated professionals rose to the unique challenge of responding to the attack. American Health Consultants, publisher of *ED Nursing*, invites you to learn from the firsthand experience of the professionals at Saint Vincents how to take a new look at your disaster plans so that you will be ready if the unimaginable happens in your community:

- Responding to the Unimaginable: How Saint Vincents Coped with the World Trade Center Attack
- Wednesday, Nov. 14, 2001
- 2-3:40 p.m. EST
- An audio conference educating you and your entire staff on how to respond effectively in a crisis situation.

The facility fee of $249 includes 1.5 free AMA Category 1 CME credits or approximately 2 free nursing contact hours. For details, visit www.ahcpub.com, or call (800) 688-2421 to register today! ■

***EDN* NOW AVAILABLE ON-LINE: www.ahcpub.com/online.html. Call (800) 688-2421 for details.**

Checklist to Revamp Plan

☐ **Focus your efforts on a general "all-hazards" plan** that provides an adaptable framework for crisis situations. The terrorist attacks have revealed that the unimaginable can become reality.

☐ **Upgrade your disaster plan.** The attacks have dramatically altered the potential range of disasters communities may face. Be sure that your plan includes components for mass-casualty terrorism, including the potential for chemical or biological incidents.

☐ **Connect with your community's emergency response agencies.** This is a good time to integrate your plan with your community's rescue squad and police and fire departments. Specifically, make sure you have the latest contact numbers for key agencies, and that they, in turn, have an up-to-date list of your hospital's key contacts.

☐ **Develop a plan to support the families of staff members.** Staff members want and need assurances that their families are protected and cared for, especially if the incident involves chemical or biological exposure. This is likely to involve agencies and resources from the broader community.

☐ **Develop a simplified patient registration procedure** in the event of a very large number of casualties.

☐ **Review your backup communications capabilities.** Traditional telecommunications mechanisms can become overwhelmed. Pay special attention to backup communications mechanisms, such as Internet-based communication tools and even couriers.

☐ **Ensure that essential hospital information systems and data storage have off-site storage and recovery capabilities.** In the event of a large-scale incident, you may have to rely on resources outside your own community.

☐ **Be prepared to talk with your community and its leaders**, lawmakers, and others about how your hospital would deal with a mass-casualty event, especially an incident with large numbers of survivors. Also be prepared to provide a medical advisory to the mayor and other public officials who may be the primary focus of the media.

☐ **Review your supply and inventory strategy.** Many hospitals have moved to "just-in-time" supply schedules, which keep enough supplies on hand to care for expected patients. While state and federal resources will become available, communities may be on their own for at least 24-48 hours. Include the possibility that traditional transportation systems could be disabled.

☐ **With the nation on heightened alert**, examine how to protect the physical security of your hospital by limiting access to the facility.

☐ **If your hospital is part of the National Disaster Medical System**, review who the contact is within your organization, and who the federal coordinator is in your area. If located in an urban area, determine if there is a Metropolitan Medical Response System (MMRS) plan in your community and know how it can complement the hospital's own plan.

☐ **Ensure that the hospital and its medical staff** report unexpected illness patterns to the public health department and, if appropriate, the Centers for Disease Control and Prevention.

☐ **Finally, with the armed services calling up reserves and the possibility that Department of Health and Human Services' Office of Emergency Preparedness may need to call up response teams (Disaster Medical Assistance Teams, Disaster Mortuary Team, and MMRS), take time to inventory who on your staff**, including medical staff, could get called, what your policies are for job retention and benefit continuation, and how activation might affect your operations.

Source: Disaster Readiness Advisory, Sept. 21, 2001, American Hospital Association, Washington, DC.

Cornell Medical Center.

As of press time, the total number of people missing was 4,979, with 393 confirmed dead. In New York, 75 hospitals treated more than 5,000 patients injured in the attacks.

"We thought we would have at least 48 hours or 72 hours of patients coming in, and the truth gradually sunk in," she recalls. "It was very disheartening at that point."

Although most nurses interviewed by *ED Nursing* agreed that private or group counseling was beneficial, many admitted they had chosen not to attend.

Continued on page 4

EXECUTIVE SUMMARY

ED nurses had to cope with emotional trauma as a result of the terrorist attacks on the World Trade Center and the Pentagon.

- Although most hospitals offered counseling and debriefing sessions, many ED nurses chose not to attend.
- Moral support from the community, such as a banner sent from Oklahoma City ED nurses, made nurses feel less isolated.
- Volunteers offered unconventional help to nurses caring for patients, such as food and massages.

Quotes from ED nurses on the front lines

Here are accounts from ED nurses who cared for patients injured in the terrorist attack at the World Trade Center towers in New York City:

● "By Wednesday morning, families and friends came in a never-ending stream, carrying fliers with photos of the missing and contact numbers. In the absence of survivors from the rubble, the nursing staff turned their attentions to this group and made every effort to deal with their emotional agony. Many of them were pinning their hopes on rumors of 'John Does' or unidentified patients.

"In order to deal with this, we set up a 'family center' in a building one block from the ED. It was staffed around the clock by counselors, psychiatric and social work staff, and spiritual care providers. A volunteer phone center was set up, and there were information people stationed at each entrance to the hospital.

"These measures were an effort to take some of the pressure off the ED staff and largely succeeded.

"There were many cases of false information being placed on the Internet that families cited as being the source for their information on the location of loved ones. In one chilling case, a woman had been called at home and told that her husband was a patient on the second floor of Saint Vincents Hospital, but there are no patient areas on the second floor. When she questioned this, stating that she had already been here and there were no 'John Does,' she was told that her husband had been misidentified and that he was now awake and had been able to give correct information. The woman was given a five-digit medical record number (ours is six) and told to report to the information desk in the main lobby. Needless to say, this was a devastating incident to the family as well as the staff."

She continues, "It would have been impossible to include all the different resources made available to us to deal with stress and emotional trauma in a formal disaster plan. I have unscientifically measured this success by noting that there has been no increase in staff sick calls, no increase in confrontations or altercations, no increase in patient and family complaints, and a general feeling that the staff are communicating with each other effectively.

"I believe our ability to deal with emotional stress and trauma effectively is a result of being aware of the potential for it and being adaptable in utilizing whatever resources presented themselves to offer to the staff."

— **Suzanne Pugh**, RN, ED nurse manager, Saint Vincents Hospital, New York City.

● "We have some staff members who are getting very anxious about the threat of hazardous materials and bioterrorism. People are whipping around, asking, 'Where is the atropine? What is our plan? Where is the shower?' These are individuals who were never terribly interested in the process before."

— **Laura Giles**, RN, ED nurse manager, Mount Sinai Medical Center, New York City.

● "When the first severely burned patient came in, some of us started to cry. You say to yourself, 'Is it appropriate for me to do that?' but at the same time, this was somebody we couldn't even recognize except that it was a female.

"I personally felt that I didn't know if I could handle any burn patients after I saw the first three or four. But no more came in, because most of them were not alive.

"Some of us had families who worked there, so at same time we were taking care of patients, that was in the back of our minds. Emotionally, you are torn in different directions.

"As an ED nurse, you feel you always have to be tough. We are on the front line of every hospital. We haven't had the chance here to sit and talk about what happened, to laugh, to cry, or anything. I really don't know why.

"Even riding to work is difficult. Normally, my eyes would sweep from lower to upper Manhattan, and I would always look at the Twin Towers. Now I look and see nothing but smoke.

"We lost three of our EMS personnel, and there is a shrine set up at the ambulance bay with their pictures hanging on the wall. To see the faces of all these young people who just started life — I can't think of anything that could have been worse. But time heals, and I believe it will."

— **Anna Chin**, RN, ED nurse at New York Presbyterian Hospital-Weill Cornell Medical Center, New York City. ■

SOURCES AND RESOURCES

For more information on helping nurses cope with emotional trauma after a disaster, contact:

- **Anna Chin**, RN
  Emergency Department, New York Presbyterian Hospital-Weill Cornell Medical Center, 525 E. 68th St., New York, NY 10021. Telephone: (212) 746-5026. Fax: (212) 746-3821.

- **Laura Giles**, RN
  Emergency Department, Mount Sinai Medical Center, One Gustave L. Levy Place, New York, NY 10029. Telephone: (212) 241-6273. Fax: (212) 427-2180. E-mail: laura.giles@mountsinai.org.

- **Marion Machedo**, RN
  Emergency Care Institute, Bellevue Hospital, 27th and First Ave., New York, NY 10016. Telephone: (212) 562-4311, ext. 6561. Fax: (212) 562-3001.

- **Suzanne Pugh**, RN
  Emergency Department, Saint Vincents Manhattan, 153 W. 11th St., New York, NY 10011. Telephone: (212) 604-2513. Fax: (212) 604-2339. E-mail: spugh@saintvincentsnyc.org.

Visit the American Hospital Association web site

The American Hospital Association (AHA) has a variety of resources on its web site (www.aha.org) related to disaster preparedness. The Disaster Readiness Advisory contains guidelines for emergency preparedness and can be downloaded at no charge. (Click on "Disaster Readiness," "AHA Communications to the Field," and "Member Advisory: Disaster Readiness.")

Nurses affected by the Sept. 11 attacks can get help from a disaster relief fund established by Nurses House, a nonprofit organization designated by the American Nurses Association, American Nurses Foundation, and New York State Nurses Association to accept contributions for registered nurses. The fund will assist nurses involved in disaster relief activities and those directly affected by the tragedy, such as those working in surrounding hospitals and those whose spouses were injured or lost in the disaster. Contributions can be made by sending a check to: Nurses Relief Fund, American Nurses Foundation, P.O. Box 96441, Washington, DC 20090-6441.

"That's the nature of working in the ED. You want to appear as if you're doing fine, but inside you're all torn up. You don't want to share it with your colleagues," says Chin.

Chin says that "deep down" she knows she needs to go to a debriefing session. "I see the personalities of nurses changing, myself included. We are all very cranky and irritable," she says.

Here is how ED nurses coped after the attacks, along with strategies to consider when your facility treats victims of a disaster. **(See checklist for ways to revamp your disaster plan, p. 2.)**

• Waiting was the worst part.

For several days, EDs in New York City and Washington, DC, were on high-alert status and expected to receive hundreds of patients at any moment.

"It didn't matter that we heard nothing encouraging. We were ever hopeful that in 10 minutes there would be 300 people to treat," says **Marion Machedo**, RN, nurse manager of the ED at Bellevue Hospital in New York City.

The ED at Saint Vincents Hospital treated more than 300 patients in the first four hours after the attack, reports **Suzanne Pugh**, RN, nurse manager.

"The first wave of patients was followed by an extreme slowdown. After that, new arrivals were primarily rescue workers," she says. **(See quotes from**

Self-Care Tips to Use

• Normal Reactions to a Disaster Event:
— No one who responds to a mass-casualty event is untouched by it.
— Profound sadness, grief, and anger are normal reactions to an abnormal event.
— You may not want to leave the scene until the work is finished.
— You likely will try to override stress and fatigue with dedication and commitment.
— You may deny the need for rest and recovery time.
• Signs That You May Need Stress Management Assistance:
— difficulty communicating thoughts;
— difficulty remembering instructions;
— difficulty maintaining balance;
— uncharacteristically argumentative;
— difficulty making decisions;
— limited attention span;
— unnecessary risk-taking;
— tremors/headaches/nausea;
— tunnel vision/muffled hearing;
— colds or flu-like symptoms;
— disorientation or confusion;
— difficulty concentrating;
— loss of objectivity;
— easily frustrated;
— unable to engage in problem-solving;
— unable to let down when off duty
— refusal to follow orders;
— refusal to leave the scene;
— increased use of drugs/alcohol;
— unusual clumsiness.
• Ways to Help Manage Your Stress:
— Limit on-duty work hours to no more than 12 hours per day.
— Make work rotations from high-stress to lower-stress functions.
— Make work rotations from the scene to routine assignments, as practical.
— Use counseling assistance programs available through your agency.
— Drink plenty of water and eat healthy snacks such as fresh fruit and whole grain breads and other energy foods at the scene.
— Take frequent, brief breaks from the scene as practicable.
— Talk about your emotions to process what you have seen and done.
— Stay in touch with your family and friends.
— Participate in memorials, rituals, and use of symbols as a way to express feelings.
— Pair up with another responder so that you may monitor one another's stress.

Source: Substance Abuse and Mental Health Services Administration, Knowledge Exchange Network, Rockville, MD.

nurses about the disaster response, p. 3.)

Waiting anxiously for survivors turned into the single biggest stress factor affecting staff, according to Pugh. "By early evening of the first day, we were beginning to realize what this meant: that there were not going to be many survivors," she says. "Over the following hours and days, this was proven true, as the last person pulled from the wreckage was early Wednesday morning."

The next hurdle for nurses was dealing with the multitudes of family and friends who descended upon the ED searching for their loved ones, says Pugh. The day of the attacks, an information table was set up in front of the ED with patient lists from several local hospitals. The table was manned by staff from the development office and volunteers who acted as "runners" between the fax machines and the table.

"We faxed updated lists to each other that enabled us to check the whereabouts of known patients for their families," Pugh explains.

• Additional help was available to assist nurses in caring for emotional needs of patients.

When Chin treated a 34-year-old woman with chest pain who said she couldn't sleep at night, she instinctively guessed it was a stress reaction from the terrorist attacks. "Then she told me that her neighbor didn't come home from the World Trade Center," she says. "When she was here, she fell asleep. I think she felt safe because we were around her."

The scenario illustrates the challenges of meeting the needs of patients after the tragedy. "We were all emotionally burnt out, and we also had patients depending on us for their mental health," says Chin, who arranged for a social worker to meet with the woman.

At Saint Vincents, social workers assisted ED nurses in dealing with the emotional needs of patients. "There were many rescue workers coming to the ED for treatment who also needed stress and crisis interventions," Machedo says.

• Staff took advantage of help offered by the community.

There were many individuals in the community who volunteered their services, including massage therapists who treated patients and family members 24 hours a day.

A separate "stress relief" area was set up for staff to

Continued on page 7

Mount Sinai

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Dear Emergency Department Staff Members,

We want to recognize each of you for your magnificent performance during the tragic week of September 11, 2001.

Within 20 minutes, the Emergency Department was prepared to treat large numbers of patients. The speed with which all levels of our staff mobilized is a tribute to you and your dedication to patients and emergency care.

Staff who could not reach the department by telephone came to work unbidden, ready to assist by whatever means necessary. Those on duty stayed faithfully at their posts, waiting to provide care. These examples of professionalism and altruism were impressive, but not out of character. We go forward assured that we are ready to perform at the highest level in any disaster situation.

We hope that those of you who were personally touched by a loss will find solace in the months to come. We are proud to join together with you as we continue to build excellence in Emergency Medicine.

Very truly yours,

Carol Leah Barsky, MD
Director
Emergency Medicine

Laura Giles, RN
Clinical Nurse Manager
Emergency Department

Source: The Mount Sinai Medical Center, New York City.

receive massage therapy, acupuncture, acupressure, and guided meditation.

"Almost all members of the staff utilized at least one of these modalities," says Pugh. "The massages were particularly popular."

Food and the ability to enjoy meals as a group was very important, says Pugh. "Volunteers coordinated food donations from various restaurants for staff and rescue workers, and leadership provided areas for staff to sit and eat together," she explains.

• Counseling was available, but not all nurses attended.

Many EDs posted schedules for debriefing sessions and offered individual and group counseling with no appointment needed. But because many nurses chose not to attend, it was important to monitor colleagues for signs of stress, says **Laura Giles**, RN, clinical nurse manager of the ED at Mount Sinai Medical Center in New York City. **(See Self-Care Tips to Use, p. 5.)**

"If a colleague seemed stressed, someone would ask him or her, 'Do you need to take some time off? Do you want to switch shifts with me?' Just reaching out to someone can be very helpful," she says.

When one ED nurse was acting out in frustration, Giles responded. "She was stomping around and carrying on, and I told her she really should go talk to someone," says Giles. "She said, 'I think you're right, I think I will try and go.' My message got through."

• Community support was shared with staff.

Because everyone in the nation was affected by the attacks, ED nurses did not feel they were suffering alone, notes Machedo.

"People were constantly talking about this, and not just in the ED. It was not the normal situation when nobody else knows what you are talking about," she says.

Machedo's ED has "been inundated" with food, letters of support, get-well cards for patients, and drawings from children.

"There was an incredible outpouring of help from the community," she says. "People have even offered spare beds if someone needed a place to stay, which was very touching."

Giles received a very special gesture of support: Deaconess Hospital in Oklahoma City sent a three-foot banner signed by the entire ED staff, which read, "Brothers and Sisters in Emergency Care: We send you our thoughts, strength, and prayers."

Giles says she makes a point of informing nurses about all the well-wishers and posting all of the material in the waiting room, vestibule, and ambulance entrance for all to see. "It is a way for all of us to understand that the community supports us," she explains.

• ED managers thanked nurses.

The day after the attacks, the entire ED staff held a group meeting. "I told everybody what a fabulous job they did, and we all talked about what had happened," she says**.**

Along with the ED medical director, Giles sent out a joint letter to all staff praising them for efforts. **(See Letter to Emergency Department Staff, p. 6.)**

"The way our staff responded showed me that I made the right decision to go into emergency nursing," she says. ■

Try these unique ways to educate staff

You'll need to be creative to effectively educate yourself and other nurses, advises **Janet K. Johnson**, RN, BSHA, CEN, SANE, coordinator of clinical forensic services and former ED nurse manager at Central Peninsula General Hospital in Soldotna, AK.

"To maintain a high level of professional practice, we must maintain our knowledge bank," she says. "There are great opportunities. You just have to open your eyes and be willing to look outside the box."

With dwindling budget dollars for staff development and increasing time constraints, finding creative solutions for education is crucial, urges Johnson.

Nurses may avoid participating in educational programs and argue that they do not have the time or the staffing to attend inservices, says **Patti R. Zuzelo**, EdD, RN, CS, assistant professor at La Salle University School of Nursing in Philadelphia, and per diem nurse in the emergency trauma care department at Abington (PA) Memorial Hospital.

"This creates a 'no-win' loop for nurses, educators, managers, and patients," she says.

Nurses must maintain clinical expertise to provide competent and safe care to patients, but they often fear

EXECUTIVE SUMMARY

Due to increased workload, ED nurses often are torn between patient care responsibilities and attending educational inservices.

- Give nurses audiotapes to listen to during daily commutes.
- Hang learning posters in the staff bathroom.
- Hold your own conferences using vendors and local experts.

SOURCES

For more information about education of nursing staff, contact:

- **Janet K. Johnson**, RN, BSHA, CEN, SANE, Central Peninsula General Hospital, 250 Hospital Place, Soldotna, AK 99669. Telephone: (907) 262-8126. Fax: (907) 262-0717. E-mail: jjohnson@cpgh.org.
- **Elaine Keavney**, RN, BSN, CEN, Emergency Department, Good Samaritan Hospital, 407 14th Ave. S.E., Puyallup, WA 98371. Telephone: (253) 848-6661, Ext. 1051. Fax: (253) 445-5075. E-mail: keavnel@goodsamhealth.org.
- **Patti R. Zuzelo**, EdD, RN, CS, La Salle University, School of Nursing, 1900 W. Olney Ave., Philadelphia, PA 19141. Telephone: (215) 951-1904. Fax: (215) 951-1896. E-mail: zuzelo@lasalle.edu.

that patient care may be jeopardized if they leave the clinical area to attend educational programs, explains Zuzelo.

"To address this, you must offer education in a variety of creative and efficient venues, using educational strategies that promote self-directed learning," recommends Zuzelo.

Here are effective ways of doing this:

• **Put on your own conference.**

It can be expensive and time consuming to fly out to conferences, notes Johnson. "I coordinated efforts to bring local, state, and national speakers to our own conference for two years," she reports.

Johnson worked with vendors to obtain support for the conference. "In return, they were able to show the 'latest and greatest,'" she says.

As a result, ED nurses received education and the ability to see the newest technology, says Johnson. "We kept our practice current and selected capital equipment as a knowledgeable team," she adds.

Johnson recommends enlisting the help of experts in your facility and community. "We need to realize that we all have an area of expertise," she suggests. "With a little education on presenting an educational offering, most individuals can be very successful."

• **Listen to audiotapes during commuting time.**

Johnson listens to educational audiotapes on her 40-minute commute to work every day. "This is a cherished time for me to stay current in the field," she says. "When you take advantage of this time, you do not feel you are cutting into your precious personal time to read journals and stay abreast of current trends."

• **Start a monthly newsletter.**

As an ED manager, Johnson wrote a monthly newsletter to keep nurses current on activities of the department. "It also allowed an opportunity to inject research findings and new guidelines," she says.

• **Use storytelling.**

At Good Samaritan Hospital in Puyallup, WA, a preceptor course uses storytelling as a basis.

"We give the students the opportunity to tell their stories about their experiences as new nurses, then pull key concepts from those stories," says **Elaine Keavney**, RN, BSN, CEN, coordinator for ED education and quality improvement.

Each participant is asked to share an incident he or she will never forget. "These are submitted to us as instructors ahead of time, to allow us the opportunity to pull out common themes," says Keavney.

For example, previous themes have included the importance of being compassionate to colleagues, ways to encourage a new nurse (including a gentle push to

Sample Learning Objectives

For preceptor class:

- Identify five characteristics of adult learners.
- List the four steps for giving effective feedback.
- Define the four stages of orientation transition.
- List eight points to remember when teaching clinical skills.
- List three disadvantages and three advantages of precepting.

For ED nursing clinical practice:

1. The ED nurse will correctly differentiate between electrocardiogram recordings of first-, second-, and third-degree heart blocks.
2. The ED nurse will correctly calculate the infusion rate of weight-based intravenous medications using a hand-held calculator.
3. The ED nurse will compare and contrast the electrocardiogram findings associated with anterior, lateral, posterior, and inferior wall myocardial infarctions.
4. The ED nurse will prepare a prioritized nursing action plan for the pediatric patient admitted with status asthmaticus.
5. The ED nurse will correctly select those patients who are safe for discharge, post conscious sedation.

Source: Objectives for preceptor class: Good Samaritan Hospital, Puyallup, WA. Objectives for ED nursing clinical practice: Patti R. Zuzelo, EdD, RN, CS, Assistant Professor at La Salle University School of Nursing, Philadelphia.

action if necessary and differences in learning styles).

• **Use an intranet for on-line education.**

Many institutions use a local intranet within their facilities to support intra-institutional communications, says Zuzelo.

"The intranet can be a highly effective way to provide on-line education to staff," she suggests.

Educational offerings may be individualized to suit the unique needs of your ED, she explains. "Also, as with self-learning modules, nurses can set their own pace for completing on-line educational offerings," she adds.

• **Provide a variety of options.**

It is important to remember that nurses, just like patients, have different learning styles, says Zuzelo.

"Some prefer cognitive learning with reading, audiotapes, or lecture," she says. "Videotapes, intranet slide shows, or posters may appeal to visual learners. Psychomotor activities may best suit those learners who prefer to 'learn by doing.'"

• **Use clear, measurable learning objectives.**

These types of objectives are critically important, says Zuzelo.

"Nurses will more likely participate in educational endeavors with clear objectives that they believe are important to safe practice," she explains. "Good communication is essential." **(See Sample Learning Objectives, p. 8.)**

• **Hang information in the bathroom.**

Johnson recommends hanging educational posters in the staff bathroom.

"In the fast pace of the ED, one of the most underutilized areas is the bathroom," she says. "This is a place to sit, relax a moment, and look straight ahead — at a learning poster!" ■

Here's what to tell patients about holiday safety

When most of the parents and children in your ED think about the holidays, injuries are probably the last thing on their minds.

However, each year EDs treat about 8,700 patients for injuries, such as falls, cuts, and shocks related to holiday lights, decorations, and Christmas trees, according to the Washington, DC-based U.S. Consumer Product Safety Commission.

In addition, Christmas trees are involved in about 400 fires annually that result in 20 deaths, 70 injuries, and an average of more than $15 million in property loss and damage.[1]

EXECUTIVE SUMMARY

Holiday-related injuries account for 8,700 ED visits every year.

- Give parents prevention information regardless of the reason the child came to the ED.
- Make sure brochures and videos are current.
- Track holiday-related injuries so you can focus prevention efforts as needed.

Education on holiday safety can be presented in a variety of ways, from posters and brochures in waiting rooms and triage areas to community presentations, says **Cindy Hearrell**, RN, BA, CEN, an injury prevention marketing assistant for Fallbrook (CA) Hospital.

Here are ways to educate patients about holiday safety:

• **Take advantage of "teachable moments."**

Don't limit your teaching to the injury that prompted the visit, advises **Janet Lassman**, RN, director of program development and training for Emergency Nurses CARE, the Alexandria, VA-based injury prevention arm of the Des Plaines, IL-based Emergency Nurses Association. For example, Lassman suggests talking about dangerous toys to a parent who brings a child in because of a sore throat or ear infection.

"It is a good idea to consider the circumstances, such as the time of year and the age of the patient," she adds.

Address fire prevention with all patients, she says. "Also talk to parents about safety with regard to sleds, ice skates, and other sports-related gifts," she recommends.

• **Include safety tips in discharge instructions.**

Lassman suggests including prevention messages in your discharge instructions. "Having the message written down to bring home helps to reinforce what has been said and also may help to educate other family members," she says.

• **Place brochures and posters in ED waiting rooms.**

Because patients sit in waiting rooms for long periods of time, consider this a golden opportunity to educate them, Lassman advises.

"A simple, easy-to-read, eye-catching poster can bring your holiday safety message to their attention," she says. "A brochure or flier that can be taken home will reinforce that message". **(See resource box for materials to order, p. 10, and patient handout with holiday decoration safety tips, inserted in this issue.)**

If your waiting room has a VCR, take advantage of this resource to show educational videos, she says.

Lassman suggests using videos from the National

SOURCES AND RESOURCES

For more information about holiday safety, contact:
- **Cindy Hearrell**, RN, BA, CEN, 388 Arroyo Vista, Fallbrook, CA 92028. Telephone: (858) 858-576-1700 ext. 5096. Fax: (858) 728-8664. E-mail: Clhear@aol.com.
- **Janet Lassman**, EN CARE, 205 S. Whiting St., Suite 403, Alexandria, VA 22304 Telephone: (703) 370-4050. Fax: (703) 370-4005. E-mail: encare@aol.com.

U.S. Consumer Product Safety Commission (CPSC) has several publications pertaining to holiday safety, including *Toy Safety Shopping Tips, Safety Commission Warns about Snowmobile Hazards*, and *Toy Safety Coloring Book.* To order these free publications, contact:
- **CPSC**, 4330 East-West Highway, Bethesda, MD 20814-4408. Telephone: (301) 504-0990. Fax: (301) 504-0124. E-mail: publications@cpsc.gov. Web: www.cpsc.gov.

The National Highway Traffic Safety Administration (NHTSA) offers media kits for its "You Drink and Drive, You Lose" campaign. Each planner provides a sample media advisory, press release, letter to the editor, talking points and fact sheets. Fact sheets on *Safe Winter Driving*, and *Safe Winter Walking* also are available at no charge. NHTSA also offers a variety of materials on child passenger safety, including a booklet, *Boost 'Em Before You Buckle 'Em: Don't Skip a Step* (Item No. IP1123), brochures on *Child Passenger Safety Programs* (Item No. IP1050), *Are You Using it Right?* (Item No. IP1062), and a fact sheet on *Child Transportation Safety Tips* (Item No. IP1045). Single copies of these materials can be ordered at no cost on the NHTSA web site: www.nhtsa.dot.gov. (Click on "Safety Materials Catalog" and submit topic "Child Passenger Safety.") Or contact:
- **NHTSA**, 400 Seventh St. S.W., Washington, DC 20590. Telephone: (800) 424-9393 or (202) 366-0123. Fax: (202) 366-7096. E-mail: custservice@nhtsa.dot.gov.

The National Safe Kids Campaign has a free brochure titled *Toy Safety*. To order, contact:
- **National Safe Kids Campaign**, 1301 Pennsylvania Ave. N.W., Suite 1000, Washington, DC 20004. Telephone: (202) 662-0600. Fax: (202) 393-2072. E-mail: communications@safekids.org.

ENCARE offers a fact sheet that addresses holiday safety. The sheet can be downloaded from the web site (ena.org) at no charge. (Click on "Encare.") A coloring book, *Learn to Buckle Up for Safety*, costs $25 for a package of 100, plus a shipping and handling charge of $9.00 for one package. To order, contact:
- **Emergency Nurses Association**, Attention: Association Services Team, 915 Lee St., Des Plaines IL 60016. Telephone: (800) 243-8362.

Highway Traffic Safety Administration about impaired driving and child passenger safety, both timely issues during the holiday season.

Are your old brochures outdated?

Ensure that the information is current, Lassman encourages. "Do your homework, and don't use videos or material that is more than a couple of years old," she says.

Many EDs stockpile brochures, and they become outdated sitting on a shelf, says Lassman. "Instead, get small amounts of material and distribute it, always giving patients the newest material available," she advises.

• **Hand out coloring books.**

Coloring books or pages are a good way to educate children about holiday safety, says Lassman.

"Sometimes a coloring page or two can be developed with a minimum of trouble by the hospital graphic arts department," she says. "Don't forget to supply a few crayons so they can get to work coloring right away."

• **Speak at a community program.**

Lassman suggests giving a presentation as a way to reach large numbers of people.

"A presentation about the hazards of Christmas trees, decorations, and fire prevention given to the PTO or a civic organization would be a great way to get the message out," she says.

Collaboration with the local fire department is a particularly good idea, says Lassman. "The police can be helpful with presentations about drinking and driving during the holiday season," she says.

• **Address safety issues regarding traveling.**

Remind parents that they need to make sure their

children are properly restrained at all times, urges Hearrell. "Their child safety seats may not fit in other vehicles as it does in their family cars," she says. "They should always make sure they have the instructions to the seat with them."

• Track past injuries.

Do some research to find out what types of holiday-related injuries are commonly seen in your ED, says Lassman. "That way, you will be able to target your message," she says. "You also will be able to evaluate whether the safety campaign helped to reduce those injuries."

For example, if you find an increase in alcohol-related motor vehicle crashes during the holidays, it would be a good idea to promote an anti-drinking and driving message before the holidays arrive, she says.

"Likewise, if you find that Christmas trees and decorations catching fire are causing most of the injuries, then that is what you should base your prevention campaign on," she adds.

Retrospective research can be time-consuming, but after getting initial data, it can be easier to track prospectively, says Lassman. "If set up ahead of time and with everyone in the ED alerted, it can be pretty easy to track," she says.

Reference

1. U.S. Consumer Product Safety Commission "Holiday Safety" News Release 01-046, issued 12/5/00, at www.cpsc.gov/cpscpub/prerel/prhtml01/01046.html. ■

SOURCE AND RESOURCE

For more information on educating your staff about EMTALA, contact:

- **Denise Casaubon**, RN, DNR Consultants, 16217 Balsam Drive, Fountain Hills, AZ 85268. Telephone: (480) 816-6695. Fax: (480) 836-8185. E-mail: casaubon@qwest.net.
- **Todd B. Taylor**, MD, FACEP, 1323 E. El Parqué Drive, Tempe, AZ 85282-2649. Telephone: (480) 731-4665. Fax: (480) 731-4727. E-mail: tbt@compuserve.com.

A complete copy of the report, *The Emergency Medical Treatment and Active Labor Act: Survey of Hospital Emergency Departments* (OEI-09-98-00220, 1/01) can be downloaded at no charge at the Office of Inspector General/Office of Evaluation and Inspections web site, www.dhhs.gov/progorg/oei. Click on "Search and Report," "Categorical Listing Search," and scroll down to find the report's title under "EMTALA."

Survey: How much do you know about EMTALA?

Are you curious about how much your staff really knows about the Emergency Medical Treatment and Active Labor Act (EMTALA)?

A recent survey from the Department of Health and Human Services provided some insights. *The Emergency Medical Treatment and Active Labor Act: Survey of Hospital Emergency Departments* surveyed ED staff.

"Key findings were that most staff members were familiar with EMTALA requirements, but not all were aware of recent policy changes," says **Denise Casaubon**, RN, owner and president of DNR Consultants, a Fountain Hills, AZ-based company specializing in health care corporate compliance.

Here are key findings:

• Staff need a better understanding of definitions such as "emergency medical condition" and "medical screening examination."

Casaubon advises you to conduct clinical record reviews for compliance.

"Draft a tool that includes the required EMTALA documentation elements," she explains. "Then audit the clinical records to discover what areas staff need to improve."

Observe staff during the course of business with regard to EMTALA requirements, she says. "Is requesting insurance information delaying the medical screening examination?" asks Casaubon. "Are patients being logged in correctly? Is all of the required information documented in the log?"

The survey brings home the need for continuous inservices and training, says Casaubon. She recommends at least two inservices a year for staff.

• Staff had adequate knowledge about many areas of EMTALA.

Strengths included a basic understanding of "patient dumping" and increased communication between sending and receiving hospitals, she reports.

However, only 70% of those surveyed knew that transfer records must be kept for five years and that hospitals are forbidden from retaliating against employees who report violations or refuse to authorize inappropriate transfers, says Casaubon.

EMTALA Keep it Short and Simple (KISS) Principles

For the hospital staff and emergency physicians inquiries:
• Do you want to see a doctor?
• I'll take you to the ED.

ED:
• Log ALL patients.
• Medical screening exam for *all* patients by physician.
— If not, document why
— Left without treatment
— Refused
• Treat *all* patients to a reasonable disposition in the ED.

Transfers:
• Obtain acceptance from the receiving facility and complete a transfer form on ALL patients not otherwise being routinely discharged.
• Accept ALL transfers if the hospital has the capacity *(bed available and ever done it before)* to treat the presenting problem. If not, document why.

Reporting:
• Set up a system for reporting suspicious transfers.
• Report ALL suspicious transfers to you and ALL suspicious refusal to accept outgoing transfers.
• Document ALL incoming and outgoing transfers.

EMTALA *KISS* PRINCIPLES

For the medical staff physician

If you are called — you are chosen if on-call for the ED:
• Respond appropriately: No excuses, no complaints.
• The emergency physician dictates appropriateness unless or until you assume care of the patient.

Transfers:
• Accept ALL transfers if the hospital has the capacity *(bed available and ever done it before)* to treat the presenting problem. If not, document why.
• Obtain acceptance from the receiving facility, and complete a transfer form on ALL patients not otherwise being routinely discharged.

ED Patient Follow-Up:
• Do what you agreed to do later or come to the ED.
• Do not demand payment up front or refer back to the ED if unable to pay or a non-contracted health plan.

Reporting:
• Set up a system for reporting suspicious transfers.
• Report ALL suspicious transfers coming to you and ALL suspicious refusals to accept outgoing transfers.
• Document ALL incoming and outgoing transfers.

How can I help you with this patient?

Source: Todd Taylor, MD, FACEP, Good Samaritan Regional Medical Center, Phoenix.

• Specialists and part-time staff lacked knowledge of EMTALA.

The report showed that only 25% of on-call physicians have received training in EMTALA.

According to **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix, this is the "major fertile ground" for EMTALA violations right now.

"This is partly from a lack of guidance from [Centers for Medicare and Medicaid Services (CMS)] on what is required, and partly due to hospital and medical staff's inability to reach viable solutions," he says.

Go to CMS web site

• There is a lack of knowledge about recent changes in guidelines.

According to the report, only 65% of ED directors knew about interpretive guidelines published by the Health Care Financing Administration (now CMS) in June 1998.

Casaubon recommends using the Medicare Learning Network on the CMS web site (www.hcfa.gov/medlearn) as a resource.

"The Medicare Learning Network allows the user to search and get information on popular topics such as EMTALA," she says. "It is easy to use and very informative. You can also keep abreast of the changes by checking the *Federal Register* weekly or monthly."

New definition of campus

As an ED nurse, you need to keep abreast of recent changes, she urges. "For example, the definition for hospital campus recently changed," she notes.

She provides a review of the new definition: A hospital campus is defined as a physical area immediately adjacent to the hospital main buildings, other structures, and areas not strictly contiguous to main buildings but located within 250 yards of the main building (42 CFR 413.65

(a)(2)). Parking lots, sidewalks, and driveways on hospital property are considered to be part of the hospital for EMTALA purposes, she adds (42 CFR 489.24(b)).

However, Taylor argues that education efforts should be focused on hospital polices, not EMTALA itself.

"Focusing on EMTALA training could leave the application of those principles up to individuals rather than in following hospital policy," he explains. "It is important that the staff understand their hospital policies, not whether they are aware of the latest CMS bulletin."

What the staff actually needs to know about the EMTALA regulation is relatively little, says Taylor. He developed a "KISS" (Keep It Short and Simple) outline to use during inservices. **[See EMTALA Keep it Short and Simple (KISS) Principles, p. 12.]**

Most have a 'compliance officer'

The complexity and frequent updates of the law have forced most hospitals to designate a "compliance officer" responsible for keeping up with EMTALA, according to Taylor.

"The survey revealed that formal EMTALA training was not universal," he acknowledges. "But in reality, EMTALA compliance principles now are standard operating procedures for hospital EDs, and formal training is less important than in the past."

You must have a single referral resource for difficult EMTALA questions and situations, such as when to report suspected violations, says Taylor. "It would be impossible for every staff member to be an expert in EMTALA," says Taylor. "In my experience, a little knowledge can do more harm than good," he says.

Taylor recommends the use of an algorithm to use for most EMTALA situations **(See EMTALA/COBRA Algorithm, inserted in this issue.)**

"When patients fall off of this algorithm, the staff needs to know who to call for help," he says. "An EMTALA compliance officer is almost mandatory in the current regulatory environment." ■

Baren JM, Shofer FS, Ivey B, et al. **A randomized, controlled trial of a simple emergency department intervention to improve the rate of primary care follow-up for patients with acute asthma exacerbations.** *Ann Emerg Med* 2001; 38:115-122.

A brief intervention for asthma patients in the ED resulted in increased follow-up with a primary care physicians, says this study from the Hospital of the University of Pennsylvania in Philadelphia.

A total of 178 ED adult asthma patients were studied, with 83 patients in the control group and 95 in the intervention group. The intervention consisted of three parts: giving patients a free five-day course of prednisone, providing patients with vouchers for transportation to and from the primary care physician, and making a follow-up telephone call within 48 hours to remind the patient to make the appointment.

44 obtained follow-up care

After a month, 44 patients (46.3%) of the intervention group had obtained follow-up care, as compared with 24 (28.9%) patients in the control group. For patients with no prior relationship with a primary care provider, five (17.2%) in the intervention group went for follow-up care, whereas no control group patients did.

The researchers estimate the total cost of the three-part intervention to be approximately $15 per patient. When patients receive follow-up care after their ED visits, it allows the provider to be a more active participant in overall disease management, argue the researchers.

"Adjustments in long-term control or maintenance medications can reduce exacerbation of symptoms and morbidity from asthma, reducing the need for episodic ED care and improving overall quality of life," they wrote. ▼

Zachary MJ, Mulvihill MN, Burton WB, et al. **Domestic abuse in the emergency department: Can a risk profile be defined?** *Acad Emerg Med* 2001; 8:796-803.

Clinical presentations and demographic characteristics of female ED patients are not good indicators of domestic abuse, says this study from Bellevue Hospital Center and Montefiore Medical Center, both in New York City.

The researchers surveyed 611 female patients in an urban ED. Recent domestic abuse (within the past year) was reported by 48 women (7.9%), and 232 (38%) of the women had been abused recently or in the past.

Victims of recent abuse were likely to include clinical presentations associated with trauma, obstetrical

and gynecological syndromes, and psychiatric symptoms and substance abuse. However, these risk factors only predicted 27 (56.3%) of recently abused women.

The researchers recommend the following steps:

• Research the costs and effectiveness of interventions in medical settings.

• Allocate resources to identify abused women who come to the ED.

• Implement systems that support routine inquiry about domestic abuse.

"The ideal of routine inquiry about domestic abuse in women in the ED, with subsequent improved identification and intervention, remains a necessary priority," the researchers conclude. ▼

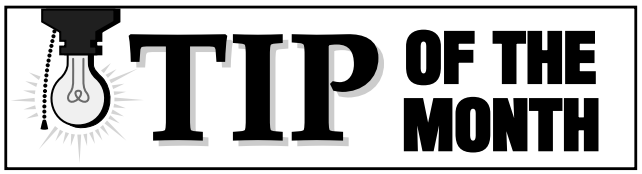
Mahabee-Gittens EM, Grupp-Phelan J, Luria JW, et al. **Is routine heparin lock placement beneficial in the evaluation and treatment of febrile children?** *J Emerg Nurs* 2001; 27:335-339.

Although nurses often use intravenous heparin locks (HL) to evaluate fever without a source in children in order to avoid an intramuscular (IM) injection if antibiotics are ordered, this practice did not result in fewer injections, says this study from Children's Hospital Medical Center in Cincinnati.

A retrospective chart review was done for 439 pediatric patients who had laboratory studies for fever without a source, with 345 in the HL group. No significant differences were found in the two groups for the number of needlesticks.

The cost of nursing time to place an HL in a patient who receives antibiotics was $8.71, compared with $2.80 in a patient who receives IM antibiotics. "By extrapolating the numbers of patients who had laboratory evaluation for fever without a source in this study, these costs translate into total costs of $11,471 for patients in the HL group each year, and costs of $3,688 for patients in the non-HL group," they wrote.

This does not take into account patient/parent satisfaction, they add. "The results of this study can be used to help the ED nurse and physician decide if an HL should be placed in this patient population while they are undergoing laboratory evaluation," they conclude. ■



Check reflexes of trauma patients

Checking a patient's gag, cough, and swallow reflexes determines how well a patient can protect his airway, according to **Laura M. Criddle**, MS, RN, CS, CEN, CCRN, CNRN, emergency, trauma, and neurological clinical nurse specialist at Oregon Health and Sciences University in Portland.

Level of consciousness is the key factor, she stresses. "It is unusual for a normally alert patient to have a gag, cough, or swallow problem unless you're dealing with a throat emergency," she says. "Therefore, *any* patient with an altered level of consciousness is at risk."

Observe level of consciousness

Patients with head injuries, stroke, metabolic disturbances, and toxicologic emergencies are at high risk, she warns. Criddle says to start your assessment by simply observing level of consciousness. Next, examine how well the patient is dealing with oral secretions.

"Is he drooling? Listen for upper airway noises," she recommends. "Is there any rattling or gurgling going on?"

If you have a patient who is at least minimally alert, try having the patient take a small sip of water, she suggests.

"You can also use a tongue blade or Q-Tip to stroke the back of the patient's mouth to check for gag reflexes," Criddle says. "In the cooperative patient, ask him to take a deep breath and cough."

The second instance in which gag, cough, and swallow are assessed is in the deeply comatose patient, she says.

"In this case, the patient should already be intubated," Criddle explains. "Now you're using gag,

COMING IN FUTURE MONTHS

- How to improve care of rape victims
- Effective ways to screen for alcohol and drug abuse
- Strategies for giving medications to children
- Update on assessment of asthma patients

cough, and swallow reflexes simply to test brainstem function."

Suction the patient through the endotracheal tube to stimulate the carina, which should cause a cough, and also suction the posterior pharynx, which should stimulate a gag, says Criddle.

"The absence of these findings represent a loss of very basic brainstem functions and are associated with a poor prognosis, unless the patient is deeply sedated or chemically paralyzed," she says.

[Editor's Note: For more information about assessment of spinal cord injuries, contact Laura M. Criddle, MS, RN, CS, CEN, CCRN, CNRN, Oregon Health & Sciences University, Mail Code UHS 8Q, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201. Telephone: (503) 494-1350. Fax: (503) 494-7441. E-mail: criddlel@ohsu.edu.] ■

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AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

BASIC EMTALA:
What EVERY Medical Professional Should Know

An audio conference designed to educate your entire staff on this critical regulation

Wednesday, December 5, 2001
2:30 to 3:30 p.m. EST

Presented by ***Robert A. Bitterman****, MD, JD, FACEP and* ***Mary Kay Boyle****, RN, JD*

Educate your entire staff for one low fee — including CE and CME!
Just $199 for your entire facility!

- ▼ Did you know that nursing triage does not fulfill the mandate for a medical screening exam (MSE)?
- ▼ Did you know that your institution must have board approval for anyone other than a physician to perform an MSE (including nurses in OB who perform an exam, confer with a physician over the phone, and then release the patient)?
- ▼ Did you know that people presenting to an ED only for collection of forensic evidence do not trigger EMTALA?

Whether you work in the ED, on the med/surg floor, in admitting, in an outpatient facility, or in another area, you have a role in helping your facility comply with EMTALA.

And while all staff members cannot be expected to know all of the ins and outs of this complex legislation, it can cost you and your hospital thousands of dollars in fines and lawsuits if you and your staff don't understand and follow the basic guidelines of the "patient anti-dumping" regulation.

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Each listener has the opportunity to earn approximately 1 nursing contact hour or up to 1 AMA Category 1 CME credit, and the first 20 receiving CE/CME are free! A processing fee of $5 per person will be charged after the first 20 receiving continuing education.

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At the conclusion of this teleconference, participants will be able to list ways in which they can help their hospital comply with EMTALA.

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CE objectives

[For more information on the CE program, contact American Health Consultants at (800) 688-2421.]

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 *Here's what to tell patients about holiday safety; Survey: How much do you know about EMTALA?; Journal Reviews; Check reflexes of trauma patients* 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. ■

CE*questions*

17. Which is recommended as an effective strategy to prevent holiday injuries, according to Janet Lassman, RN, director of program development and training for Emergency Nurses CARE?
    A. Limiting prevention messages to the injury the patient is seeking care for
    B. Obtaining large quantities of brochures and storing excess material
    C. Including prevention information in discharge instructions
    D. Giving equal attention to all holiday-related injuries
18. Which is a strong point regarding staff knowledge about EMTALA, according to a survey from the Department of Health and Human Services?
    A. Communication between sending and receiving hospitals
    B. Length of time transfer records must be kept
    C. Retaliation against employees who report violations
    D. Interpretive guidelines
19. Which of the following is a finding about domestic abuse screening, according to a study published in *Academic Emergency Medicine*?
    A. Clinical presentations are good indicators of domestic abuse
    B. Demographic characteristics are good indicators of domestic abuse
    C. Neither clinical presentation nor demographics are good indicators of domestic abuse
    D. Trauma identified almost all recently abused women
20. Which of the following is true regarding assessment of trauma patients, according to Laura M. Criddle, MS, RN, CS, CEN, CCRN, CNRN, emergency, trauma, and neurological clinical nurse specialist at Oregon Health and Sciences University?
    A. Gag, cough, and swallow reflexes should not be assessed in a deeply comatose patient
    B. Suctioning through the endotracheal tube should cause the patient to cough
    C. Suctioning through the endotracheal tube should cause the patient to gag
    D. Suctioning the posterior pharynx should cause the patient to cough

HOLIDAY DECORATION SAFETY TIPS

Consumer Product Safety Commission Document 611

TREES

Many artificial trees are fire resistant. If you buy one, look for a statement specifying this protection. A fresh tree will stay green longer and be less of a fire hazard than a dry tree. To check for freshness, remember:

- A fresh tree is green.
- Fresh needles are hard to pull from branches.
- When bent between your fingers, fresh needles do not break.
- The trunk butt of a fresh tree is sticky with resin.
- When the trunk of a tree is bounced on the ground, a shower of falling needles shows that tree is too dry.

Place tree away from fireplaces, radiators and other heat sources. Heated rooms dry trees out rapidly, creating fire hazards.

Cut off about 2 inches of the trunk to expose fresh wood for better water absorption. Trim away branches as necessary to set tree trunk in the base of a sturdy, water-holding stand with wide spread feet. Keep the stand filled with water while the tree is indoors.

Place the tree out of the way of traffic and do not block doorways. Use thin guy-wires to secure a large tree to walls or ceiling. These wires are almost invisible.

SNOW

Artificial snow sprays can irritate lungs if inhaled. To avoid injury, read container labels; follow directions carefully.

LIGHTS

Indoors or outside, use only lights that have been tested for safety. Identify these by the label from an independent testing laboratory.

Check each set of lights, new or old, for broken or cracked sockets, frayed or bare wires, or loose connections.

Discard damaged sets or repair them before using.

Fasten outdoor lights securely to trees, house, walls, or other firm support to protect from wind damage.

Use no more than three standard-size sets of lights per single extension cord.

Turn off all lights on trees and other decorations when you go to bed or leave the house. Lights could short and start a fire.

Never use electric lights on a metallic tree. The tree can become charged with electricity from faulty lights, and any person touching a branch could be electrocuted! To avoid this danger, use colored spotlights above or beside a tree, never fastened onto it!

Keep “bubbling” lights away from children. These lights with their bright colors and bubbling movement can tempt curious children to break candle-shaped glass, which can cut, and attempt to drink liquid, which contains a hazardous chemical.

CANDLES

- Never use lighted candles on a tree or near other evergreens.
- Always use nonflammable holders.
- Keep candles away from other decorations and wrapping paper.
- Place candles where they cannot be knocked down or blown over.

TRIMMINGS

Use only noncombustible or flame-resistant materials.

Wear gloves while decorating with spun glass “angel hair” to avoid irritation to eyes and skin.

Choose tinsel or artificial icicles or plastic or nonleaded metals. Leaded materials are hazardous if ingested by children.

In homes with small children, take special care to:

- *Avoid decorations that are sharp or breakable.*
- *Keep trimmings with small removable parts out of the reach of children. Pieces could be swallowed or inhaled.*
- *Avoid trimmings that resemble candy or food. A child could eat them!*

FIRES

Before lighting any fire, remove all greens, boughs, papers, and other decorations from fireplace area. Check to see that flue is open.

Keep a screen before the fireplace all the time a fire is burning.

Use care with “fire salts” that produce colored flames when thrown on wood fires. They contain heavy metals that can cause intense gastrointestinal irritation or vomiting if eaten. Keep away from children.

PAPER

When making paper decorations, look for materials labeled noncombustible or flame-resistant.

Never place trimming near open flames or electrical connections.

Remove all wrapping papers from tree and fireplace areas immediately after presents are opened.

Do not burn papers in the fireplace. A flash fire may result as wrappings ignite suddenly and burn intensely.

GENERAL RULES FOR HOLIDAY SAFETY

- Keep matches, lighters, and candles out of the reach of children.
- Avoid smoking near flammable decorations.
- Make an emergency plan to use if a fire breaks out anywhere in the home. See that each family member knows what to do. PRACTICE THE PLAN!
- Avoid wearing loose, flowing clothes — particularly long, open sleeves — near open flames such as those of a fireplace, stove, or candlelit table.
- Never burn candles near evergreens. Burning evergreens in the fireplace also can be hazardous. When dry, greens burn like tinder. Flames can flare out of control and send sparks flying into a room or up the chimney to ignite creosote deposits.

Plan for safety. Remember, there is no substitute for common sense. Look for and eliminate potential danger spots near candles, fireplaces, trees, and/or electrical connections.

The U.S. Consumer Product Safety Commission (CPSC) protects the public from the unreasonable risk of injury or death from 15,000 types of consumer products under the agency’s jurisdiction. To report a dangerous product or a product-related injury, you can go to CPSC’s forms page (www.cpsc.gov/talk.html) and use the first on-line form on that page. Or, you can call CPSC’s hotline at (800) 638-2772 or CPSC’s teletypewriter at (800) 638-8270, or send the information to info@cpsc.gov. Consumers can obtain this publication and additional publication information from the Publications section (www.cpsc.gov/cpscpub/pubs/pub_idx.html) of CPSC’s web site or by sending your publication request to publications@cpsc.gov. If you would like to receive CPSC’s recall notices, subscribing to the e-mail list will send all press releases to you the day they are issued.

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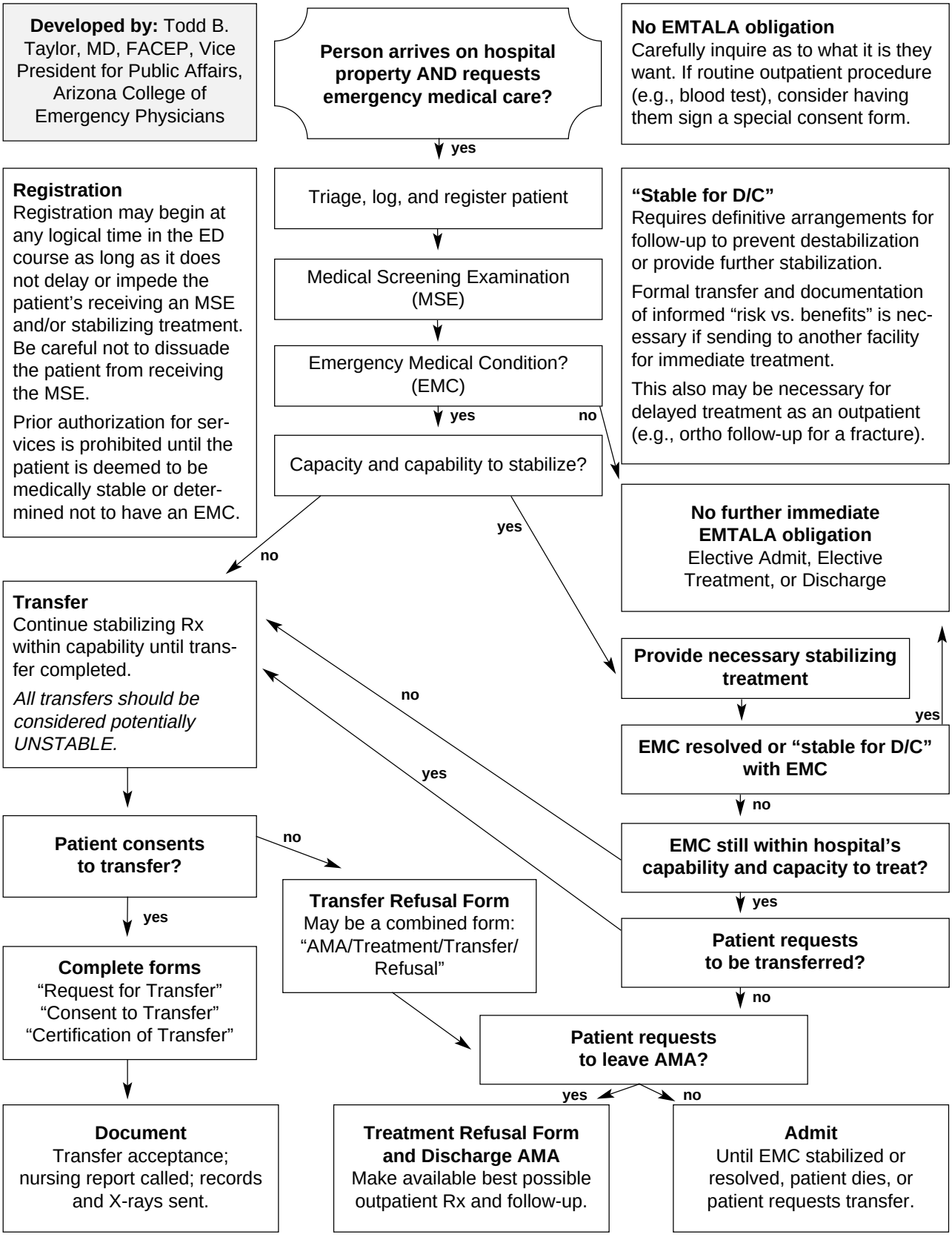
EMTALA/COBRA Algorithm



Source: Todd Taylor, MD, FACEP, Good Samaritan Regional Medical Center, Phoenix.

BIOTERRORISM WATCH

Preparing for and responding to biological, chemical and natural disasters

Clinicians must be voice of reason, reassurance now that bioterrorism battle has been joined

The threat is real, but we are far from defenseless

A new era of bioterrorism has begun with the intentional anthrax scares that have left several people dead and many more exposed as this issue went to press.

But amid the shrill coverage of the widening anthrax investigations, the scramble for gas masks and the expected hoarding of Cipro, there must be a voice of calm and reason. That voice must be your own.

Infection control professionals, hospital epidemiologists, and other key clinicians involved in health care bioterrorism readiness and response must set the tone for a panicky public and an uneasy health care work force, emphasizes veteran epidemiologist **William Schaffner**, MD, chairman of preventive medicine at Vanderbilt University School of Medicine in Nashville.

"We have to re-instill a sense of confidence for people who work in the health care system," he says. "Start with the doctors. They are the ones who are going to be more panicked than the nurses."

Restoring calm to health care community

The current situation is reminiscent of the early stages of the HIV epidemic, when there was much anxiety about the communicability of the disease and whether even casual contact would spell a death sentence for health care workers.

In that chilling time of alarmist reactions and burning mattresses, Schaffner recalls that ICPs, epidemiologists, and other clinicians, stepped into the fray to provide calming confidence and accurate risk data.

"I'm beginning to think that we may be in a similar position now," he says. "We could have a very powerful educational and reassuring effect. Everybody's anxious about this, but I think we can diminish the level of anxiety," Schaffner adds.

Infection control methods in place

Health care workers must be educated about bioterrorism agents and provided reassurance that the patient isolation precautions developed by the Centers for Disease Control and Prevention (CDC) are extremely effective, urges Schaffner.[1]

"The barrier precautions are going to work for bioterrorism. Once you get to chemical [weapons] then you get into the whole 'moon suit' issue. But for bioterrorism, we don't need that," he says.

For example, systems of barrier precautions such as gloves, gowns, and masks to isolate patients infected with all manner of infectious diseases are already in place in virtually all U.S. hospitals.

"They work," he says. "Look, we all know pulmonary tuberculosis is communicable. I'm an infectious disease doctor, have been for 30 years. I've seen a lot of patients with tuberculosis, but I have also been meticulous about my use of [face masks and respirators]. My tuberculin test continues to be negative."

This supplement was prepared by Gary Evans, editor of *Hospital Infection Control*. Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

A Bioterrorism Time Line

1155 Barbarossa uses the bodies of dead soldiers to poison the wells at the battle of Tortona.

1346 Mongols catapult corpses of plague victims into the city of Kaffa to infect the defenders.

1763 British commander Sir Jeffrey Amherst ordered the transfers of blankets used by British smallpox victims to Native American tribes, ostensibly as a gesture of goodwill, with the intention of inducing illness.

1970 The United States ends its programs of developing biological agents for use in warfare. The offensive use of such weapons was forbidden by U.S. policy under executive orders of President Richard Nixon.

1972 Soviet Union signs off on Biological and Toxin Weapons Convention, but continues a high-intensity program to develop and produce biological weapons at least through the early 1990s. Hundreds of tons of weaponized anthrax spores are stockpiled, along with dozens of tons of smallpox and plague. Many of these agents are reputed to have been specifically designed to be resistant to common antibiotics.

1984 Members of the Rajneesh cult contaminated salad bars in Oregon with salmonella, resulting in the infection of 751 people. The Paris Police raided a residence suspected of being a safe house for the German Red Army Faction. During the search, they found documentation and a bathtub filled with flasks containing *Clostridium Botulinum.*

1990s Japan's Aum Shinrykyo cult plans attacks using biological agents, specifically, anthrax and botulinum toxin. While these biological attacks were not successful, cult members later implemented the release of sarin nerve gas in the Tokyo subway system.

1995 A U.S. microbiologist with right-wing ties orders bubonic plague cultures by mail. The ease with which he obtained these cultures prompts new legislation to ensure that biologic materials are destined for legitimate medical and scientific purposes.

1998 A variety of feigned exposures to anthrax spores occurred in several U.S. cities including Indianapolis, where a full-scale response by emergency services and public health occurred before the episode was found to be a hoax.

Sources

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2. Bosker G. Bioterrorism: An update for clinicians, pharmacists, and emergency management planners. *Emergency Medicine Reports* (in press) 2001. ■

And anthrax, of course, is not communicable from person to person, reminds Schaffner, who investigated a case of occupational anthrax in an animal-hide worker when he was a epidemiologist for the CDC in the late 1960s.

"The bacteria do not cause a conventional pneumonia," he says. "They replicate locally and then release toxins. Because the bacteria never replicate to very high numbers the person is not communicable. It is not so much an infection as it is an intoxication."

Inordinate fear of anthrax could cause another problem — hoarding and misuse of Ciprofloxacin and other antibiotics. That tactic eventually could contribute to emerging resistance in pathogens such as *Streptococcus pneumoniae,* Schaffner notes.

"It is one thing for a hospital and the health department to develop an inventory in the event of an emergency," he says. "I do not recommend that individuals do that. I'm quite concerned that with antibiotics in their medicine cabinets there will be a temptation to just use it now and again for inadequate reasons in inadequate doses. If there was a recipe for antibiotic resistance — that's it."

More terror than toll

While the anthrax mailing campaign now under way sends out another shock wave with every news report, the tactic will likely result in more terror than actual toll. The rapid administration of antibiotics has offset illness following exposures, the disease is not communicable from those actually infected, and everyone is now on high alert for suspicious mailings.

Indeed, if the wave of anthrax mailings continues, postal-treatment technologies may become a growth industry.

Regardless, anthrax is problematic as a bioweapon because only a certain micron size of the inhaled spore will lodge in the upper lungs where it can release its toxins, says **Allan J. Morrison Jr.**, MD, MSc, FACP, a bioterrorism expert and health care epidemiologist for the Inova Health System in Washington, DC.

"If it is too large, it won't go in," says Morrison, a former member of the U.S. Army Special Forces. "If it's too small, it goes in and moves about freely without ever lodging. This is not as easy as getting a culture, growing it in your home, and the next day having infectious microbes.

"The sizing, preparation, and ability to deliver such a weapon are extremely difficult," he adds.

The Aum Shinrykyo cult in Tokyo attempted at least eight releases of anthrax or botulism during 1990 to 1995 without getting any casualties, he recalls. **(See time line, p. 2.)** Variables such as humidity can come into play, clumping up spores even if they are perfectly sized for inhalation. Anthrax spores bound for human targets are also at the whims of ultraviolet light, rain, and wind dispersal patterns, Morrison says.

"It is a very hostile climate for microbes on planet earth." Morrison says. "The intent may be widespread, but the ability to deliver weapons grade agents is going to be restricted to a very small subgroup. And even among them, they still will require optimal climatic conditions to carry it out. There will be causalities, as in war, but the distinction here is that there has not been widespread infection."

While anthrax is the current weapon of choice, the direst scenarios usually turn to the most feared weapon in the potential arsenal of bioterrorism: smallpox.

"Invariably, I have seen smallpox described as 'highly infectious,'" Schaffner says. "It's not. That is erroneous." For example, during the global eradication efforts in the 1960s, African natives infected with smallpox were often found living with extended families in huts, he adds. "It would usually take two to three incubation periods for smallpox to move through an extended family."

"It doesn't happen all it once. This was a critical concept in the strategy to eradicate smallpox. If you could find smallpox, you could vaccinate around that case and prevent further transmission. If it had been a frighteningly [rapid] communicable disease, that strategy would never have worked," Schaffner explains.

In addition, some medical observers question the certitude of the general consensus that all those vaccinated decades ago are again susceptible to smallpox. They argue that those immunized during the eradication campaign may at least have some greater protection against fatal infection.[2]

Regardless, rather than dropping like flies, as many as 70% of those infected with smallpox actually survive and then have lifelong immunity.

While there are many other agents to discuss and prevention plans to outline in the weeks and months ahead, perhaps the greatest protective factor is the unprecedented level of awareness in the health care system. The world has changed so much since Sept. 11th that hospitals are probably more prepared for bioterrorism than they have ever been. Everywhere, lines of communication have been opened with health departments and affiliated clinics, emergency plans have been reviewed and hot-button phone numbers posted on the wall.

"We're on alert," says **Fran Slater**, RN, MBA, CIC, CPHQ administrative director of performance improvement at Methodist Hospital in Houston. "We are *all* on alert."

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Should clinicians get smallpox vaccinations?

Questions arise, stockpile expansion fast-tracked

The recent decision to accelerate production of a new smallpox vaccine is raising the complex question of whether health care workers — front-line soldiers in the war against bioterrorism — should be immunized against the disease.

As opposed to the current anthrax attacks, a biological release of smallpox would result in incoming patients with an infectious disease. Even health care workers directly exposed to anthrax could be treated with ciprofloxacin and several other antibiotics, so the anthrax vaccine is not a likely candidate for health care.

On the other hand, legitimate questions have been raised about whether health care workers will stay on the job during a smallpox outbreak unless they and their families are rapidly vaccinated. The only known stocks of smallpox virus are held by the United States and Russia, but many bioterrorism experts have warned for years that another nation or group might have secret stocks.

"I think if smallpox [vaccine] became available, we should definitely immunize all the health care workers," says **Martin Evans**, MD, hospital epidemiologist at the University of Kentucky Chandler Medical Center in Lexington. "A lot of people think [health care workers] ought to

be high on the list because they are part of the response team if there was an outbreak in the community. Not to sound self-serving, but I think we ought to immunize the medical community."

But the question currently is somewhat moot because the Centers for Disease Control and Prevention (CDC) is not wavering from its established policy of mobilizing the available vaccine only if smallpox is released. "I'm sure CDC wants to conserve its current stocks for dealing with an outbreak so it could immunize contacts," Evans says. "If [the agency has] already used [its stock] by immunizing all the health care workers in the country, then it won't be able to respond."

15 million doses stockpiled

Currently, there are some 15 million doses of the old smallpox vaccine available, according to Secretary of Health and Human Services **Tommy Thompson,** who recently announced plans to accelerate production of a new smallpox vaccine. Forty million new doses of vaccine are expected to be available by mid-to-late 2002, moving the project up considerably from its original completion date of 2004 or 2005.

The manufacturer of the new vaccine is Acambis Inc. (formerly OraVax) — based in Cambridge, UK, and Cambridge and Canton, MA. The new vaccine will be a purified derivative of the same strain of cowpox virus (vaccinia) that was used in the United States previously, because the old vaccine's efficacy was clearly demonstrated by direct exposures to those infected. While the method of immunization through scarification will be essentially the same, the new vaccine will be produced in a mammalian cell culture that contains no animal protein.

Acambis stated on its web site that it would have no other comment on the project other than to confirm it has "accelerated" its production plans. But when the project was first announced in 2000, company officials said they had the ability to scale up production well beyond the requested 40 million doses. They were even scouting for other global markets. That means the capability to produce smallpox vaccine in abundance is on the horizon, and the question of immunizing health care workers will invariably arise. *Bioterrorism Watch* was unable to get a CDC response on the question as this issue went to press, but CDC director **Jeffrey Koplan**, MD, MPH, outlined the agency's position in an Oct. 2, 2001 Health Alert posted on a CDC web site.

"Smallpox vaccination is not recommended and, as you know, the vaccine is not available to health providers or the public," Koplan said. "In the absence of a confirmed case of smallpox anywhere in the world, there is no need to be vaccinated against smallpox. There also can be severe side effects to the smallpox vaccine, which is another reason we do not recommend vaccination. In the event of an outbreak, the CDC has clear guidelines to swiftly provide vaccine to people exposed to this disease. The vaccine is securely stored for use in the case of an outbreak."

One factor in favor of the CDC's position to rapidly deploy the vaccine — rather than do widespread vaccinations — is that immunization should still be effective several days after a smallpox exposure. In the smallpox global eradication campaign, epidemiologists found they could give vaccine two to three days after an exposure and still protect against the disease. Even at four and five days out, immunization might prevent death. Still, though the new vaccine will be improved in many ways, the hazards and risk factors of introducing cowpox into the human body are expected to be roughly the same as those documented with the old vaccine.

"We are looking at probably about one death per million primary vaccinations," says **D.A. Henderson**, MD, director of the Center for Civilian Biodefense Studies at Johns Hopkins University in Baltimore. "We are looking at one in 300,000 developing post-vaccinal encephalitis — an inflammation of the brain, which occasionally is fatal and sometimes can leave people permanently impaired."

Based on those estimates, if the new stockpile of 40 million doses is eventually rolled out, approximately 40 of those immunized will die, and another 133 will develop encephalitis. In addition to those severe outcomes, the arm lesion created during inoculation can be very large and painful, serving as a reservoir to self-inoculate the eyes or even infect immune-compromised patients.

The downside is real, but as more vaccine becomes available immunization will certainly be discussed at hospitals in previously targeted areas such as New York City and Washington, DC. If they are not immunized in advance, health care workers are going to want vaccine very quickly if they are expected to take care of smallpox patients, says **Allan J. Morrison Jr.**, MD, MSc, FACP, health care epidemiologist for the Inova Health System in Washington, DC. "Forget about smallpox patients. We're talking about taking care of any patients." ■