July 2006 Volume 30, Issue 4

California Emergency Nurses Association
THE MONITOR

For the Record

In the Beginning, We Were Roadrunners....

The following article is taken from a history of Cal ENA written by our own Historian, Liz Taylor, with the help of our co-Founder, Judy Kelleher. It is continued from last issue.

They (EDNA) decided to form nine major districts, find leaders in each district and this resulted in the first National Board of Directors, meeting in New York City on October 6, 1971. Mrs. Dorr, with her interest in organization, served as the first Executive Director. Mrs. Kelleher, whose main interest was in education, served as West Coast Chair as well as Chair of By-laws, Resources and Education Committees. It soon became evident that it would be wise to follow the Department of Health Education and Welfare (DHEW) regional designations, so ten regions were designated. The first meeting of the ten regional directors was held on January 19, 1972, in Sommerset, New Jersey, as guests of Johnson and Johnson Company. By this time, there were 26 states represented.

The first budget was planned with 3,400 members. It was deemed necessary to increase dues from $5 to $10 with projected income of $51,500 for the next year. There was also an accumulation of some $15,000 in the bank account, which indicated there were few disbursements for expenses that first year.

At this time, Barbara Bauer, from Johnson and Johnson, offered to publish the first EDNA newsletter, titled *The Roadrunner.*

In July 1972, it was discovered that Mrs. Dorr was terminally ill, so it was decided to obtain professional management services from Art Auer, who also provided services for the American College of Emergency Physicians. The office was moved to East Lansing, Michigan.

Ruth Miller became Executive Director in 1972. Many local chapters were formed, job descriptions written and committee functions developed. The Constitution and By Laws were completed. Membership increased to over 4,000. The first joint EDNA-ACEP Scientific Assembly was held in Dallas on October 22-25, 1973. Dr. Cosgriff gave the first Anita Dorr Memorial Lecture, which was to become an annual event. Over 1000 nurses attended.

At the 1973 Assembly business meeting, **Judy Kelleher was elected the first President of EDNA**. With the help of Art Auer and Gloria Westerback in the National Office, priorities were set and the following goals were accomplished:

- Obtained grant to develop skills list for ED nurses;
- Obtained grant to develop Core Curriculum (with much credit to Peg Caldwell, Karen Frillell, and Diane Anderson);
- Wrote a chapter for ACEP's book entitled – "Organization and Management of the Emergency Department".
- Production of JEN started - first issue was to be January 7, 1975;
- An Insurance Plan was developed;
- Educational programs presented throughout the country with RNs as speakers;
- Work progressed on defining emergency nursing, what kinds of education were needed and a process for developing national certification for the Emergency Nurse Specialist;
- Saw many nurses appointed to local, state and national EMS Committees;
- Membership increased to 8,500 with 105 local chapters;
- Does increased to $25.00 to include JEN;
- Utilized an Advisory Committee composed of Dr. James Cosgriff, Dr. Henry Huntley, Dr. George Anast, Dr. Ben Moore, Mr. Robert Rock of J & J, Dr. James Mills and Dr Eleanor Lambertson. We will always be indebted to these fine people for their expertise and guidance.

(Next issue: highlights from the early years of ENA)

Inside this issue:

Annual ED Summit Postponed until next spring **(see page 10)**

Cal ENA Directory

Board Members 2006

President: Robert Toman
President-Elect: Matt Powers
Past-President: Diana Contino
Secretary: Janet O'Leary
Treasurer: Michelle Ruiz
Treasurer-Elect: Jackie Magnuson
Dir-at-Large: Jody Haynes

California State Council
Emergency Nurses Association

Contact all Cal ENA leaders at: www.CalENA.net

Sponsorship Rates

The fees per insertion are:
Business card: (2 x 3.5)
$125
1/4 page: (3.5 x 4)
$250
1/2 page: (7 x 4)
$450
Whole page: (7 x 8.5)
$800

Committee Chairs

Bylaws: Diana Contino
Cal Nursing Coalition: Diane Schertz
Cal ACEP Rep: Lani Williams
Education: Becky Petersen
EMS Commissioner: Jan Ogar
EMS Committee: Diane St. Denis
ENAF/*Fun Raiser*: Diane Schertz
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Newsletter: Mark Wandro
Nursing Leadership In Practice: Julie Wanstreet
Pediatrics: Michael Vicioso
Recruitment & Retention: Ellie Encapera
Trauma: Anita Ruiz-Contreras
Web Master: Tom Trimble

Chapter Leaders

223	**East Bay**	Michael G. Bertram
224	**Greater LA**	Catherine Kaliel
225	**Mid-Valley**	Suzanne M. Kruzic
226	**Orange Coast**	Jody R. Haynes
228	**San Diego**	Ricarda G. Jackson
230	**San Francisco**	Mark Wandro
232	**Loma Prieta**	Garret Chan
253	**Sacramento**	Diane Schertz
362	**Inland Empire**	Terri M. Sturgill
378	**Channel Islands**	Janet O'Leary
379	**Superior**	Kara L. Davis
442	**Kern County**	Francis Harris
443	**North Coast**	MaryAnn Mahoney

The California Emergency Nurses Association is a non-profit professional organization with a membership of approximately 2203.
The State Council meets 5 times a year.
Correspondence may be sent to:

Cal ENA
President Robert Toman
president@calena.net

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For inquiries, article submission, or ad placement, please contact the editor:
editor@calena.net

Probability vs. Potentiality: The Nurse's Balancing Act between Mind and Heart

Douglas Miller, RN, BSN
Trauma Case Manager, Memorial Med Ctr, Modesto

As critical care and Trauma Nurses we see plenty of 'negative outcomes". We are surrounded by statistics and experiences that tell us (usually correctly) how a case will go. But every now and then a case comes along that breaks the rules, embarrasses the statistics and forces us to work against our brains and to stand with the heart to fight on in the patient's interest. This is one of those cases.

A 35 year old female was an unrestrained passenger in a high speed rollover crash. Both the patient and the driver were intoxicated. When Paramedics arrived the patient had agonal respirations with no measurable blood pressure. She was intubated by the EMS crew after approximately 20 minutes extrication time. One large bore IV was inserted and fluid resuscitation begun. Wounds were dressed and patient was placed in full C-spine precautions on a backboard. After breath sounds were evaluated, the left chest received a needle thoracotomy due to severely diminished breath sounds with little improvement after the procedure. Findings in the field were as follows: Deep flesh wound with exposed muscle tissue along the medial aspect of the right forearm as well as right shoulder. Abrasions on upper right arm. Deformity of right wrist, left elbow and hand swelling & deformity. Right side of the head had deep degloving wound from the occipital area to just inferior of the zygomatic arch exposing bone. Bleeding was profuse. The right thigh was mildly deformed and swollen with distil pulses absent. During the flight to the Level 11 Trauma Center fluid resuscitation continued with a maximum blood pressure of 75/46. The patient's GCS decreased to 3. On arrival at Memorial Medical Center in Modesto, the patient again had no measurable blood pressure. A trauma team consisting of both the ER Doctor and Trauma Surgeon were present, accompanied by the Trauma Case Manager (RN), 2 staff RNs, OR RN, Respiratory Therapist as well as lab & radiology techs.

The resuscitation phase began with 0-negative blood given through rapid infuser. X-rays of chest, hip and pelvis were obtained. Fast scan revealed free fluid in the abdomen and retroperitoneal space. Crystaloids were started to support blood pressure. Initial lab values were as follows: ABG: 6.876/60.3/557.9/ -21.5/10.9; K: 2.5; Ca: 5.6; PT: 32.3, INR: 3: WBC: 19.2; Hgb: 9.9; Hct: 30; Plt: 105. While the OR was being prepared the patient was taken to radiology for CT scans of head, neck and chest. All radiological exams revealed the following: Left pneumothorax, inferior pubic ramus fracture with dislocation of right hip, bilateral pulmonary contusions, right acetabulum fracture, distal right radius fracture, bilateral rib fractures, a small mediastinal hematoma, minimal sub-arachnoid hemorrhage in the left sylvian fissure, puntate left frontal contusion, C7 non-displaced fracture of the transverse process, L14 transverse process fractures and nasal bone fractures.
Within 49 minutes of arrival the patient was in the OR for an exploratory laparotomy and repair of injuries. During the operation no major organ injuries were discovered to explain the blood loss except for the right kidney which had a small suprarenal hematoma. A Nephrologist was called to the OR but declined to do any surgical intervention due to the risk of causing a major increase in bleeding which could not be stopped due to the developing DIC. The right hip dislocation was reduced. Some intra-operative lab values were as follows ABG:6.097/22/285/-22/10; Ca: 1; K: 1.7. Blood pressures were as low as 52 /30. Afterwards the patient was admitted to the ICU for definitive care.

During the next 36 hours the patient received almost continuous 2:1 nursing care as well as the continuous interventions of the unit-based Respiratory Therapists. Just as in the ED, a rapid infuser was ready upon the patient's arrival and transfusions began immediately and continued non-stop for the next 4 hours. Warming measures were instituted for a core temperature of 35.2 C. Lab values shortly after arrival to the ICU were: ABG: 7.117/37.6/470.3/-15.4/12.2; K: 2.1; Ca: 5.8; AST: 706; ALT: 248; PT: 51.4; INR: 5.5; WBC: 4.2; Hgb: 1.6; Hct: 4.6; Plt: 48. Crystalloids, BiCarb and Calcium were just some of the many interventions instituted on the patient's behalf during this time, including pressure control ventilation. The major source of bleeding was from the scalp. Suturing was delayed due to the risk of exsaguination if the pressure dressing was released long enough to suture. More definitive closing of the lacerations was done approximately 12 hours later after coagulation studies improved. Approximately 24 hours after admittance to the ICU, minute ventilation dropped as did tidal volumes. The abdomen was enlarging and becoming more taught. With a diagnosis of abdominal Compartment Syndrome, the surgeon came in and did an emergent decompressing of the abdomen by applying a "Bogota bag" to the opened abdomen that allowed a drop in the abdominal pressure with subsequent relief to the diaphragm and a resuming of normal ventilation. A drain was applied to allow fluid to escape without raising pressures again. Repeat CT scans were done revealing left lobe liver laceration, questionable colon laceration, right perinephric hematoma & adrenal hemorrhage. Laboratory values were improving as noted: ABG: 7.389/35.8/164.5/-3.4/21.2; K: 18.8; INR: 1.5; Hgb: 10.6; Hct: 30.9; Plt: 119; Ca: 7.3.

(cont'd on next page)

Education and Event Calendar

TNCC Dates: 2006

August 3 & 4 - Doctors Medical Center - Modesto
Elaine Paradis (209) 576-3614

September 16 & 17 - UC Davis Medical Center
Elaine Paradis (916) 734-9787

September 21 & 22 - San Francisco General—John Fazio, (415) 206-8196

September 30 & October 1 - St. John's Regional Medical Center - Oxnard, Janet O'Leary

November 2 & 3 - Doctors Medical Center - Modesto,
Elaine Paradis (209) 576-3614

November 30 & December 1 - San Francisco General,
John Fazio, (415) 206-8196

CATN-II Dates: 2006

October 5 & 6—San Francisco General —
John Fazio, (415) 206-8196, Cost: $300

ENPC Dates: 2006

July 19 & 20 - Memorial Medical Center - Modesto
Elaine Paradis (209) 548-7880

September 6 & 7 - Memorial Medical Conference Center – Modesto, Elaine Paradis (209) 548-7880

October 5 & 6 - Doctors Medical Center - Modesto
Elaine Paradis (209) 576-3614

October 13 & 14 - Rancho Springs Medical Center - Murrieta, Gail Dodge (909) 472-2680

October 20 & 21- Children's Hospital & Health Center - San Diego, Marty Hay chay2@cox.net

October 21 & 22 - UC Davis Medical Center - Sacramento, Elaine Paradis (916) 734-9787

November 16 & 17—San Francisco General—John Fazio, (415) 206-8196, Cost: $275

Courses and Educational Events maybe added or cancelled after publication. Please confirm dates with course directors or at: www.calena.net and then to Educational Opportunities for current course listings.

CEN Review Classes

Call one of these providers for their next class:
Selfridge, Sparger, Shea & Assoc. (800) 270-2500
CME Associates (714) 998-2208
Fazio/Ruiz & Associates (800) 339-2RNS
Randolph Associates (707) 875-9422

Important Dates

Board and State Council meetings

August 17, 7pm: Conference Call
September 12: San Antonio, TX
November 2 & 3: Orange Coast
January 18 & 19, 2007: San Fran Bay Area
April 19 & 20: Lake Tahoe, in conjunction with "Emergency Summit".
July 12 & 13: San Diego
August/Sept: Conference Call - TBA
November 8 & 9: Los Angeles

Next Newsletter Deadline: Sept. 30

Mind Vs Heart*, (cont'd from page 3)*
By the third day the patient's status had improved dramatically. Pressors were weaned down, bleeding had slowed with concurrent normalized coagulation studies, ventilator status was such that pressure control ventilation was discontinued and plans were being made to take the patient to surgery to close the abdomen and debride the arm & head with application of a wound vac.

Throughout the process of resuscitation and critical care nursing, the thought is always in the back of the mind as to the futility of our efforts. We continue however because we know in our hearts that we must give the patient every chance to beat the odds. The ER physician, the Trauma Surgeon, The Trauma Case Manager, The Anesthesiologist and the ICU nurses all reminded the family of the dire condition of the patient and the likely outcome, despite our efforts. Priests were called and Prayers were said.

As of this writing, the patient is alert, oriented, eating and receiving physical therapy.

Term Limits Debate

This year CalENA has put forth a proposed bylaw amendment to Article VII, titled *Requirements Eligibility*. I would like to focus on the portion of that amendment concerning term limits. Similar to California's election process, I support term limits for several reasons. Term limits have the potential to:

- produce more competitive elections;
- provide for a Board more "in harmony" with the grass-roots members;
- reduce the influence of the buddy-buddy relationships;
- decrease spending. Studies by the Cato Institute confirm that the longer people are in office, the bigger spenders they become.

The main arguments against term limits are:

- the loss institutional memory;
- an inexperienced Board (e.g., they are easy prey for special interest groups and staff will dominate them).

I have always believed it is the role of the Past President to mentor potential new members and support them in their bid for office. I support this amendment because as the rationale states, "ENA's strength comes from it's diversity." New ideas and fresh approaches on the latest issues are important at the National Level of ENA. New Board Members can empower our members to receive a global perspective on current issues. This amendment has the ability to afford all members an opportunity to achieve ENA Board and Officer leadership roles. Our Organization will continue to grow and ENA would be adhering to its vision statement: promoteing advocacy, diversity and excellence of emergency nursing practice by its own professional behavior.

Several other professional nursing organizations have also taken this stance. Bylaws from the **American Nurses Association (ANA)** state that "no officer or director shall serve more than two consecutive terms in the same office nor more than eight consecutive years on the Board of Directors. An officer or director who has served one half term or more shall be considered to have served a full term." Bylaws from the Air and Surface Transport Nurses Association (ASTNA) state that the "The President-Elect shall be elected for one term, accede to the office of President for a one year term, then serve a one year term as the Immediate Past President" and that "the Secretary/Treasurer shall be elected for a two (2) year term," while the "Directors-at-Large shall be elected for two year staggered terms, such that three (3) Directors-at-Large are elected each year" and the Secretary/Treasurer and the Directors-at-Large may serve two consecutive terms in the same office; provided that in the event the Secretary/Treasurer or a Director-at-Large is appointed to fill a vacancy for one year or less of a two year term, such appointment shall not be considered in determining the number of consecutive terms he or she may serve" and "Directors shall take office at the conclusion of the Association's Annual Meeting closest to their election or appointment and shall continue in office until after successors are duly elected or appointed and qualified."

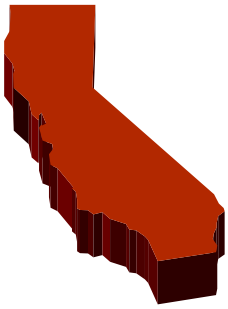
Similarly, bylaws from the **Association of PeriOperative Registered Nurses (AORN)** state that for the term of office "no officer or member of the Board of Directors shall serve more than two consecutive terms in the same office." Bylaws from the **American Association of Critical Care Nurses (AACN)** state that "officers shall be elected by ballot to serve a term of two years or until their successors are elected" and that "the Secretary and Treasurer may not serve more than two consecutive terms in the same office. The President and the President-elect may not serve more than one full, elected term in the office. No one shall hold more than one office at a time." Bylaws from the **American Association of Nurse Attorneys (AANA)** state that "each Director shall be eligible to serve no more than three full consecutive terms." Bylaws from the **Federal Nurses Association (FNA)** state that no officer or director shall serve more than two consecutive terms in the same office or more than four consecutive terms on the Board of Directors. An officer or director who has served 12 months or more shall be considered to have served a full term." Finally, bylaws from the **National League of Nursing (NLN)** state that "the Presidency shall be filled by the President-Elect who shall take office following the close of the annual meeting and shall serve for a term of two years and until a successor is elected" and that "a President-Elect shall be elected at the annual meeting in the manner provided in Article VII of these bylaws, to serve a term of two years following the close of such meeting, and shall then secede to the Presidency for a term of two years" and that the Secretary shall be elected at the annual meeting in . . . to serve for a term of three years. No person shall be elected to serve for more than two consecutive terms in the office of Secretary"

There are many ways to serve. I am currently the Chairperson of ENA's NP Validation Work Team. I am also currently the co-editor of ENA's Core Curriculum. Some ENA members have remarked to me that if an individual doesn't want a candidate then they will "vote them out of office." That is yet another perspective. If this portion of the amendment does not survive, one could argue to "just vote them out". Maybe that too will occur. I ask you to consider these perspectives.

K. Sue Hoyt, PhD, RN, FNP, APRN,BC, CEN, FAEN
Past President, San Diego ENA, 1985
Past President CalENA 1991
Past President, National ENA 1997

Committee News

Recruitment and Retention Report



Your recruiting efforts have paid off! We have almost 2500 members, so we are entitled to **49** delegates and **2** alternates at General Assembly in San Antonio.

Regarding **"unassigned members"**: When someone joins ENA for the first time and does not indicate a chapter preference, they are assigned to a chapter based on geographical location. If any member chooses to change their chapter affiliation for any reason, just notify the Membership Services Office at National by calling **1-800-2-GET-ENA**. Remember that any member may choose to belong to any one chapter within a state (3 tiered) by request, through the National office.

Sponsoring a new member? Tell them what chapter number to write on their application according to their address or personal chapter choice.

To receive timely communications and optimal membership services, we encourage all members to **keep email & mailing addresses current with the National office.**

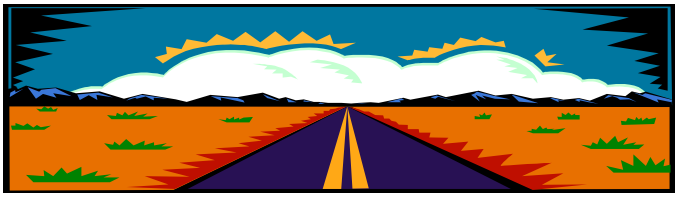
These are the most current totals for our now 13 active Chapters and overall total for the California Council as of June 2006:

Chapter # & Name	3/06	6/06
(223) East Bay	185	205
(224) Greater LA	339	390
(225) Mid-Valley	196	204
(226) Orange Coast	203	231
(228) San Diego	270	308
(230) San Francisco	157	177
(232) Loma Prieta	171	193
(253) Sacramento	248	270
(362) Inland Empire	205	231
(378) Channel Islands	80	89
(379) Superior	60	70
(442) Kern County	15	18
(443) North Coast	21	32
(NCA) No Chapter Assigned	76	36
Totals	**2226**	**2454**

Join the ENA Connection on-line at www.ena.org. Find professional development, networking opportunities and on-line shopping. The "members only" section is great so check it out and sign up today!

Spread the word to educational coordinators and recruiters that this committee prepares Cal ENA mailing labels for approved buyers. **Encourage them to advertise in your local and state newsletters.**

Ellie Encapera, Chair



Win a FREE Registration to the 2006 National ENA General Assembly in SAN ANTONIO

EVERY CalENA member is eligible to win.

Here is how it works…

Two (2) winners will be randomly chosen from the official CalENA 2006 Delegate List, two (2) from the 2006 State and Local Chapter Leaders and two (2) from the general membership roster on July 1, 2006. All winners will be notified by mail and their names announced to the California membership via email.

Four winning names will be sent to the national office for their specific reimbursement instructions.

The two Delegate winners will be sent a special certificate signed by the current CalENA President and Treasurer. These winners will register and send payment for the event to the national office to attend the Scientific Assembly. Following the event, proof of payment and attendance will then be mailed along with the original certificate sent to the winner to the state treasurer for reimbursement. CalENA will then mail a check, in the amount of the publicized cost of early registration, to that person.

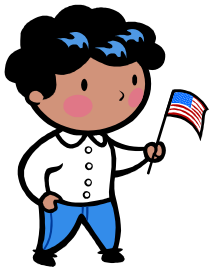
Remember to register early, as CalENA will only reimburse for the cost of the early registration fee.

Cal ENA Mailing Labels are available to approved buyers. Need to invite members to educational events? Contact Ellie Encapera, RN, Recruitment and Retention Chair, for order processing and pricing at: misellern@socal.rr.com

Pediatric Committee

Request from the committee to have an instructor course somewhere in the state. Several facilities are requesting more instructors. Some facilities have closed classes to outside people. Some of the complaints about running a course are: too much paperwork and not affordable.

Cal ENA PEDS committee agreed to increase one time per year assistance to run a course from $500 to $1000. Request for assistance must include a complete budget estimate for running a course.



Kiwanis club is helpful in subsidizing local pediatric courses and education.

Request through Staff Development at your own facility to help pay for personnel to travel to take classes.

PALS in conjunction with ENPC is working well for Marty Hay in San Diego.

New PALS guidelines are currently being taught by some facilities. No real plan on how to deal with staff who are trained in old PALS and staff who are trained in new PALS when both respond to a pediatric code.

The EDAP qualification in LA County is completely voluntary and has specific education requirements for the clinical staff.

Cal ENA Pediatric Committee evaluated several comments from various sources regarding Pediatric ED certification. This would provide a minimum level of training and equipment for community EDs. It would also establish what hospitals in your area are designated Pediatric Emergency Specialist. Continue to pursue standardization of pediatric care in EDs. See the article: "Pediatric Specialist in the Emergency Department" on the following page.

Injury prevention. Jackie Jones presented the new *Choices* CD-ROM, available on the ENA website in "Marketplace" . This CD ROM is for educating the community about teen injury prevention.

Michael Vicioso, Peds Chair

Leadership in Practice

Rapid Response Teams and their benefit to decreasing stress on the ED continued to be the first topic for discussion. Pioneered in Australia, these teams usually respond to intervene upstream from a potential code when a patient shows signs of deterioration on the medical floors. Most often they are comprised of a critical care nurse, respiratory care practitioner and in some facilities an intensivist. It is most ideal to have teams that consist of critical care personnel excluding the ED staff. Intervening early and preventing a code situation proves to decrease length of stay, and provides open beds needed for ED admissions and helps to maintain that critical forward flow in the ED. The facilities that have the availability of intensivists and a large population of experienced ICU nurses use this team to respond and head off codes there by reducing the time the ED physician and nurse must leave the department to deal with in house emergencies.

St. Joseph's / CHOC Emergency Department in Orange County reported that they have a Pediatric Rapid Response Team that also responds to emergencies in the ED. This is another added support to the ED staff freeing up personnel to keep the ED moving. Many facilities have chosen to call their teams Medical Evaluation Teams.

Many counties are working on plans to provide more efficient care for STEMI patients coming in from the field to the ED. Orange County reports that most paramedics units now have 12 lead EKG capability. Paramedics are trained to read the EKG interpretation as ST elevation and deliver the patient to the nearest cardiac receiving center with a cardiac cath lab. These centers must meet criteria set by the county. The goal of door to balloon time in less than 90 minutes is the community standard as set by the American Heart Get with the Guidelines Program.

Many facilities also continue to work on Get with the Guidelines for Stroke. Counties have not reported any movement yet in creating Stroke Receiving Centers, however the group consensus was that it is a likely possibility.

Finally, the new American Heart ACLS, BLS and PALS guidelines are out and rollout is to start in June with BLS, then ACLS and PALS to follow. Facilities report various stages in implementing the new guidelines with most making June the goal. More emphasis is place on circulation and maintaining forward flow. The 3 stacked shocks of the well known pulseless arrest algorithm have been replaced by shocks one at a time separated by 2 minutes (or 5 cycles of 30:2) CPR. Immediate CPR while preparing to defibrillate is also emphasized. Maintaining forward flow in arrest situations, and maintaining forward flow in the ED were the items of discussion.

Julie Wanstreet, Chair

Pediatric Specialist in the Emergency Department

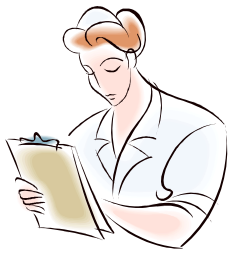
The following is an article submitted by the Pediatric Committee.

Several new studies shed light on U.S. hospitals' capacity to treat pediatric emergencies, indicating that adult EDs are poorly prepared to treat young patients and identifying opportunities for improvement. A February study by the CDC's National Center for Health Statistics finds that although few EDs nationwide strengthened their pediatric specialty expertise and child-appropriate supply availability between 1998 and 2003, children most often seek care at high-volume pediatric centers, which are best prepared to treat that population. Meanwhile, a study in the January 2006 Journal of Pediatric Surgery reinforces the importance of pediatric resource availability, finding that children's hospitals achieved lower mortality, LOS, and charges than adult facilities when treating pediatric trauma cases; research in the March 2006 Pediatrics further supports those findings and identifies opportunities for hospital-based improvements (CDC report, 2/28/06; Watch interview, 3/9/06; Densmore et al., Journal of Pediatric Surgery, January 2006).

CDC finds most EDs under-prepared for pediatric emergencies …

Although children under age 18 log 30 million ED visits annually and account for one-quarter of overall ED volumes, relatively "little is known" about the care they receive in a largely adult-centric system (CDC report, 2/28/06). Seeking to close that knowledge gap, the National Center for Health Statistics added a 10-question pediatric resource survey to its 2002 to 2003 National Hospital Ambulatory Medical Care Survey, inquiring about a range of services, equipment, and resources that the American College of Emergency Physicians (ACEP) and American Academy of Pediatrics (AAP) consider "essential" to pediatric emergency care.

Based on responses from 376 EDs, the report concludes that facilities failed to make "significant improvement" since 1998. For instance, the percentage of U.S. hospitals with pediatric ICUs (10%) and the percentage of EDs with pediatric emergency medicine-trained attendings (23%) remained unchanged; the share of hospitals that lacked a pediatric trauma service but had a written transfer arrangement also held steady at roughly 75%. Pediatric resource availability also remained bleak, with merely 5.5% of facilities reporting full compliance with the ACEP and AAP guidelines for child-appropriate supplies such as tracheotomy tubes and Foley catheters; even though most EDs reported stocking at least 80% of recommended pediatric supplies, one ED director called the resource deficiencies "shocking" (Watch interview, 3/9/06).



… but best-equipped centers handle majority of cases

In a reassuring twist, however, researchers found that children often receive care in facilities best-equipped to treat that population. Nearly 47% of all annual pediatric ED visits occur at the 17.1% of U.S. EDs that treat more than 10,000 pediatric patients annually. Such high-volume centers are more likely to have a pediatric "inpatient structure"—separate pediatric wards and pediatric ICUs—along with board-certified pediatric and emergency medicine attending physicians and recommended pediatric supplies. In addition, the researchers found that EDs not equipped to handle pediatric patients did a "good job" transferring critically ill patients to higher levels of pediatric care, seamlessly redirecting 90.7% of pediatric trauma patients and 97.5% of pediatric intensive care patients.

Researchers compare outcomes, identify key areas for improvement

Meanwhile, a study published in the January 2006 Journal of Pediatric Surgery reinforces the need for specialized pediatric resources, finding that children's hospitals produce better pediatric trauma outcomes than adult facilities (Densmore et al., January 2006). For the study, researchers from the Milwaukee-based Medical College of Wisconsin evaluated more than two million discharge records across 27 states and found that in-hospital mortality, LOS, and hospital charges were "uniformly higher" among pediatric trauma patients treated in adult hospitals and children treated in children's units within adult centers, compared with patients treated at children's facilities ($p<0.0001$ for all); the "same pattern" held in a subgroup analysis of the youngest and most severely injured children. In light of the findings, researchers note that "significantly improved outcomes" are possible when children are treated at well-equipped facilities.

Seeking to guide hospital efforts to improve pediatric emergency outcomes, research published in the March 2006 Pediatrics identifies a number of quality gaps (Hunt et al., Pediatrics, March 2006; United Press International, 3/6/06). For the study, researchers from Baltimore-based John's Hopkins Children's Center

and Durham, N.C.-based Duke University Medical Center used "mock codes" to evaluate 35 North Carolina EDs' ability to stabilize pediatric trauma patients. Identifying 44 discrete "stabilization tasks," the researchers scored EDs on a qualitative one-to-five scale; scores of four and five were considered "meeting expectations," while scores of one, two, and three were considered "needing improvement." Although they found that "mistakes are ubiquitous," several areas were particularly ripe for improvement.

The researchers recommend that hospitals use this data to guide improvement initiatives, especially in perfecting initial injury assessments, delivering time-sensitive therapies such as CT scans, and achieving "rapid vascular access" with appropriately sized supplies. In addition, the authors advise hospitals to reassess their intrahospital transfer protocols to ensure smooth transportation of patients, for instance, from the ED to the radiology department.

Industry experts envision regional pediatric COEs, targeted training

Taking stock of the recent flurry of research, Dr. Bernard Dannenberg—the medical director for pediatric emergency medical services at Palo Alto, Calif.-based Lucile Packard Children's Hospital—told the Watch (interview, 3/9/06) that hospitals face several obstacles to improving pediatric ED care. For instance, while small hospitals may see too few pediatric patients to become experienced in diagnosing and treating a variety of illnesses, other facilities may struggle with the high cost of stocking pediatric-specific equipment and supplies. Moreover, given poor reimbursements for pediatric care and disproportionate malpractice risks, hospitals also may opt not to admit children at all—a route that 10% of facilities nationwide have taken (CDC report, 2/28/06).

To bolster the availability of pediatric care and prevent children's hospitals from becoming increasingly overrun, Dannenberg recommends that communities designate one local facility as a "pediatric center of excellence." By pooling pediatric expertise and supplies at one location, communities could keep volumes local, improve care quality, and give the designated facility valuable public exposure. A Chicago pediatric emergency physician, meanwhile, suggests that hospitals focus on provider training, recommending that facilities train clinicians—even those who typically do not treat younger patients—in the use of pediatric medical equipment (Shockman, Toledo Blade, 3/2/06).

EMS Committee

The pilot program for the ESAR/VHP [**ESAR/VHP** (**E**mergency **S**ystem for **A**dvance **R**egistration of **V**olunteer **H**ealth **P**rofessionals] program is underway. Those in attendance at the March State Council meeting who signed up to participate in the pilot received an email with the application. At the May meeting, we critiqued the application, and comments will be sent to California Emergency Medical Services Authority.

Matt Powers presented an update on the EMT1 regulations. AB1811 was pulled, and the Fire Chiefs have submitted their own bill, AB2554. This bill will allow local entities to certify their own EMTs. It would also authorize the employer to be the sole disciplinary authority, and they would not have to share that information with the local EMS Agency or medical director. Also, there would be no requirement for standardized background checks. CalENA will oppose AB2554.

The last EMS Commission meeting was in Sacramento on June 28.

Judy Scott advised that the focus of the Disaster Interest Group will be twofold: (1) is guidelines for austere medical care, and (2) is mutual aid. Much of it addresses the Sacramento County Region. Must specify what 'region' means. Evacuations = buddy hospital. Many issues are on the table. Roger Richter from the CHA should hear concerns.

Janet O'Leary reported that the OSHPD Paramedic Pilot Project has had a site visit. This pilot utilizes paramedics in the ED as Nurse Extenders. They work under the direct supervision of an RN, and perform tasks to their own scope of practice. While the goals of the program have been changing as the pilot progresses, there was positive feedback on the program, which is continuing.

If you have any questions or items for the EMS Committee agenda, email the chair, Diane St. Denis, at EMSChair@CalENA.net.

Diane St. Denis
EMS Committee Chair

Loma Prieta Chapter members who passed the CEN in 2005 were: Karen Kosmala, Emily Magid & Jean Parrish.
LPENA was given 8 free memberships from CalENA. The recipients of these awards are: Caren Wheeler

(Regional Medical Center,SJ), Maureen Holder (El Camino), Cathy Davis (St Louise Regional), Claudette Ferguson (O' Conner Hospital), Sukyoul Kim (Kaiser Santa Clara), Ziba Fasihi (Kaiser Santa Clara), Robert Jackson (Regional Medical Center) and Ma Teresa Ocampo-Santos (Seton Medical Center, San Francisco).

LPENA had a very successful Annual Update educational event. Regional Med Ctr sponsored a fabulous breakfast. Other sponsors were Westmed College, Innercool, and Schering-Plough. We are already discussing topics for next year's Update offering.

San Diego Supports Y-ME

The San Diego Chapter and several individual members, were most generous in supporting me and Cathy Tylka, by donating to the Y-ME Breast Cancer Organization, Mother's Day Walk to Empower, May 14, 2006.

In March 2004, I was diagnosed with metastatic breast cancer and spent most of 2004 going through surgeries and four months of chemotherapy. In searching for answers to many questions, I found the Y-ME website (www.y-me.org.) The nurse in me was immediately drawn to their approach to education, support and their 24/7 Hotline, available in 150 languages, and the only hotline staffed by all volunteer breast cancer survivors.

The Mother's Day 3 Mile Walk in San Diego, one of nine participating cities nationally, raised over $200,000. Sacramento was the other California city to participate and raised over $150,000. Nationally, $6 million dollars were raised. 80% of fundraising supports the free programs. Y-ME is NOT in competition with Susan B. Komen fundraising, as Komen donations are focused on "research." The mission of Y-ME is to ensure, through information, empowerment and peer support, THAT NO ONE FACES BREAST CANCER ALONE.

Please consider participating in the 2007 MOTHER'S DAY WALK TO EMPOWER

24 hour hotline: 1-800-221-2141

Susan Morse has been an ENA member for over 20 years, having worked in emergency departments of St. Joseph Hospital, Orange, St. Joseph Hospital, Eureka and Tri-City Medical Center, Oceanside.

Education

The August **Emergency Summit** is postponed until **April 19-21, 2007, in Lake Tahoe**, due to time constraints. It will be held in conjunction with the April 2007 State Board & Council meetings. More info to come as planning progresses.

Becky Petersen,, Chair

SAVE this DATE!!!

ORANGE COAST Chapter of ENA
Presents a Unique Educational Offering:

Emergency Nursing in the Real OC

DATE:
Thursday, November 2, 2006
TIME:
0730-1500

Guest Speakers, Vendors, and Sponsors

Program content includes:
Sepsis, Stroke, Burns, Pediatrics,
Club Scene Drugs
An opportunity to attend a Local Chapter Meeting and be treated to a day full of learning and fun!
Join us on Friday 11/3/06 @ the same location for the CalENA State Council Meeting from 0900-1600

LOCATION:
Hilton Irvine/Orange County Airport
(Located on MacArthur directly across from the OC airport)

Cost includes:
Continental breakfast, sit down lunch, wine and cheese reception, 7.5 CEs, reduced cost parking, free shuttle serve from OC Airport

Special conference rates/luxury accommodations for overnight guests
Special ENA member cost to be determined

Non-ENA members…
Join ENA @ the door and
get the ENA price
Watch for a special registration brochure to follow this summer…

GMI Wants Nursing Opinions

GMI (Global Market Insite, Inc.), one of the world's leading market intelligence solution and online panel providers, has launched **www.nursesurveys.com**, a new online specialty panel of nursing professionals. GMI and its medical research partners are currently seeking the expert and qualified opinions of nurses to shape the future of medical research and products by participating in quick online surveys. Survey participation benefits include:

- Earning cash or gaining pre-paid subscriptions to Vivísimo, an exclusive biomedical web search tool specifically custom-developed for GMI, as compensation for providing online opinions
- Driving the direction of medical research and product development with direct feedback
- Participating in a highly secured environment that protects the privacy of all panelists' contact information

GMI's panelists are highly profiled, undergo a rigorous double opt-in recruiting process and are well-compensated for their efforts.

With panelists in over 200 countries, participating in 37 languages, and profiled on hundreds of attributes, GMI provides high-integrity global panels for the medical profession's traditional and online research needs.

For more information or to join GMI's panel, please visit www.nursesurveys.com.

(The preceding is a paid promotion for GMI that promises to share a percentage of the revenue they generate with Cal ENA.)

Coalition of Nursing Organizations in Calif.

Review of numerous bills was the agenda of our last meeting. AB 2984 (Maze) would grant statutory authority to BVNPT to define and interpret the scope of LVN and LPT Practice. There is strong opposition to this legislation. The time may be right to move to a single Board for Nursing. California is one of only 3 or 4 states that have two Boards.

California School Nurses Organization continues to do battle against unlicensed personnel administering medications. They put forward language to amend AB 1667 and are opposing AB1137 which establishes a program to add nebulized Albuterol to the portion of the Education Code that allows for the emergency use of Epi-Pens. They are seeking the support of other nursing organizations in their efforts.

SB 1204 Lift Teams is supported by nursing organizations. It was place on the Senate Appropriations suspense file.

ENA Foundation

The Foundation will sponsor "Fiesta Night at La Villita" on Friday, September 15th in San Antonio, TX, to raise money for scholarships and research grants. Encourage every one attending Annual Meeting to join in the fun. Pre-registration is required and the fee is $40. There will be costumed folkloric dancers, Mariachi and a live band playing salsa/fiesta music.

The Foundation will be holding an ON-LINE Auction of "cool" items from August 21 to September 16, 2006. If you wish to donate please contact the Foundation's Bev Saiz at BSaiz@ena.org. Remember to check the auction at ena.org for some "cool" items and maybe get your Christmas shopping done early!

Diane Schertz, Liaison

You can earn one (1) CE, at no cost for reading the Monitor. After reading the newsletter, complete the evaluation below and email to: petersenr@medamerica.com

Or mail to: **Becky Petersen**
2100 Powell St. Ste. 900
Emeryville, CA 94608-1803

You will receive your CE certificate within 30 days by mail. Provider approved by the California BRN Provider #10609 for 1 contact hour.

Objectives:

After reading the Monitor the reader will be able to:

1. Discuss the human side of trauma.
2. Know how to find ENA classes.
3. Be aware of issues at General Assembly.
4. Understand the complexities of treating children.

Name_____ License#_____

Address_____

1. Were the education objectives met?
   Yes □ No □
2. What is a Bogota bag?
3. Where will the Term Limits debate take place?
4. What is the chief benefit of Rapid Response Teams?
5. Name the plan that would bolster the availability of pediatric care.

Next Meeting

Thursday, August 17

7pm Conference Call

Committees and chapters are encouraged to "meet" before this conference call and give your report during the call. Issues coming before the national General Assembly will be discussed.
Get access to the phone number by contacting Robert Toman, Cal ENA President

Tuesday, September 12

General Assembly, San Antonio, Texas

5-7pm Conference Room 12

(There will be a short Board and State Council meeting as a great number of Cal ENA members will be present.)

Upcoming Meetings and Events:

November 2 & 3: Orange Coast
January 18 & 19, 2007: San Fran Bay Area
April 19 & 20: Lake Tahoe
July 12 & 13: San Diego
August/Sept: Conference Call - TBA
November 8 & 9: Los Angeles

California Emergency Nurses Association

THE MONITOR

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Report email and address changes to the National ENA office: (800) 243-8362 or enainfo@ena.org