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IN THIS ISSUE

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New EMTALA regs are finally here: You'll be surprised at the changes

Experts: Don't forget that basic requirements still stand

Are you having problems providing on-call specialists to patients after-hours? Have you been overwhelmed by the need to educate off-campus sites about Emergency Medical Treatment and Labor Act (EMTALA) requirements? Are you confused about what your ED is required to do when patients have medical emergencies in other areas of the hospital?

The new EMTALA rules from the Baltimore-based Centers for Medicare & Medicaid Services (CMS) address all three of these problem areas. Although there are significant changes in the law, which takes effect Nov. 10, the basic requirements for a medical screening examination, stabilization if an emergency medical condition exists, and transfer requirements are the same, according to **Charlotte S. Yeh**, MD, FACEP, administrator of the CMS Boston Regional Office.

"This provides clarification of thorny issues that have come up over the years, but no one should interpret this as a wholesale change," she says. "The intent and obligations of EMTALA still stand and have not changed."

The bottom line is that no one seeking emergency care should be turned away without a medical screening examination, she emphasizes. "The standard that triage is not a medical screening examination hasn't changed," says Yeh.

Stephen A. Frew, JD, a consultant with PIC Wisconsin, says, "At this stage,

Audio conference clarifies final EMTALA regulations

The final version of the recently proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) takes effect Nov. 10.

To provide you with critical information on the updated regulations from the Centers for Medicare & Medicaid Services, Thomson American Health Consultants offers New EMTALA Regulations: Are They Too Good to be True? — an audio conference on Tuesday, Oct. 21, from 2:30-3:30 p.m., EST.

While the new rule clarifies many points and is intended to reduce the

(Continued on page 141)

I would not loosen any EMTALA compliance in the ED unless and until site review guidelines give any further guidance." PIC Wisconsin is a Madison-based company specializing in risk management for health care professionals.

It's a mistake to assume the new regulations are more lenient, urges Yeh. "Use the publication of these new regulations as an opportunity to re-educate yourself about EMTALA obligations," she advises. **(See related story on educating staff on EMTALA, p. 139.)** Penalties for EMTALA violations will not change and include fines of up to $50,000 per violation and possible termination of Medicare participation. In addition, patients still will have the right to sue hospitals for EMTALA violations.

"There is a great deal of language that is new to the regulations, but it is exactly what CMS has been saying and applying for many years," says Frew. "There are some surprises, however."

Here are key changes in the EMTALA regulations:

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EXECUTIVE SUMMARY

There are significant changes in the newly revised Emergency Medical Treatment and Labor Act (EMTALA) regulations, which are effective Nov. 10, but the basic requirements still will exist.
- Off-site locations will no longer fall under EMTALA.
- EMTALA will no longer apply to inpatients.
- Medical screening examinations still will be required.

• The definition of "hospital property" where patients are entitled to emergency care has narrowed.

"Off-campus" sites now will fall under EMTALA only if they are licensed as an ED, held out to the public as a place that provides emergency care, or if emergency cases accounted for at least one-third of all outpatient visits in the prior year.

EMTALA will not apply to doctors' offices, rural health clinics, nursing homes, or other "nonhospital entities," even if they are adjacent to the main hospital building and are owned or operated by the hospital.

"We have several off-site medical office buildings that this affected," reports **Val Gokenbach**, RN, MBA, director of emergency services and observation at William Beaumont Hospital in Royal Oak, MI. "Those are now not considered under EMTALA."

This change will relieve an ongoing burden to educate off-site staff in emergency care, she explains. "The incidence of problems was so incredibly low that we were finding it difficult to keep individuals comfortable with emergency conditions that they don't face regularly."

The ED will continue to assist off-site locations if a patient is being transported, adds Gokenbach. "We do maintain open lines of communication for support to them in the event that they need advice from us," she says.

The law does require that off-site facilities have protocols for what to do if an emergency does occur, notes Yeh. "It is in the ED's best interest to work with other areas of the hospital to develop response protocols, but that's just part of good patient care," she says.

• EMTALA no longer applies to admitted patients.

EMTALA no longer will apply to inpatients, whether they are in the ED or on the floors, says **Todd B. Taylor**, MD, FACEP, an ED physician at Phoenix-based Banner Good Samaritan Regional Medical Center.

"This recognizes that EMTALA was never intended to apply to inpatients, no matter how they came to be there," he says. "CMS now appears to be comfortable

SOURCES AND RESOURCE

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The final Emergency Medical Treatment and Labor Act (EMTALA) rule was published in the Sept. 9, 2003, *Federal Register* and becomes effective Nov. 10, 2003.

that the other Medicare Conditions of Participation will cover issues regarding how care, including specialty physician care, will be delivered to inpatients."

However, although EMTALA no longer applies to admitted patients being held in the ED, this does not mean that you are no longer responsible for these patients, warns Frew.

"CMS states that patients being boarded in the ED are admitted patients under EMTALA but remain the legal obligation of the ED," he says. "This is a setback both in terms of getting necessary help to care for these patients, and exposes the ED physician and nurses to ongoing liability for care of the patient."

The new regulations won't change the fact that ED nurses must observe, care, and document for inpatients being held in the ED, while caring for ED patients at the same time, notes Frew. "I strongly caution that boarded patients are legally perceived as entitled to the level of nursing care that they would receive in the destination unit."

This is an ongoing problem resulting in potentially dangerous overextending of ED nurses, he says. "Every effort should be made to pressure administration for unit nurses to cover boarded patients, to ensure that overburdened ED nurses are able to provide care to emergency patients," Frew advises.

• On-call specialist requirements are more flexible.

The new rule says that on-call specialists will no longer be required "around the clock," and it specifies that physicians can be on-call at more than one hospital simultaneously and can schedule elective procedures while on call.

"No one can really mandate down to the last detail how on-call services are provided, because every community and ED are different," says Yeh. Under the revised regulations, on-call lists can be developed in a way that best meets the needs of the community, she explains.

However, there is a danger of receiving hospitals interpreting the new rules to mean that they are no longer obligated to accept transfers for patients who require a higher level of care, warns Frew. "This will have a major impact on EDs without full-time physician coverage," he says.

Although CMS has warned that hospitals still must accept transfers and that this will be enforced under Medicare's Conditions of Participation, Frew predicts there will be problems.

"Hospitals throughout the country have attempted to dodge transfer acceptance of admitted patients for the past 17 years," he says. The new rules will make this more likely, Frew adds.

"When you attempt to arrange a transfer, you may be confronted with the question: 'Has the patient been admitted?'" he says. "If the answer is "yes," the next question will be about insurance, and the likelihood is that uninsured transfers will be declined."

It is illegal under EMTALA to misrepresent a patient's admission status to obtain a transfer acceptance, so resist this temptation, he adds.

"The goal of the conscientious ED nurses in these cases must be to do everything within their power to obtain transfer orders prior to admission and then transfer out of the ED, so that EMTALA clearly controls," says Frew. ■

Now's the time to educate nurses on EMTALA

Now that the long-awaited new Emergency Medical Treatment and Labor Act (EMTALA) rule has been published, rumors about changes in the law are abounding in many EDs. For that reason, this is an

excellent time to review what is required by EMTALA, says **Pamela Rowse**, RN, ED assistant nurse manager at St. Rose Dominican Hospital-Rose de Lima Campus in Henderson, NV.

"The changes in the rule are welcomed, but we feel that we should continue our strict observance of all the *old* EMTALA regulations" that remain in effect, says **Shawn Keenan**, director of the ED and float pool at Monongalia General Hospital in Morgantown, WV. "Relaxing our vigilance over this complicated law may allow for some subtle aberrations that could lead to a violation."

At St. Rose Dominican Hospital, the following steps will be taken to inform ED nurses of the changes in EMTALA:

• Educational materials will be updated.

• A self-study packet will be created and distributed to all ED staff, with an acknowledgement page to be signed and returned for their education files.

• The changes will be addressed in detail at staff meetings and mandatory charge nurse meetings.

To ensure EMTALA compliance in your ED, do the following:

• Discuss real-life EMTALA cases at staff meetings.

At staff meetings, ED nurses learn about EMTALA requirements by reviewing actual events, says Rowse. "At least half of our staff meetings address a component of the law," she says. "Using real-life events reinforces a concept that might otherwise be difficult to understand."

SOURCE

For more information on educating staff on the revised regulations, contact:

- **Pamela Rowse**, RN, Assistant Nurse Manager, Emergency Department, St. Rose Dominican Hospital-Rose de Lima Campus, 102 E. Lake Mead Drive, Henderson, NV 89015. Telephone: (702) 616-4600. Fax: (702) 616-4604. E-mail: prowse@chw.edu.

For example, if a case occurred involving a patient being given inappropriate information at triage, the EMTALA implications would be reviewed, says Rowse. "Cases are discussed from the perspective of how to do it better next time," she says.

Patient transfers also are routinely reviewed at meetings. "When we have been faced with an EMTALA violation from another provider, we review how to deal with that immediate situation and how to notify management for follow-up," says Rowse.

• Give nurses an annual EMTALA test.

Every ED nurse is required to participate in an annual ED Skills Day, which includes EMTALA education, says Rowse. "We offer them every six months for two full days to allow everyone to find a time to fit them

EMTALA Quiz for ED Nurses

1. The Emergency Medical Treatment and Labor Act (EMTALA) is a federal mandate: ☐ True ☐ False
2. EMTALA Violations can result in facility and or provider fines of up to $50,000 per event: ☐ True ☐ False
3. EMTALA is only applicable to the facility and the patients that they are seeing in the ED: ☐ True ☐ False
4. Patients have the right to refuse transfer: ☐ True ☐ False
5. Triage is considered appropriate medical screening: ☐ True ☐ False
6. The emergency department is not responsible for the intervention or care of individuals who experience emergencies outside of the hospital but still on hospital property: ☐ True ☐ False
7. It is an EMTALA violation to refuse to accept a patient from an emergency medical services provider who is on your property: ☐ True ☐ False
8. Registration can be completed prior to medical screening examination (MSE) if it does not interfere with or delay the MSE: ☐ True ☐ False
9. Transfer of patients to another facility must have an Authorization of Transfer From/Nursing Assessment Transfer form with all appropriate areas documented: ☐ True ☐ False
10. Patients being discharged but being sent directly to a physician's office for continued and definitive care do NOT require transfer documentation: ☐ True ☐ False
11. Patients transferred emergently to us from a skilled nursing facility must have transfer forms initiated when transferred back: ☐ True ☐ False

Answers: 1. True 2. True 3. False 4. True 5. False 6. False 7. True 8. True 9. True 10. False 11. False

Source: St. Rose Dominican Hospital — Rose de Lima Campus, Henderson, NV.

into their schedule," she says.

Before the skills day, nurses are given self-study packets with a written exam. **(See EMTALA quiz on p. 140.)**

The completed packets are returned to ED nurses for review, with any errors addressed, says Rowse. "It's a very positive experience for nurses, and as managers, we are able to assess where additional focused information needs to be disseminated," she adds. **(For information on an EMTALA audio conference and resource book, see cover page and article below.)** ■

Sign up for update on EMTALA revisions

You and your facility waited more than a year for the final revisions to the Emergency Medical Treatment and Labor Act (EMTALA), but are they really good news?

Emergency department managers and practitioners, hospital administrators, risk managers and others must quickly digest this complex regulation and determine how the changes will affect patient care. The revised regulation takes effect Nov. 10.

EMTALA: The Essential Guide to Compliance from Thomson American Health Consultants, publisher of *ED Nursing, ED Management, Emergency Medicine Reports, ED Legal Letter,* and *Hospital Risk Management,* explains how the changes to EMTALA will affect emergency departments and off-campus clinics. In-depth articles, at-a-glance tables, and Q & As on real-life situations are presented, and key differences between the "old" EMTALA and the new changes are succinctly explained.

Here are some of the vital questions you *must* be able to answer to avoid violations and hefty fines:

• How does EMTALA apply to inpatients admitted through the ED?

• Do the revisions mean hospitals are less likely to be sued under EMTALA?

• How does EMTALA apply during a disaster?

• What are the new requirements for maintaining on-call lists?

• What are the rules concerning off-campus clinics?

EMTALA: The Essential Guide to Compliance draws on the knowledge and experience of nurses, ED managers, physicians, medicolegal experts, and risk managers to cover the EMTALA topics and questions that are most important to you, your staff, and your facility. The publication is edited by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine, Peoria, and reviewed by **Kay Ball**, RN, MSA, CNOR, FAAN,

Audio conference

(Continued from cover)

compliance burden for hospitals and physicians, it's only good news if you implement it correctly. You still could face violations, hefty fines, confusion, and misinterpretation. Find out the answers to the following questions:

- How do you provide emergency treatment during a national emergency?
- How does EMTALA apply to inpatients, including those admitted through the ED?
- What should be the procedure regarding on-call lists?
- What's the new rule regarding hospital-owned ambulances?
- How are off-campus clinics affected?

Ensure that you and your staff are prepared with straightforward advice from a panel of EMTALA experts. The program will be presented by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine in Peoria; and **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care, department of emergency medicine, Carolinas Medical Center in Charlotte, NC.

Our expert advice will help you steer clear of potential pitfalls. "The new rule could aggravate an existing problem," Bitterman told *The New York Times*. "Specialists are not accepting on-call duties as frequently as we would like. As a result, hospital emergency departments lack coverage for various specialties like neurosurgery, orthopedics, and ophthalmology. The new rule could make it more difficult for patients to get timely access to those specialists."

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $249, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. The conference package also includes handouts, additional reading, a free 48-hour replay of the live conference, and a CD recording of the program.

For more information, or to register, call Thomson American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, or e-mail customerservice@ahcpub.com. When ordering, reference effort code: **83941**. ■

perioperative consultant/educator, K&D Medical, Lewis Center, OH.

EMTALA: The Essential Guide to Compliance also provides 18 AMA Category I CME credits and 18 nursing contact hours.

Order your copy today for the special price of $249! Call (800) 688-2421 to receive this valuable guide to the new EMTALA. ■

New stroke treatments coming soon to your ED

When a young woman came to the ED at University of California-Los Angeles after suffering a severe stroke, she presented with aphasia and right-side paralysis.

"We were called by the ED radio room nurse while the patient was still en route to the ED, allowing us to be there within minutes of her arrival," says **Judy Guzy**, RN, research coordinator for the University of California-Los Angeles Stroke Network.

ED nurses rushed the patient directly to magnetic resonance imaging (MRI), she explains. "They grabbed a blood pressure and drew blood while still on the paramedic gurney, then pushed her out the door," says Guzy.

After the MRI, the woman went directly to the angio suite, where the clot was removed with a concentric retrieval device inserted through a femoral artery.

As a result of this cutting-edge intervention, the woman's motor skills returned immediately, and she was talking within five hours of stroke onset, says Guzy.

While waiting for an intensive care unit bed, the woman was brought back to the ED, she recalls. "The same nurses were still on duty and were thrilled to see her moving normally and communicating," says Guzy. "All too often, the ED nurses do not get to see the results of their efforts."

When a stroke patient presents, you need to respond with a rapid assessment, continuous monitoring, laboratory draws, transport to computed tomography (CT)/MRI, and rapid mobilization of the patient, says Guzy. New mechanical interventions, coupled with these actions, soon will result in dramatic success stories at your ED, she and others predict.

"New developments in technology and pharmaceuticals will greatly change the way we treat stroke in the upcoming years," predicts **Lauren Brandt**, RN, MSN, CNRN, clinical director of the Neurosciences, Brain, and Spine Center at Brackenridge Hospital.

The new technologies include laser emulsification of the clot, clot retrieval devices that remove the clot, and obliteration devices that draw in the clot, fragment it, and aspirate the surrounding thrombus, says Brandt. Although none are currently approved by the Food and Drug Administration, experts in stroke care predict they soon will be used in EDs.

To prepare to update your stroke protocols, consider the following:

• Know indications for the new interventions.

Cerebral vessels are smaller and more fragile than cardiac vessels, notes Brandt. "This limits what can be done to open up that vessel," she explains.

In addition, the composition of the clot or source of ischemia has to be taken into account for the right treatment to be identified, says Brandt. For example, although angioplasty is the mainstay of cardiac intervention, this is not as effective in cerebral disease because of the high incidence of embolic disease, she notes.

"Angioplasty works much better on the plaque

EXECUTIVE SUMMARY

New technologies for stroke patients include laser emulsification, clot retrieval devices, and obliteration devices.

- Combination therapies, using mechanical and pharmaceutical interventions, show great promise.
- The time window for treatment is expected to increase up to 24 hours, so the number of patients eligible for treatment will increase dramatically.
- Stroke patients eligible for treatment will require blood pressure stabilization, strict blood glucose control, and temperature regulation.

SOURCES

For more information about new interventions for stroke patients, contact:

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developed in thrombotic disease," explains Brandt.

• Understand how combination therapies work.

Combination therapies, using mechanical and pharmaceutical interventions, show great promise, according to Brandt. These include therapies such as ultrasonification of the clot, followed by the use of thrombolytics to destroy the remaining residual, she explains.

Another example of a combination therapy would be using either angioplasty or cerebral stenting in order to open a vessel so that intra-arterial thrombolysis can be utilized, says Brandt.

• Update protocols to add new approaches.

You'll need to update your protocols significantly to reflect new technologies and approaches, advises Brandt. Here are changes to expect:

— Perfusion imaging will identify the extent of viable tissue vs. infarcted tissue.

— CT or MRI angiography will identify the individual location of the clot.

— Blood pressure stabilization, strict blood glucose control, and temperature regulation will be incorporated into ED stroke protocols. "This will make this a very intense patient population for the ED nursing staff," says Brandt.

• Expect the number of stroke patients to increase.

With the use of new technologies, the time window for treatment will expand to eight to 12 hours for anterior circulation and up to 24 hours for posterior circulation, says Brandt. "However, this does not make it a less emergent situation," she cautions. "Time is still brain."

What it does mean is that every stroke patient who arrives within a longer time window will need to be started on an aggressive stroke protocol, as compared with the small number of stroke patients who are eligible for treatment currently, she says.

"The ED clinical nurse is the starting point of successful treatment and implementation of the appropriate protocol," says Brandt. "This will have a huge impact on the patient's outcome." ■

Dramatically improve care of pediatric trauma cases

Unless you work in a pediatric ED or trauma center, you probably treat only a handful of major pediatric trauma cases each month.

For this reason, you must be aware of important differences between children and adults that will change the way you care for these patients, says **Kaaren Fanta**, RN, MSN, CPNP, trauma nurse practitioner at Cincinnati Children's Hospital.

"Unique anatomic and physiologic differences in children predispose them to different patterns of injury and resuscitative needs," she explains.

EXECUTIVE SUMMARY

Pediatric trauma patients have unique needs for equipment, dosages, and interventions.

- Almost all pediatric cardiopulmonary arrests are caused by a respiratory problem.
- Give medications and fluids using per-kilogram dosages.
- Early signs of shock are tachycardia and cool, pale skin, whereas decreased blood pressure is a late sign of shock.

To dramatically improve care of pediatric trauma patients, incorporate the following into your practice:

• Secure an adequate airway, and evaluate the patient's breathing.

Almost all pediatric cardiopulmonary arrests are caused by a respiratory problem as opposed to a cardiac problem, notes Fanta.

"Bag mask until appropriate medical personal are available to intubate," she advises.

You must address these questions, says **Becky Cook**, RN, MSN, CPNP, also a trauma nurse practitioner at Cincinnati Children's:

— Is the airway patent?
— Is the child crying/talking?
— Is the child's breathing noisy?
— Is the child able to maintain his or her airway?
— What is the child's level of consciousness?
— Is there a potential for airway edema?
— Is there extensive facial trauma?
— Does the child have a large amount of secretions?

There are important anatomical differences between an adult's and a child's airway, stresses Cook. Children have proportionally larger heads and tongues, smaller nasal passages, more anterior larynx, and shorter tracheas, which can make intubation and ventilation more difficult, she says.

Infants are obligate nasal breathers, so it is important to keep their nostrils patent, says Cook. "This can be done by simply suctioning blood or secretions from their nose," she says.

Securing an adequate airway and providing oxygen does not ensure that adequate ventilation and gas exchange has occurred, so you also must evaluate breathing, says Fanta. **(See list of questions to evaluate breathing, p. 144.)**

• Ensure correct dosages are given.

For children, fluids and drugs are given per kilogram

Questions to Evaluate Breathing in Pediatric Trauma Patients

- What is the respiratory rate?
- Is breathing easy? Labored?
- Does the child demonstrate nasal flaring? Grunting? Retractions?
- How does the child look? Color? Mucus membranes? Capillary refill?
- What is the child's level of consciousness?
- Is chest wall movement symmetrical?
- Are breath sounds equal? Clear?
- Is the child's abdomen distended?
- What are blood gas results?

Source: Kaaren Fanta, RN, MSN, CPNP, Trauma Nurse Practitioner, Cincinnati Children's Hospital.

instead of unit doses as with adults, advises Fanta. To ensure correct dosages, use cheat sheets to approximate pediatric ages to weight, she suggests.

The ED uses these for newborns and children ages 3 months, 1 year, 3 years, 6 years, 8 years, 10 years, 12 years, and 14 and older, she explains. "These are helpful, since we are usually not able to get an accurate weight but we do usually know the age," says Fanta.

• Have necessary equipment easily accessible.

Your ED should have all of the pediatric equipment recommended by the Washington, DC-based National Emergency Medical Services for Children, says **Laura L. Kuensting**, MSN, RN, CPNP, pediatric nurse practitioner for the ED at St. John's Mercy Medical Center in St. Louis.[1]

Your goals are twofold: To acquire the appropriate equipment, and to organize these items so they are easy to locate in an emergency. Designate a person, such as a pediatric clinical nurse specialist or a staff nurse, to handle this task, advises Cook.

Guidelines for Rapid Sequence Intubation (RSI) in the Traumatically Injured Child

Definition:
A rapid controlled method to facilitate endotracheal intubation that minimizes the complications associated with intubation.

Rationale:
To provide adequate oxygenation, reduce aspiration risk, prevent cardiovascular instability, and prevent intracranial hypertension related to intubation.

Protocol:
1. Maintain in-line cervical spine immobilization.
2. Evaluate for any contraindications to rapid sequence intubation (relative contraindications may include upper airway obstruction, "difficult" airway, and hemorrhage obscuring vocal cord visualization).
3. Prepare intubation equipment, suction, monitors, and medications.
4. Preoxygenate child for 2-5 minutes with 100% oxygen. Use positive pressure ventilation with bag valve mask only in apneic patients.
5. Apply cricoid pressure.
6. Pretreat:
   a) Lidocaine: 1.5 mg/kg if suspected head injury (administer two minutes prior to succinylcholine).
   b) Atropine: .02 mg/kg if child is less than 6 years of age to reduce reflex bradycardia.
7. Administer etomidate 0.3 mg/kg. (Rationale: rapid onset, cerebro-protective effect, minimizes cardiovascular instability.)
8. Administer succinylcholine 2 mg/kg: allow 45-60 seconds for muscle relaxation. (Rationale: rapid onset less than 45 seconds; short duration of action less than 10 minutes.)
9. Place endotracheal tube.
10. Release cricoid pressure.
11. Clinically assess for proper tube placement (adequate rise and fall of the chest, bilateral breath sounds, mist in the endotracheal tube, adequate oxygen saturation, and end-tidal carbon dioxide detection).
12. Reposition tube, and reconfirm proper endotracheal tube placement as necessary.

Source: Cincinnati, Children's Hospital.

SOURCES

For more information on caring for pediatric trauma patients, contact:

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"Once you have done this, the staff function much less frantically in a traumatic situation," she says.

• Address fluid resuscitation and intravenous access.

Look for early signs of shock, such as tachycardia, slowed capillary refill, and cool, pale skin, says Fanta. "Decreased blood pressure is a late sign!" she stresses.

If you are unable to obtain peripheral access, use the interosseous route, she says.

Interosseous needles need to be easily accessible, so remind physicians to use them, says Fanta. This is typically used in children younger than 6 years of age and can be used to infuse anything given intravenously, including medications, fluids, and blood products, she adds.

Look for these indicators of good interosseous placement, she says:

— Fluid infuses easily with no swelling to surrounding tissues.

— The interosseous is fixed in place.

"It is very difficult to move or manipulate an interosseous if it is properly placed," says Fanta.

You may or may not see blood or marrow aspiration, she adds.

Ensure adequate oxygenation and circulation for children with head injuries.

Adequate oxygenation and circulation is key to preventing secondary brain injury, warns Fanta.

If you are able to maintain the airway, provide supplemental oxygenation, says Fanta. "If you are unable to maintain an airway, consider endotracheal intubation," she says.

You must ensure adequate fluid resuscitation for good perfusion, says Cook. Consider inotropic support if fluid resuscitation does not provide adequate perfusion as demonstrated by heart rate, capillary refill, color, pulse, and blood pressure, she adds.

For rapid sequence intubation, use pre-made intubation kits containing the medications lidocaine, atropine, and etomidate, and use a standard intubation policy to minimize confusion, recommends Fanta. "Nurses can draw up medications in advance," she adds. **(See the facility's guidelines, p. 144.)**

"Doses are standardized based on weight so nurses can draw them up quickly, but remember these are short-acting medications, so the child may need stronger sedation or paralytic after proper intubation is confirmed," says Fanta.

Reference

1. Committee on Pediatric Equipment and Supplies for Emergency Departments, National Emergency Medical Services for Children Resource Alliance. Guidelines for pediatric equipment and supplies for emergency departments. *Ann Emerg Med* 1998; 31:54-57. ■

Use committees to boost morale of ED nurses

Give your nurses a voice

Higher acuity patients. Fewer resources. Increased overcrowding.

It's no wonder that for many ED nurses, morale is at an all-time low. But there is a proven way to boost morale of nursing staff, while improving your ED's operations, say ED nurse managers.

"Committees can boost the morale of ED staff by allowing them a voice in the change and planning

EXECUTIVE SUMMARY

Committees can boost the morale of nurses and have a dramatic impact on your ED's operations.

- Nurses can explore interests and gain expertise in new areas.
- Involve nurses with major changes such as implementing a new triage system or facility redesign.
- Ask nurses to work on improving areas such as scheduling and employee satisfaction.