Emergency Department Update

Friday, September 8, 2023
Issue # 152

GENERAL

Chaplain Carl

Chaplain Carl Magruder of our Chaplain Service was recently in a motorcycle accident and is currently in the ICU at John Muir. His partner, Micha, has asked for prayers or supportive healing energy be sent their way. She has also set up a webpage to keep Carl's friends, co-workers, and community updated as to his condition (https://www.caringbridge.org/visit/carlmagruder).

BERT Safety Tip of the Month

Choose Wisely What You Insist Upon

- It's Important to be thoughtful in deciding which rules are negotiable and which are not.

Tips when Choosing Wisely What You Insist Upon

- Ask yourself is a rule negotiable or not, would exhibiting a bit of flexibility head off an altercation? Would insisting on something lay the groundwork for a power struggle?
- Keep your eyes on the big picture—remember to see the individual behind the challenging behavior. Often times it's a person who is confused, hungry, tired, scared, or anxious.
- If a person does not want to shower in the morning, can you allow them to choose the time of day that feels best for them?
- If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations.

Examples of Criteria for a BERT Call:

Emergent Calls (AKA "BERT Activation"):

- Agitated, threatening, or displaying disruptive behavior that is not responsive to initial verbal de-escalation
- Additional staff needed to help support the behavioral health of a patient displaying acute changes in behavior

Non-Urgent Calls:

- Questions about psychiatric medications
- Specialty Clinics in Building 5: concerns about a future appointment (Activate BERT during the appointment time)
- Questions that do not require BERT to be present at the caller's location

Contact Information:

Monday – Sunday: 24-hours, 7 Days a week

Emergency Line for Building 5 and Building 25
(PAGE BERT TEAM): x62999
- Indicate patient/visitor's location

Non-Urgent Line: x69867
(For phone support; BERT will not respond to the location)

Emergency Department
BERT ED Line: x69863

EQUIPMENT, SUPPLIES, PRODUCTS

On Back Order

- 12-Lead EKG paper—is available via a substitution
- Wristbands—2 boxes in back and more on order ETA tonight
- Coban—substitute should becoming in this weekend
- Yellow Urine tubes—ETA tonight or over the weekend
- Suture trays—Substitute ordered. Remaining kits at CN desk with the last 10 in Deb and Yesenia's office
- 16f foley—ETA 9/27

EDUCATIONAL OPPORTUNITIES

PEM PEARL

Dina Wallin, MD, FACEP, FAAP

Unless you spent August under a rock, you've likely heard about my medical students' QI project, aimed to **decrease length of stay for kids with lacerations**. Their pilot project includes:

- Lidocaine-epinephrine-tetracaine **(LET) gel and liquid** are now available in the Omnicell ***without provider order***!
- We created a **bundle** in the Omnicell, the "Laceration Medication Package," or **LacMedPack**. This contains both, LET and injectable lidocaine.
- We created **specialized laceration kits**, available in the pod B medication room and clean utility room, with all the supplies you need for LET application --> lac repair.
- We created a 2 minute **educational video** demonstrating how to apply LET

We observed that Black and Native American/Indigenous children with lacerations have longer length of stay than children of other races/ethnicities, and we're hoping to close/eliminate that gap. Please help our students out by **applying LET ASAP** to all kids with lacerations, potentially grabbing our handy kits so all supplies are ready in the room. ☺

Given this context, I was fascinated to read this new study, which sought to increase local anesthetic application in a pediatric ED. The things that surprised me:

- Authors used **EMLA** instead of **LET**.
    - LET is traditionally preferred for open skin ("LET it into the wound"), with EMLA/LMX for intact skin (IV start, abscess, foreign body). However, according to the authors, EMLA is also effective on open skin. It takes longer to work-- 45-60 minutes compared with 20-30.
    - Authors made this choice because LET was too expensive for their ED.
- Authors increased EMLA use from **23% to 60%.**
- Patients receiving EMLA had ***longer*** **length of stay!**
    - I suspect this may be because previously, providers defaulted to sedation and immediate repair.
- Providers were not fully satisfied, primarily because of the longer LOS, as well as the fact that EMLA didn't affect patient anxiety.

We are very grateful to have access to fast-acting LET at SFGH. Let's use it! ☺ Please LMK if you have any questions or feedback, and/or you're welcome to submit feedback to the students here.

PEM PEARL #2

The Pediatric Trauma Society, Western Trauma Association, and the Eastern Association for the Surgery of Trauma just released their systematic review and management guideline for **pediatric ED resuscitative thoracotomy**. Although the overall quality of data was poor, they were nonetheless able to release several recommendations:

- Conditionally **recommend ED thoracotomy** in the following children who present **pulseless with signs of life*:**
  - Penetrating thoracic injury
  - Penetrating abdominopelvic injury
  - Blunt injury thought to be thoracic in source
- Conditionally **recommend AGAINST ED thoracotomy** in the following children who present **pulseless withOUT signs of life*:**
  - Penetrating thoracic injury
  - Penetrating abdominopelvic injury
- Strongly **recommend AGAINST ED thoracotomy** in children who present **pulseless withOUT signs of life*** after blunt injury

** signs of life: cardiac electrical activity, respiratory effort, pupillary response, palpable pulses, measurable blood pressure, or extremity movement*

So, super helpful. Not only is ED thoracotomy traumatic to the child's body and any parents/loved ones who may be in the room, there is a real risk of injury to providers and staff (1.6% of team members reported exposure to bodily fluid during ED thoracotomy in one study). In kids withOUT signs of life, we probably should not be doing the procedure. (Please see below for a PEM Pearl from October 2020 discussing a similar point.)

October 2020:

A new article in the *Journal of Trauma and Acute Care Surgery* reviewed the National Trauma Data Bank for ED thoracotomies in patients younger than 16 years old. Major finding? Mortality was 90%, similar in penetrating (88%) and blunt (94%) mechanisms, and **no children without signs of life* on ED arrival survived.** We want so badly to do the right thing for all of our patients, especially kids, and here, sure seems like the right thing to do if the child arrives in traumatic arrest without signs of life is NOT ED thoracotomy. *(*signs of life: organized ECG activity, pupillary responses, spontaneous respiratory efforts or movement, or unassisted blood pressure)*

ENPC COURSES 2023

- September 14-15 To register go to https://Sept2023ENPC.eventbrite.com
- November 2-3 To register go to https://Nov2023ENPC.eventbrite.com

CELEBRATIONS/ANNOUNCEMENTS

CELEBRATIONS

Send me your celebrations (david.staconis@sfdph.org) that you would like included in the ED Updates and I will share them here.

Selin Senel, nightshift **RN**, was very prompt in contacting me (PES nightshift attending psychiatrist) regarding a suicidal patient who presented to ED triage and had a suicidal plan, but suddenly bolted from the hospital. I was impressed with her conscientiousness and attention to detail in handling this complicated situation. She ultimately notified the appropriate individuals to address this issue. Her quick thinking and care of a psychiatric patient in distress was heartwarming for me to observe. Keep up the great work, Selin, and thank you. **~Raj Kalapatapu, PES MD, PhD.**

On Saturday we had a busy and understaffed day at Triage. All the people I worked with were awesome and made the chaos bearable. **Ana Lopez, MEA** worked hard all day drawing blood and getting EKGs done. She was truly fantastic. **Linda Lee, RN** had a rough moment with a patient harassing and filming her, but she dealt with it and stuck it out without losing her Linda-cool. **Sarah Dice-Goldberg, RN** is never one to slack off and switched back and forth from greeter and triage. So much awesomeness with these co-workers! **~Kate Matthew, RN**

Thank you to my **Pod A Dayshift team** on **Thursday 8/31** and to everyone else who came over to help with the outbursts there! You all slogged through a rough shift with several sick medical and behavioral cases. **~Sarah Dice-Goldberg, RN**

I would like to thank **Liz Berryhill, RN** for coming to help in Code in H32. We had long code and needed to give TPA. **Floyd Frazier, Charge Nurse** provided with a Lucas and Liz to make sure we knew how to utilize it. Liz was very helpful at code we had in H32. Thank you very much. **~Shino Honda, AOD**