Emergency Department Update

Friday, January 19, 2024
Issue # 159

GENERAL

RESPIRATORY ILLNESS

- Please wear at least an isolation/procedure mask in the hospital, including computer workstations. N-95 are highly encouraged for direct patient care.
- All patients and visitors are required to wear isolation/procedure mask while in the hospital

RESUS CART EXCHANGE SCHEDULE

- **At 7:30 am CPD staff will call CN to help facilitate getting carts exchanged from rooms 1, 2, and 6**
- **At 15:30 CPD staff will call CN to have rooms 3,4, and 5exchanged**
- **At 23:30 CPD staff will call CN to have rooms 1,2 and 6 exchanged**
- **At any time if we need a new cart call CPD**

CPD will contact the CN and let them know they are in the ED unit, the CN will then delegate one of the MEA's to facilitate the switch out.

Please DO NOT check carts for stocking levels. The carts need to be switched out each time regardless if they are full or not. This is the workflow, please do not deviate.

EQUIPMENT, SUPPLIES, PRODUCTS

On Back Order

- Spit Masks—No ETA
- 1” tape—ETA 1/22
- Small Moldex N95—ETA 1/22
- Prob covers—ETA 2/05 working on substitute
- 20 ml syringes

Medication Shortages

- LET gel and Kit
- Ketamine 50 mg/5 ml syringes
- Viscous lidocaine 2%
- IV Nitroglycerin

- Buffered lidocaine syringes
- Penicillin IM syringes
- Oxycodone 10 mg
- Dextrose 50% syringes
- Hydromorphone 4 mg tab
- Diazepam IV
- Phenobarbital IV
- Hypertonic saline 23%

EDUCATIONAL OPPORTUNITIES

PEM PEARL

Dina Wallin, MD, FACEP, FAAP

To be honest, I'm a bit nervous about posting this PEM Pearl, because I have some concerns about increasing CT use. That being said, I recognize that I have a preference against CT imaging in favor of instead performing a thorough history and physical and serial observations; this practice has its own downsides (longer ED length of stay, potential delayed diagnosis or missed injury), and want to make sure our team is exposed to all the info out there.

A recent retrospective review looked for risk factors for **severe thoracic injury** in kids with **blunt thoracic trauma**. Younger children have very pliable rib cages and are less likely to have rib fractures after trauma, but, alas, are more likely to have the force transmitted directly to their lungs. Despite these significant physiologic differences from older kids and adults, we don't yet have a widely accepted clinical decision instrument to risk stratify children, in the way we do for head, C-Spine, and abdominal injuries. These authors looked at charts of **373 children** with a mean age of **11 years**, and found the following to be predictive of **major thoracic injury missed on CXR:**

- **Chest pain** (odds ratio 4.9)
- **Abnormal chest auscultation** (odds ratio 3.6)
- **Tachycardia** for age (odds ratio 2.9)
- **Age > 15 years** (a very weak odds ratio of 1.1)

So, does this change my practice? Well, I don't *love* getting chest CTs on stable kids without hypoxia or respiratory distress, because you're heavily irradiating thyroid and breast tissue in one fell swoop, but if I have a kid with blunt thoracic trauma who is reporting significant chest pain, has abnormal chest auscultation when calm, or has unexplained tachycardia for age, especially if they're a teen, I may consider escalating beyond a CXR. Interested to hear others' thoughts and experiences!

PEM PEARL #2

A few years ago, I cared for a febrile teenager who was Covid positive and presented with chest pain. When his troponin returned elevated, I admitted him with a concern for myocarditis-- and the next day read a semi-snarky note from pediatric cardiology citing a bunch of papers stating that troponin can be elevated in routine viral illnesses *without* myocardial involvement and I should've known better and discharged him.

I still maintain that, from an ED perspective, if a pediatric patient without any other reason to have an elevated troponin (ex. CKD) presents with chest pain and has an elevated troponin, I am admitting them to eval for myocarditis-- nonspecific viral troponin elevation is definitely a diagnosis of exclusion for us. However, a recent study does show that febrile pedi ED patients can have elevated trop/BNP without myocarditis, and the sicker kids have higher values, likely tied to multisystem organ dysfunction rather than specific myocardial inflammation.

Again, not particularly practice-changing for us in the ED, but good to know. As a reminder, myocarditis can present very insidiously, with fever, N/V/D, abdominal pain, cough, and/or URI symptoms rather than overt chest pain or dyspnea-- this is because the vast majority of cases of myocarditis in the US are viral, with Coxsackie, adeno, and influenza as common offenders. Most kids won't have evidence of fluid overload on exam, and their only abnormal findings on exam or EKG may be sinus tachycardia. The key is to have a high index of suspicion-- there's a reason why most kids ultimately diagnosed with myocarditis have 3+ prior healthcare encounters before the diagnosis is made.

LMK if you've ever had a similar case, with a well-appearing febrile child with viral symptoms who had an elevated trop and turned out to not have myocarditis. I suspect that there are way more of them out there-- we're just not checking labs.

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.

NRC Patient Survey Comments

"I think everything was all done in a timely manner I was very satisfied "

"You folks were terrific in every way"

"The nurse, Annie, was superb."

"Impressed with such efficient and thoughtful care. Thanks to the entire team!"

"Dr A Jimenez was so patient and very nice ? ? "

Celebrations From Staff

I want to thank **Lisa Verduzco, RN** for being an excellent and proactive acuity on a busy Pod A night 1/8. Also a special shoutout to **Matt Hogan, RN** for coming over from C and helping us with some difficult IVs. A great job to all the hard working RNs in Pod A that night with their incredible work ethic and attitude and getting through a great deal of the night at 4:1. **~Greg Andrews, RN**

Response Strategies *for* Bystanders

Working together to maintain a workplace free from discrimination and harassment

Direct

Directly intervene and address the situation in the moment. Ask the person to clarify their statement or action.

- *Question directly:* "What did you mean when you said…?"
- *Assume the best:* "I know you didn't really mean that, but it came across this way..."
- *Call someone in:* "Can we talk about what just happened?"
- *Call someone out:* "That's not cool. We have to do better."
- *Call out jokes:* "I know you think it's just a joke, but I don't think it's that funny."
- *Be honest:* "The truth is, what you just said makes me uncomfortable."
- *Be curious:* "I wonder if we could provide better care if we...?"

Distract

Cause a distraction to stop the offensive conduct.

- Interrupt & start conversation with the person being offended.

Delegate

Speak to a supervisor and ask them to help address the situation.

- "What they said is not an appropriate way to interact with our team members. As the attending physician or charge nurse, will you speak to them?"

Debrief/ Delay

Check in with the person who experienced the offensive conduct. This is key!

- "Are you ok? I saw that, and I'm sorry I didn't say anything in the moment, but I wanted to check in with you."
- "I saw that, and I'm sorry that it happened again; let's huddle with the clinical team to decide on what to do next."

Document

Report incident using the ZSFG SAFE reporting system. Other reporting mechanisms for UCSF faculty, learners, and staff:

Office for the Prevention of Harassment and Discrimination
415-502-3400
OPHD@ucsf.edu

Confidential reporting for trainees
tiny.edu/safefeedbackform

Office of Ombuds
415-502-9600

GME confidential hotline
415-502-9400

UCSF University of California San Francisco

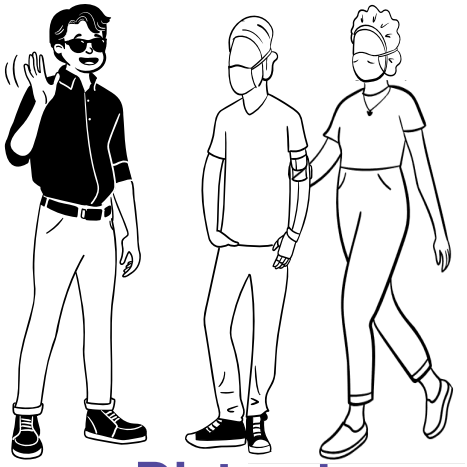
ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

More information & resources:
tiny.ucsf.edu/bystanders

Response Strategies *for* Bystanders

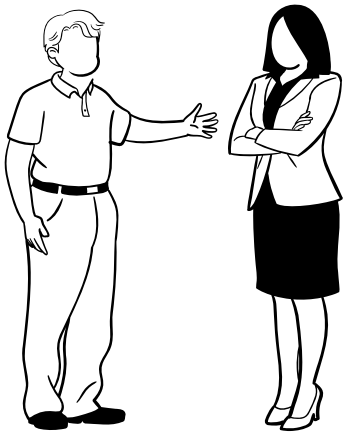
Direct

Directly intervene and address the situation in the moment. Ask the person to clarify their statement or action. Be genuinely curious and respectful.



Distract

Cause a distraction to stop the offensive conduct.



Delegate

Speak to a supervisor and ask them to help address the situation.

Debrief/Delay

Reflect on the moment and support one another. This is a key step that should always be taken.

Document

Report incident using the ZSFG SAFE reporting system.

UCSF
University of California San Francisco

ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

More information & resources:
tiny.ucsf.edu/bystanders

Bee Safe Monthly Buzz

FROM SFDPH OCCUPATIONAL SAFETY AND HEALTH

January 2024 • Issue 24 • Volume 3

CLICK HERE FOR OUR ENTIRE BUZZ LIBRARY

Body mechanics-related injuries and blood and body fluid exposures are the highest occurring OSHA-recordable injuries among SFDPH staff. The 'Bee Safe Monthly Buzz' offers education and prevention tips each month to help keep our workers safe from these hazards.

SHOULDER SAFETY RESOLUTION

DON'T SHRUG THIS OFF! NEW YEAR'S DO'S AND DON'TS!

DO:

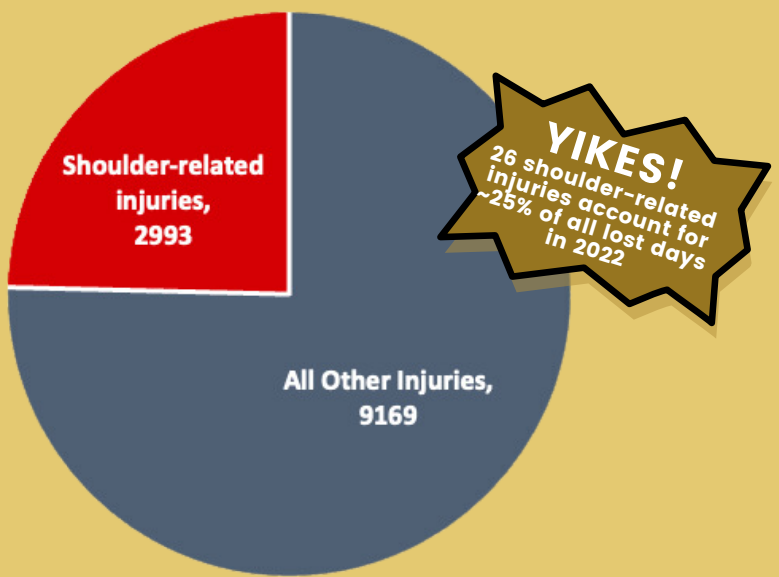
Lift Smart: Bend knees, keep the load close, and use leg muscles when lifting
Maintain Posture: Relax shoulders, straighten spine, engage core for support
Take Breaks: Regularly rest and stretch to avoid overworking your shoulders
Use Ergonomic Tools: Use equipment to reduce shoulder strain during tasks.
Exercise and Stretch: Include shoulder exercises for flexibility and strength.
Listen to Your Body: Address any persistent shoulder discomfort promptly.
Adjust Work Setup: Modify workstations to ease shoulder strain, alter heights if needed.

DON'T:

Overextend: Don't lift heavy objects with arms extended away from your body.
Slouch: Avoid slouching or leaning to one side.
Overwork: Avoid repetitive movements without breaks; rotate tasks if possible.
Ignore Discomfort: Don't ignore persistent pain or discomfort.
Forget Nutrition: Neglect proper hydration and nutrition can impact shoulder muscle health.

SFDPH OSHA-Recordable Body Mechanics Injury Claims
Missed and Modified Days
2022
Shoulder-Related Injuries vs All Other Injuries

OHS OSHA Log, 2023



Don't let this bee you:

OUCHY STORIES

"I was mopping when the mop was caught under a door. I pulled mop free and injured my shoulder rotator cuff." ***190+ days***

"I was moving a patient from gurney to bed without a slideboard. I felt pain down my shoulder, back, and breast." ***360+ days***

"I was moving bed through threshold and felt pain in my elbow and shoulder" ***172+ days***

Want more? Take a class! SFDPH offers "Office Ergonomic Awareness Training" every two months. Sign up for the next online class with this QR Code

SCAN ME!

Contact Us at Monthly.Buzz@sfdph.org