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Is capnography used by ED nurses? It may give life-saving information

Valuable tool not routinely used in ED

Is your intubated patient being transported for radiological studies? This increases the chance of disastrous consequences due to an unrecognized displaced or dislodged endotracheal (ET) tube, warns **Catherine Payne**, RN, MSN, CCRN, CEN, an ED nurse at the University of California Davis Medical Center in Sacramento.

“Partial dislodgments of tubes have been found to be several times more dangerous to patients than complete removal of the tube,” she says, explaining that capnography can prevent life-threatening situations due to early recognition of tube displacement.

“We all know, and studies are showing, that when we move a patient, there is a risk of ET tube displacement,” says **Sean Hall**, RN, an ED nurse at Mount Desert Island Hospital in Bar Harbor, ME, who teaches waveform capnography as a Maine Emergency Medical Services (EMS) paramedic instructor. “With waveform capnography, displacement of an ET tube is detected almost instantly.”

If there is a change in the patient’s respiratory status, adds Hall, capnography, coupled with good respiratory assessment skills, can save a patient’s life due to early intervention.

Capnography provides a continuous confirmation of tube placement, says Payne, and a way to maintain ET_{CO₂} levels to avoid hyperventilation and hypocapnia. “Pulse oximetry can take several minutes to detect changes in saturation, whereas capnography can reflect changes in about 10 seconds,” she says.

EXECUTIVE SUMMARY

Capnography can potentially prevent complications in critically ill patients and indicate the need for aggressive therapeutic interventions, but the tool isn’t often used in EDs. ED nurses can use capnography to:

- Help confirm tracheal tube placement.
- Give information on airway patency during transport.
- Show improvement or decline, when used in conjunction with pulse oximetry.

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More critically ill in ED

Capnography can alert you to low values of carbon dioxide, which may indicate the need for more aggressive therapeutic interventions, says Payne, whose ED implemented a standard of care in 2008 requiring ETCO₂ monitoring for all intubated patients.

Critically ill patients are staying longer in the ED due to a lack of available staffed intensive care unit (ICU) beds, says Payne, and the standard of care should be the same in the ED as in the ICU. “Capnography is one example of an adjunct therapy needed to assist in monitoring patients to prevent potential complications,” she says.

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Editorial Questions

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There are many potential complications associated with mechanical ventilation, she adds, adding that the artificial airway poses a risk for obstruction, displacement, or dislodgment. “This requires ED nurses to rapidly identify a life-threatening situation that requires immediate intervention,” she says.

Follow EMS lead

Payne surveyed 94 emergency nurses caring for intubated patients who had been trained on the use of capnography, and 95% agreed that capnography improved patient care.¹

“This provides evidence that monitoring intubated patients with capnography is considered necessary by ED nurses,” says Payne, noting that this tool *isn't* routinely used by the ED nurse, despite recommendations from several medical societies in support of the use of ETCO₂ monitoring.

ED nurses “should follow the EMS lead,” according to Hall, adding that the expense of the technology is one reason capnography isn't widely used in smaller EDs.

“The standard in pre-hospital care has risen to using waveform capnography,” says Hall. “Many EMS agencies are already ahead of the curve, with training and equipment in place.”

New protocols for Maine EMS are in effect, he reports, which require that any patient with a transglottic device or ET tube be placed on either adult or pediatric use waveform capnography.

Some hospitals have the capability to do waveform capnography, adds Hall, which he says is especially useful in traumatic brain injury, sepsis, and respiratory emergencies.

“With capnography, one is able to prevent hyperventilation in a traumatic brain injury by keeping ETCO₂ between 35 and 45,” he explains. “As we all know, hyperventilation can cause increased intracranial pressures, which can result in poor outcomes in those patients.”

Some hospitals have the equipment and policies in place, says Hall, but may lack the education component. If ED nurses become proficient in capnography, says Hall, this will greatly improve management of ventilated patients, and the use of side stream waveform capnography will greatly improve the care of respiratory patients.

“I personally have used this technology with outstanding results,” says Hall. “Used in conjunction with a pulse oximetry, it can show improvement or decline. This can have a dramatic impact

on the patient's course of treatment." (See related story, p. 15, on use in patients with respiratory compromise.) ■

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SOURCES

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Monitoring ETCO₂ may mean fewer treatments

Using tool can be challenging

Capnography "is a fantastic tool that is not being utilized enough in the ED," says **Anne Eizyk**, BA, RN, CEN, an ED nurse at St. Elizabeth Healthcare in Florence, KY.

After months of reading about capnography use in the ED and studying waveforms, Eizyk was finally able to use the tool on two nonconscious sedation patients and apply the information to her assessments. "Using the end-tidal carbon dioxide [ETCO₂] monitor in our department is sometimes a bit of a challenge," she explains, adding that hospital policy requires that ETCO₂ be monitored while giving conscious sedation.

"But using it in patients with respiratory compromise can also give us very useful information, if one is familiar with the implications of the waveforms," she says.

However, although there are two ETCO₂ monitors in the ED, only one has the capability of monitoring the waveform, she explains. "It can be piggybacked onto any of our cardiac monitors, but

sometimes it takes time to locate it. It seems that it is often out for repair," says Eizyk. The other monitor is connected to an infusion syringe pump for patient-controlled anesthesia, and because it only displays numbers, it is only used when administering conscious sedation, she explains.

Despite these challenges, Eizyk was able to locate the monitor and the tubing before receiving a woman in her 50s in respiratory distress who was brought in by paramedics. The patient presented wearing a 100% non-rebreather, sitting in a tripod position, and was tachypneic and tachycardic with a pulse oximetry in the low 80% range.

"Surprisingly, I heard more lung sounds than I thought I would, but they were decreased," says Eizyk, who took the patient off the non-rebreather and placed her on 4 L oxygen per the ETCO₂ nasal cannula, and studied the waveform.

"From reading this waveform, I could deduce that despite her increased respiratory rate, she was still retaining a large amount of carbon dioxide," says Eizyk. "Because of her lung disease, she was not able to fully exhale. Her baseline remained elevated."

Monitoring the ETCO₂ waveform probably saved the patient from getting a few more bronchodilator treatments in the ED, she says, adding that just two treatments were given.

With a few bronchodilator treatments, Eizyk saw that the baseline was decreasing, the waves were becoming less tall and narrow, and her respiratory rate was becoming normal. "This information was more helpful to me than just following her pulse oximetry or constantly listening to her lung sounds, which really didn't change that much after therapy," says Eizyk. ■

Use these practices to treat ED patients using "meth"

Keep in mind that patient is addicted

If the patient standing in front of you appears jittery, unable to sit still, and is continually scratching at sores on his or her face and body, it's likely he or she is using methamphetamine. "It's unfortunate to say, but we can usually tell by looking at someone that he or she is a meth user," says

Sue Williams, RN, a nurse with SSM Behavioral Health Services at St. Joseph Health Center-Wentzville in Wentzville, MO.

Although ED nurses report a continuing increase in methamphetamine users, five out of six Kansas EDs surveyed lacked formal treatment protocols for these patients, according to a recent study.¹

“We have had increasing numbers of meth users over the past five years,” says Williams, adding that they usually come in because they are hallucinating. “When they are using, they see and hear things. That can carry over into their non-using time and scare them,” she says. “They think they have a psychiatric disorder.”

J. Kimberlee Bagby, RN, an ED nurse at Sutter Delta Medical Center in Antioch, CA, says she continues to see a high number of patients using methamphetamine, with users complaining of abdominal pain, rapid heartbeat, or anxiety. Some are completely delusional and need immediate psychiatric intervention.

“Meth users require some unique approaches when trying to collect necessary basic health information to treat them,” she says. “Staff need to be calm, stern, and have lots of patience!”

Don't be judgmental

Williams says to be careful not to give any impression you're judging the patient. “Even though you may think they're unaware of it, they do recognize when they are being looked down upon,” she says. “Treat it like any other disease.” Remember that the patient isn't making rational judgments because of an addiction, she underscores.

Avoid raising your voice or glaring, says Williams, as this can be dangerous for you and the patient. “Some people feel like they shouldn't back down with these patients, but you shouldn't try to make a point that you are in

EXECUTIVE SUMMARY

ED nurses are continuing to see high numbers of patients using methamphetamine, who often come in because they're experiencing hallucinations. Use these practices:

- Treat patients in a non-threatening manner.
- Remember that patients aren't behaving rationally because of an addiction.
- Ask the same questions multiple times if necessary.

charge,” she says.

Remember how frightened your patient is, she says, and present the calmest possible demeanor. “They really respond so much better to gentleness — very rarely do they want to strike out at us,” she says. “Try to act with them the same way you would with a frightened little kid.”

ED nurses at Sutter Delta Medical Center take these steps:

Obtain a medical history, including dental care.

“Meth users tend to have ‘meth mouth,’ with cracked, chipped, or discolored teeth, or advanced decay,” says Bagby. (See related story, p. 16, on obtaining a history, and clinical tip, p. 17, on physical assessment.)

Address dietary intake.

Since methamphetamine is a potent form of amphetamine, which can work as an appetite suppressor, many meth users tend to have a poor dietary intake, says Bagby.

Carefully review vital signs, lab work, or EKGs, which will determine the next steps in treatment.

“We are fortunate that we have a social services team to help meth users receive the necessary psychiatric care, or referrals to appropriate agencies in our county,” says Bagby. ■

REFERENCE

1. Tompkins-Dobbss, Schiefelbein J. Emergency department policies and procedures for treatment of patients abusing methamphetamine. *J Emerg Nurs* 2001; 37:437-443.

SOURCES

For more information on caring for ED patients using methamphetamine, contact:

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Get a history from a meth user

Methamphetamine users may be euphoric one minute, but paranoid, agitated, and violent the next. “This creates a challenge to get the needed information to complete their initial health

assessment,” says **J. Kimberlee Bagby, RN**, an ED nurse at Sutter Delta Medical Center in Antioch, CA.

Methamphetamine users may minimize how much they’re taking, similar to the way alcoholics often report drinking less than they actually do, says **Sue Williams, RN**, a nurse with SSM Behavioral Health Services at St. Joseph Health Center-Wentzville in Wentzville, MO.

“People may tell you they use it a few times a week when it’s actually every day,” says Williams. “Each person who interviews them gets a little clearer picture.”

Methamphetamine users may become physically or verbally abusive to staff, which can complicate getting them the necessary treatment, Bagby says, adding that patients tend to hide the truth about their use of methamphetamine, the reasons for their ED visit, and their health history.

“In my experience, patients who use methamphetamine require more physical and mental energy from staff trying to treat them, compared to patients who don’t use methamphetamines complaining of the same ailments,” says Bagby.

It’s often difficult to keep the patient focused, says Bagby, so you’ll need to ask the same questions multiple times to get the needed answers. “For heavy meth users, you always have concerns about the patient’s overall cardiac health due to the stress caused by long-term use of the drug,” she adds. ■

CLINICAL TIP

Always have meth users don gowns

If you suspect your patient is using methamphetamine, have him or her don a hospital gown regardless of his or her complaints, says **J. Kimberlee Bagby, RN**, an ED nurse at Sutter Delta Medical Center in Antioch, CA. “This is necessary in order to get a complete assessment of the patient’s body,” she says. “Look for skin abscesses, injection sites, as well as burns from smoking meth.” ■

Prevent infections caused by contaminated ED equipment

Don’t use unsafe practices

If a tuberculosis patient just left your ED to go to a negative pressure room, housekeeping must come and disinfect the room wearing full contact precautions garb, leave the room unused for four hours, and remove all hanging curtains and replace these with clean ones.

“Basically, the room that patient was in is a HAZMAT scene,” says **John Provost, RN, BSN**, an ED nurse at St. Mary’s Hospital in Tucson, AZ. “Yet all too often, equipment, such as fluid pumps, are quickly snatched up because there is a dire need for it in another room.”

After being alerted to the fact that the pump was in a tuberculosis-positive room, an ED nurse may respond, “Thanks. I’ll wipe it down,” says Provost, but this isn’t sufficient.

“Clearly, equipment in a patient’s room is open to the organisms that the individual is being treated for,” he warns. “Now tuberculosis is introduced into the environment — and especially to the nurse who has just grabbed it.” Use these practices:

- **Don appropriate disposable personal protective equipment (PPE) before entering the patient’s room, and dispose of it before exiting the room.**

“At my current facility, our negative pressure room has a subroom used for putting on and taking off PPE, to best allow for a noninfectious individual entering the general population,” says Provost.

- **Never allow equipment to be reused.**

“If your facility is stocking disposable items for the treatment of infectious organisms, *don’t* make the mistake of recycling,” says Provost. “It may seem like an excellent idea at the time of an emergency, but this is such bad practice.”

EXECUTIVE SUMMARY

Both ED patients and nurses may be exposed to infections caused by contaminated equipment. To prevent this:

- Dispose of personal protective equipment before leaving the room.
- Never re-use disposable equipment.
- Place used disposable items in biohazard bags.

CLINICAL TIP

Never reuse ET tube in this circumstance

Has an attempt at intubation resulted in the endotracheal (ET) tube going into the patient's esophagus? If so, use a new ET tube to avoid introducing bacteria from the esophagus into the airway, advises **Kelly Coddington**, RN, BSN, nurse manager of emergency services at OSF St. Joseph Medical Center in Bloomington, IL.

Make sure the cuff is properly inflated to decrease the chance that oral secretions will pass into the airway, she adds, and secure the tube well to prevent movement and accidental extubation. "A well-secured tube is less likely to move or be pulled out, which can result in needing to adjust or reintubate," says Coddington. ■

Could a suicidal patient be discharged from ED?

Some come with unrelated complaints

While assessing a 40-year-old male who complained of abdominal pain, nurses did a routine mental health screening, which included asking if he was currently suicidal. "He answered 'yes' to all of the questions," says **MaryEllen Swanson**, RN, a senior staff nurse in the ED at Hennepin County Medical Center in Minneapolis. "It would have been missed if the screening had not been done."

EXECUTIVE SUMMARY

Routine screening at triage can identify potentially suicidal patients, even if their chief complaint is something completely unrelated. Use these practices:

- Watch for avoidance of eye contact, a withdrawn appearance, and lack of hygiene.
- Take all statements about suicide seriously.
- Don't hesitate to ask directly if patients are suicidal.

He says to ask yourself this question: "Am I simply going to make a bad situation much worse by using an item that was used on an infectious patient?"

- Use disposable items such as gowns, gloves, goggles, masks, shoe covers, stethoscopes, blood pressure cuffs, pulse oximeters, and anything else your facility has to offer.

"By transporting ED equipment from room to room without wiping it down and cleaning properly, we run the risk of exposing our patients to infections," warns **Delores Alexander**, RN, BSN, MBA, clinical outcomes manager at Mercy Continuing Care Hospital in Chesterfield, MO.

- Label and bag items properly so the cleaning team can easily identify these.

"If the patient was identified to have a difficult-to-treat infectious organism, a barrier such as a plastic bag needs to cover the entire item, which will not allow any of the organism out," Provost adds. (See clinical tip, p. 18 on avoiding infection in intubated patients.)

Place any used disposable instruments or equipment in biohazard bags before discarding them, says Alexander, and closely follow your hospital's protocol for disposal.

- If disposable items such as suture trays and intubation equipment aren't possible due to cost issues, clean equipment appropriately. (See related story on endotracheal tubes, p. 18.)

"We use Saniflush wipes. They must be allowed to dry on the equipment for two minutes to kill infectious material," Alexander says. "Bleach wipes have a one-minute contact time."

However, you have to be careful that the equipment you use can be cleaned with these products, cautions Alexander. "Make sure you know what the user manual states before using any products on your equipment," she says. ■

SOURCES

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In fact, the patient had no medical problems that needed to be addressed, she reports, and instead was admitted to the mental health unit for treatment.

“Patients presenting to the ED for vague complaints often are seeking help for something other than their original complaint,” says Swanson, adding that patients have returned to hospitals and committed suicide in ED waiting rooms.

To address this, a task force of ED and psychiatric nurses and physicians developed a set of questions to ask every adult at triage in May 2011, with the exception of patients with altered mental status due to alcohol or substance abuse, who are screened once they are sober. ED nurses first ask, “Are you suicidal?” (See **clinical tip, p. 19, on the importance of asking this question.**)

If the patient answers yes, he or she is asked, “Do you have a plan for harming yourself?” “Have you ever harmed yourself?” and “Have you ever been hospitalized for this?”

If the patient reports being suicidal, these steps are taken:

- Patients are immediately placed in a direct observation room and all items that they may attempt to use to harm themselves are removed, including blood pressure cuffs and monitor cables.

- If the ED physician believes the patient is at risk after an initial screening, he or she is placed on a “hold.” “Once the medical issues have been addressed, the patient is transferred to our Emergency Acute Psychiatric Services area,” says Swanson.

- The patient is then evaluated further by a mental health counselor and a psychiatrist. “They will either admit the patient or place them in a day treatment program, based on the risk for harming themselves,” says Swanson.

Triage assessment

Erin Cavanagh, RN, BSN, MBA-HCM, clinical coordinator in the ED at Henry Ford Hospital in Detroit, says she sees a significant number of patients with suicidal ideation in her ED.

“We have a dedicated six-bed psychiatric area in our ER,” she says. “This is frequently occupied due to economic issues and limited mental health outpatient services for the underinsured.”

With a quick glance, says Cavanagh, you might notice that a patient doesn’t make eye contact, appears withdrawn, and lacks personal

hygiene. He or she may not want to talk in detail about why they came to the ED, and instead tell you, “I just want to talk to the doctor.”

These are all signs your patient is possibly suicidal, says Cavanagh, adding that patients are at higher risk if they’re using drugs and alcohol. “Never make decisions based on the patient’s personality,” she adds. “Patients at most risk might be the most difficult to work with.”

Patients who come to the ED frequently while intoxicated may routinely make comments about suicide, notes Cavanagh, but you need to take all such statements seriously.

“Nurses can never be complacent on these threats,” warns Cavanagh. “If you believe a patient could be at risk, advocate for the patient. Nurses must stop a discharge of an at-risk suicidal patient.” ■

SOURCES

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CLINICAL TIP

Ask this simple question of patients

The single best tool you have available to determine if a patient is suicidal is a simple question, according to **Erin Cavanagh**, RN, BSN, MBA-HCM, clinical coordinator in the ED at Henry Ford Hospital in Detroit. Simply ask patients in a nonjudgmental manner, “Are you suicidal? Have you ever had thoughts of harming yourself?”

“Nurses should never be afraid to ask,” she

says. “Patients are often relieved to have the subject opened up.” ■

ED patients may be overdosing on meds

Alert them to risks

If a patient reports taking antibiotics during your medication reconciliation, you may learn these were prescribed for a urinary tract infection or dental work months earlier. “For whatever reason, they didn’t take the antibiotics as prescribed, and now they will take a pill whenever they have a sore throat,” says Kimberly Barker, BS, RN, CEN, an ED supervisor at St. David’s South Austin (TX) Medical Center.

In this case, she says to inform the patient *why* this approach is harmful. “Explain that taking one [Zithromax] is not going to kill off a bladder infection. It *could* make it change into a more resistant bacteria and lead to a more damaging infection,” Barker says. Here are other scenarios:

Patients may be taking “as-needed” medications on a daily basis.

A patient may take a nitroglycerin pill every morning because he or she thinks it will prevent chest pain, instead of only when he or she is experiencing chest pain, for example. “In this case, the patient may end up in a situation where their blood pressure suddenly drops,” warns Barker. Patients may be doing something that they wouldn’t be doing if they actually had chest pain, such as driving, she adds, which can lead to injuries.

Similarly, asthmatics may take rescue inhalers every day instead of only when they are short of breath. “People may get confused and decide to

take pills that are supposed to prevent an exacerbation, without realizing that it doesn’t work instantly,” she adds.

Patients may be taking too much of a prescribed medication.

Did your patient tell you he or she takes three pills of acetaminophen and hydrocodone every two hours, when the prescription indicates one should be taken every four hours? “Make them aware of the dangers of doing that,” says Barker. “Inform them that medication should be taken only as prescribed.”

A patient may be seeing multiple different doctors and is receiving pain medications from both.

In this case, says Barker, “our physician needs to contact the other physicians, so that everyone is on the same page and the patient is not getting overmedicated.”

The patient may have already taken medications at home that are also given in the ED.

If your ED patient reports having taken no medications, listen closely to his or her health history. “Many times I will ask, ‘Are you taking any medications on a daily basis?’ and the patient says no,” says Barker.

The patient may then report congestive heart failure, diabetes, or asthma, in which case, Barker asks, “How are you treating this?” In some cases, patients may be getting infusions or injections of medicine, or wear transdermal patches, and may not think of this as “taking” medications, says Barker.

If you ask, “How are you treating this?” the patient may then give you a list of medications. “You have to ask direct questions,” says Barker. “You may need to ask the same question in a variety of ways.”

The ED physician may prescribe the patient medication they’ve already taken at home.

For instance, if a beta-blocker is prescribed and you know the patient is already taking this medication, ask the ED physician if he or she really intended for the patient to take both medications, Barker says.

Never give medications to lower the blood pressure of a patient in a hypertensive crisis without asking “Did you take anything before you came?” she stresses.

“A lot of times, they will take their home medicines and forget to tell you,” she says. “If you don’t know, you are up for a big surprise when *both* medicines kick in and their blood pressure plummets.” (*See clinical tip, p. 21, on blood pressure medications.*) ■

EXECUTIVE SUMMARY

Your ED patient may be taking previous prescriptions that are no longer indicated, or may be unintentionally overdosing on prescribed medications. Use these practices:

- Inform patients that as-needed medications shouldn’t be taken on a daily basis.
- Contact physicians if multiple pain medications are prescribed.
- Ask patients how their condition is being treated.

SOURCES

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CLINICAL TIP

Be specific about blood pressure medications

If your patient answers “no” when you ask about a history of high blood pressure, and the blood pressure is within normal limits, also ask if your patient takes medication for high blood pressure.

“Some patients think they don't have high blood pressure anymore because they're taking the medicine,” says **Kimberly Barker**, BS, RN, CEN, an ED supervisor at St. David's South Austin (TX) Medical Center. “They don't understand that the condition isn't gone — it's just being temporarily fixed by the medication.” ■



Identify signs of dangerous pediatric airway problems

Intubation may be necessary

Children are more susceptible to acute airway compromise due to the unique characteristics

of a child's airway, according to **Eileen Callahan**, RN, BSN, an ED pediatric nurse educator at Tufts Medical Center and the Floating Hospital for Children in Boston, MA.

“Maintaining a patent airway is essential for adequate oxygenation and ventilation,” she warns. “Failure to do so can be life-threatening.” Here are points to consider:

- The pediatric airway is small in diameter and short in length, which may result in marked increased resistance to airflow when edema, increased secretions, or a foreign body is present.

“The shorter length may result in an increased risk of right mainstem bronchus intubation or accidental extubation,” says Callahan.

- The tongue, which is large in relation to the size of the oral cavity, can be a major cause of airway obstruction, especially in the unconscious or somnolent infant in the supine position.

“A jaw thrust maneuver, oral or nasopharyngeal airway, and a towel roll under the shoulders are all potential ways to improve airway management,” says Callahan.

- Infants younger than four months of age are obligatory nasal breathers, and the nares are easily obstructed by secretions, edema, blood, or even oxygen nasal prongs that are too large.

“All of these may result in signs of airway compromise,” says Callahan. “Keeping the nares clear with a simple bulb syringe will allow the infant to breathe more easily, as well as tolerate feedings without difficulty.”

Look for these signs

Watch for decreased level of consciousness, restlessness, anxiety, diaphoresis, excessive drooling, stridor, grunting, or any sign of increased work of breathing, says Callahan, as these are signs

EXECUTIVE SUMMARY

Pediatric patients are at higher risk for acute airway compromise due to their unique anatomy, and failing to maintain a patent airway can be life-threatening. Use these approaches:

- Consider use of a jaw thrust maneuver, oral or nasopharyngeal airway, or a towel roll under the shoulders.
- Watch for signs of air hunger, hypoxemia, or compromise in gas exchange.
- Use supplemental oxygen, airway adjuncts, or position changes as needed.

of air hunger, hypoxemia, or compromise in gas exchange.

Intubation is indicated most frequently for acute respiratory failure, upper airway obstruction, shock or hemodynamic instability, neuromuscular weakness with progressive compromise, absent protective airway reflexes, inadequate respiratory drive, or cardiopulmonary arrest, says Callahan.

“Supplemental oxygen, airway adjuncts, or position changes may assist in airway management,” she says. “If no improvement is seen with these modalities, then bag mask ventilation should be initiated and preparation for intubation should be underway.” (See **clinical tip**, p. 22, on **bag mask ventilation**.) ■

SOURCES

For more information on pediatric airway management in the ED, contact:

- **Eileen Callahan**, RN, BSN, Pediatric Nurse Educator, Emergency Department, Tufts Medical Center and the Floating Hospital for Children, Boston, MA. Phone: (617) 636-9649. E-mail: ecallahan@tuftsmedicalcenter.org.
- **Chris Ruckman**, RN, MBA, CEN, Manager, Adult Emergency Services, Vanderbilt University Hospital, Nashville, TN. Phone: (615) 875-4606. Fax: (615) 322-1494. E-mail: christopher.ruckman@vanderbilt.edu.

CLINICAL TIP

Avoid decompensation with bag mask ventilation

Administering oxygen to a child via bag mask ventilation “can significantly alter the patient’s outcome for the better,” says **Chris Ruckman**, RN, MBA, CEN, manager of adult emergency services at Vanderbilt University Hospital in Nashville, TN.

A child’s cellular system compensates for an elongated period of time until they have reach maximum compensation, explains Ruckman, then they decompensate rapidly over a short period of time.

“Providing them with positive pressure ventilations allows for oxygen to be forced into the lung fields, then passed through the circulatory system throughout the vital organs and body,” says Ruckman. ■

Get stroke patients CT scans more quickly

Every part of the process in stroke care — from the time the patient begins to have symptoms to the time treatment is initiated — is constantly examined for ways to cut minutes, reports **Sharon Pulver**, MSN, RN, CEN, network stroke coordinator for the SSM Neurosciences Institute in St. Louis, MO.

“Time is of the essence in stroke treatment,” she says, adding that according to the American Stroke Association, one minute of brain ischemia can kill two million nerve cells and 14 billion synapses. The ED set a door-to-drug goal of 60 minutes or less, she reports, and goals for door-to-CT within 25 minutes and door-to-report in 45 minutes. These steps were taken:

- **Protocols were established and everyone involved was educated.**

“A team approach based on standardized stroke protocols has proven to be effective in reducing time to treatment,” says Pulver.

- **Emergency medical services (EMS) is allowed to call a “Code Stroke” from the field.**

EMS requires education, says Pulver, so that they can identify signs and symptoms of stroke. “When they call a stroke in the field, we begin the process in the ED — a ready bed, CT notified, and registration notified,” she says. “If possible, we take the patient directly to CT after a brief check for life-threatening symptoms.” (See **clinical tip**, p. 23, on **giving blood tubes to EMS**.)

EXECUTIVE SUMMARY

To reduce delays in stroke treatment, look at every part of the process to cut minutes, including time to CT scan. To reduce delays:

- Allow emergency medical services (EMS) to call a “Code Stroke” from the field.
- Include CT technicians on your stroke team.
- Supply (EMS) with blood tubes.

Registration may use a computer on wheels and register the patient en route to CT, says Pulver, or may do a “quick registration” and complete it when the patient returns to the ED.

- **The radiologist calls the ED physician with the report on all Code Strokes.**

Document the time of the call on the official read, advises Pulver, which allows data to be easily collected for process improvement. “It also allows the physician to be seeing patients while the CT is being read, instead of hovering over a fax machine or the computer for results,” she says.

- **Include CT technicians on your stroke team.**

“Review the data at every meeting. It keeps everyone on track,” says Pulver. “Competition drives down times.” ■

SOURCES

For more information about reducing delays to CT scan for stroke patients, contact:

Sharon Pulver, MSN, RN, CEN, Network Stroke Coordinator, SSM Neurosciences Institute, St. Louis, MO. E-mail: sharon_pulver@ssmhc.com.

COMING IN FUTURE MONTHS

- Prevent dangerous misunderstandings of ED instructions

- Find out about recreational drugs taken by patients

- What you must document if you ID infection at triage

- Get life-saving info on elder patient from nursing home

CLINICAL TIP

Give EMS blood tubes: Speed CT scans

To eliminate a step that could delay an ED stroke patient from receiving a CT scan, supply emergency medical services with a packet of your hospital’s blood tubes, recommends **Sharon Pulver**, MSN, RN, CEN, network stroke coordinator for the SSM Neurosciences Institute in St. Louis, MO.

“As soon as they start the IV, they can draw the labs and hand them off to the nurse. The labs can be processed as the patient is in CT,” she explains. “Many times, it is the wait for the labs to be drawn that delays the trip to CT.” ■

CNE INSTRUCTIONS

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CNE OBJECTIVES/ QUESTIONS

Upon completion of this educational activity, participants should be able to:

- identify clinical, regulatory, or social issues related to ED nursing;
- describe the effects of clinical, regulatory, or social issues related to ED nursing on nursing service delivery;
- integrate practical solutions to ED nursing challenges into daily practice.

1. Which is true regarding use of capnography, according to

Catherine Payne, RN, MSN, CCRN, CEN?

- A. Partial dislodgments of tubes are much less dangerous to patients than complete removal of the tube.
- B. Capnography takes several minutes to detect changes in saturation.
- C. Capnography should not be used to help confirm tracheal tube placement.
- D. Pulse oximetry can take several minutes to detect changes in saturation, but capnography can reflect changes in about 10 seconds.

2. Which is recommended to prevent infections caused by

contaminated ED equipment, according to **John Provost**, RN, BSN?

- A. It is not advisable to dispose of personal protective equipment before exiting the patient's room.
- B. ED nurses should never allow disposable equipment to be reused.
- C. If a patient was identified to have a difficult-to-treat infectious organism, ED nurses should avoid covering the item with a barrier such as a plastic bag.
- D. If an attempt at intubation has resulted in the endotracheal tube going into the patient's esophagus, it is not necessary for ED nurses to use a new tube.

3. Which is recommended to reduce delays in getting stroke patients to CT scan, according to **Sharon Pulver**, MSN, RN, CEN?

- A. Emergency medical services (EMS) should be supplied with hospital blood tube packets so labs can be drawn en route to the ED.
- B. Emergency medical services should not be allowed to call a "Code Stroke" from the field.
- C. The radiologist should not call the ED physician directly with the report.
- D. CT technicians should not be included on hospital stroke teams.

4. Which is recommended for ED nurses caring for patients using

methamphetamine, according to **Sue Williams**, RN?

- A. ED nurses should remember that patients may report using methamphetamine less often than they actually do.
- B. ED nurses should not hesitate to raise their voices to avoid giving the impression of "backing down" to the patient.
- C. It is not necessary to have the patient don a hospital gown if no injuries are reported by the patient.
- D. ED nurses should avoid asking the same questions multiple times to get needed answers.

When looking for information on a specific topic, back issues of ED Nursing newsletter, published by AHC Media, may be useful. To obtain 2011 back issues, go online to www.ahcmedia.com. Select "activate your subscription." Or contact our customer service department at (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: customerservice@ahcmedia.com.

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