Emergency Department Update

FRIDAY, JULY 9, 2021

GENERAL

VACCINATION STATUS

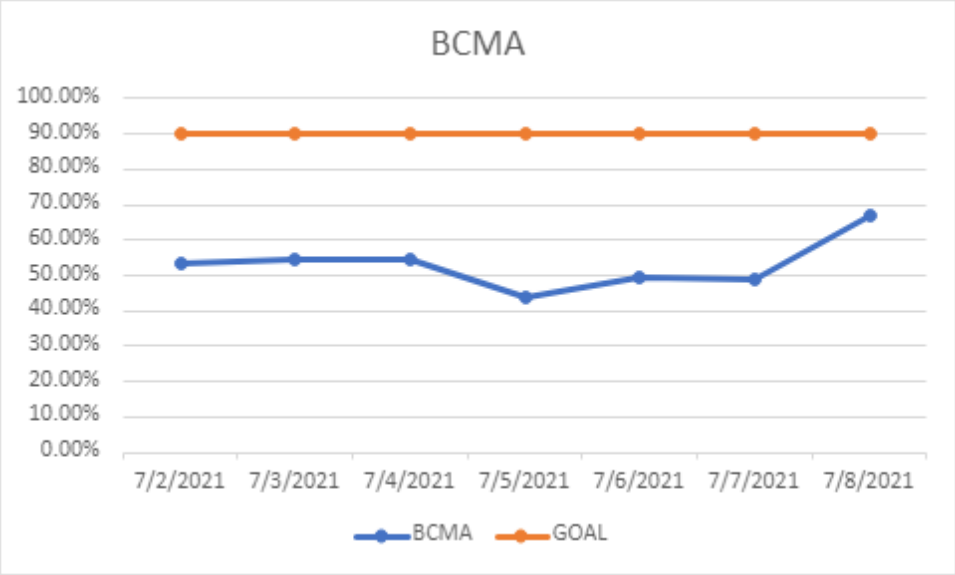
Vaccine history feeds from 4 sources: Vax administered by DPH, vax records in Care Everywhere, Vax from the California Immunization Registry and manually added historical vaccines.

If you have records of detailed information of past vaccines, use the Single Historical Immunization documentation template by following these steps:

1. Open the patient's chart and click on the triangle drop down on the right side of the chart and select "Immunizations".
2. In the Immunizations activity tab, click the arrow next to Historical Immunizations and select **Single Historical Immunization** in the drop down.
3. Search for the name of the immunization to activate the additional fields. Enter at least the date and any other information into the fields (Lot, NDC, Time, External source of information, etc) and click accept when done.

BARCODE MEDICATION ADMINISTRATION (BCMA)

We have hit our highest barcode scanning compliance yesterday 66.7%!! Keep up the good work. Our department goal is 90%.



NURSE MANAGER'S CORNER

TRIAGE

- You can now "expect" a PES patient and put in a call in. When you PPID the patient, it will pop up with a window showing their PES encounter. Click "new" and it will expect the patient into the ED census and take you to the area to put your call in.
- The EMTALA waiver will be expiring at the end of July. In lieu of that, we will be piloting a new process with Urgent Care starting July 13th to help streamline our referrals to Urgent Care. Stay tuned and we will be here to answer any questions you may have.

PATIENT BELONGINGS

When booking patient belongings and placing them in the cart in the resus hallway, please remember to label the property and attach a booking slip. All property missing a label and/or a booking slip will not be taken by Facilities Management for long term storage. Please help us ensure our patients are able to have their property returned to them.

COVID-19

ADMITS

- No need to send ROUTINE swab on admitted patients if patient is fully vaccinated **AND** asymptomatic
- Continue to send ROUTINE swab for all admits:
  - If patient is unvaccinated OR
  - If patient has symptoms

URGENT PROCEDURES/TRANSFERS:

- NO need for rapid testing if fully vaccinated **AND** asymptomatic

ASYMPTOMATIC AND PES BOUND

- No need for rapid testing if:
  - Fully vaccinated
  - Negative BINAX Antigen test in field
  - Negative COVID (rapid/routine/BINAX) test within last 7 days

EMPLOYEE VACCINATION STATUS-ACTION REQUIRED****

- The Department of Human Resources (DHR) has issued a new policy which requires that all employees disclose their vaccine status. Employees are to input their information and supporting documentation through the secure self-service feature of the Employee Portal by **July 29, 2021**
- Although you may have provided the information to the DPH Occupational Health department, your vaccine status must also be entered into the Employee Portal
- Here is a link to instructions-- How to Submit your COVID-19 Vaccine status via SF Employee Portal Solution Article

PHARMACY

LET'S TALK ABOUT NALTREXONE FOR ETOH USE DISORDER

Q. Is the PO trial required?

A. NO! It used to be, but not any more.

Q. What monitoring is required? Is there minimum time needed to hold a patient prior to discharge?

A. There is no minimum time required to monitor the patient prior to discharge.

Q. Are there adverse side effects we should watch out for?

A. Surprisingly, this medication is very well tolerated. As always, watch out for anaphylaxis. Side effects of Naltrexone include insomnia and potentially nausea but nothing immediate.

Q. Are there things we should be educating our patients regarding this medication and future ETOH use?

A. No. This medication can be used while drinking alcohol. There is no associated disulfiram reaction. It is really quite safe. The only real concern with Naltrexone is concurrent opioid use. Naltrexone will precipitate opioid withdrawal.

Q. Someone had an experience with a ACT provider coming in, giving a patient an IM shot and then leaving. Is this what we can expect if this medication is ordered? If so, how should it be documented in EPIC?

A. When the ACT comes to the ED to administer naltrexone IM, everything is done by the team. The LVN will document administration of medication, the ED nurse is not required to do anything on behalf of the team, including obtaining the medication from inpatient pharmacy.

QUICK TIPS!

- Add 3.4 mL of diluent into vial with powder right before administration (to minimum time between compounding and administration). Total volumne of administration is 4mL
- Shake VIGOROUSLY and minimize time between mixing and administration because the longer the time in between the two, the more risk there is of clogging the needle.

- There are two different sized gauges in the box for IM administration. There are TWO of each size. The nurse can EXPECT the first needle used for administration to clog, the compounded solution is VERY viscous. If this happens, withdrawal the needle from the site, attach the second needle and attempt second administration.
- Administration is into gluteal muscle

EQUIPMENT, SUPPLIES, PRODUCTS

SOLUTION SET WITH DUOVENT SPIKE

- The DUO-VENT is on backorder until 7\15. The ED has done the following:
  - Placed Solution Set with Duo-Spike in Resus Core for access
  - Reminder: You can use the Secondary Medication Set with Duo-Vent Spike as a replacement device.

BLUE TOP VACCUTAINERS

- There continues to be a nation-wide shortage of blue top vacutainers and Lab is working on securing an alternate product
- Please do not draw blue tops as part of the routine "Rainbow" draw
- Blue tops tubes have been pulled from the IV Carts in the Pods and are available at the TL's and CN's desks
- They should still be being stocked in the Resus Room IV Carts. When checking your resus rooms, please be sure your carts have blue tops in them.

PPE

- Additional PPE supply has been moved to the back closet
- TLs, please remember to check your PPE carts to ensure they are up to par and refill with the stock in the back

ENDOSCOPE

- Still out on repair

EDUCATIONAL OPPORTUNITIES

PEM PEARL—Dina Wallin, MD, FACEP, FAAP

While 70% of term neonates will show some degree of breast enlargement (an effect of maternal hormones), **neonatal mastitis** is a bacterial infection of the breast and surrounding skin and needs antibiotic therapy. In a new retrospective study in *Pediatrics*, infants with mastitis had low rates of culture-positive concomitant serious bacterial infection (like UTI or meningitis); one infant grew MRSA from the mastitis site as well as CSF. 1.5% of infants had sepsis or shock, with 0.5% requiring ICU admission; no infants died.

I share this article with you because I see two major takeaways:

a. Remember **mastitis** as a diagnosis. Although these infants do well, most of them require hospitalization and IV antibiotics.
   i. *Because of the potential need for surgical intervention (22% of infants in this study!), early consideration / discussion of transfer to Mission Bay is appropriate in these cases.*
b. Contrary to classic teaching, these results suggest that **in well-appearing, full term, *afebrile* infants with mastitis, a full sepsis workup (cultures of blood, urine, and CSF) may not be necessary.**
   i. *The one infant with a positive CSF culture, the one with MRSA meningitis, was febrile but well-appearing.*

AHA & ENA Courses

BLS, ACLS, and PALS Blended Learning which includes Online Part 1 and Skills Testing Part 2 - 4th Friday monthly Sign-up link--https://tinyurl.com/2021-ED-AHA

ACLS Renewal Course - August 6th
ACLS EP Course - August 13th
ACLS - September 9th & 10th
PALS - September 28th & 29th
ENPC - August 19th & 20th
TNCC - September 16th & 17th

CELEBRATIONS/ANNOUNCEMENTS

A message from our Chief of Medicine. Christopher Colwell, MD:

I want to take a moment to thank you for the amazing work you have done during some of the most challenging times I have ever been a part of.

I also want to acknowledge that we in the Emergency Department have not had the chance to take a pause. A pause to reflect on the fact that we have been on the front lines, and in fact have defined the front line, for the greatest pandemic this world has seen in over a century, and have been doing this for over a year now. Yet even as the impact of sick COVID patients has lessened recently, the surge in mental health uses, substance use, and interpersonal violence we have faced has made it hard to even take a deep breath. Perhaps more than anywhere else, we in the Emergency Department need to take a deep breath. To acknowledge the impact this has had on all of us. To refuel and regenerate so that we can continue to care for our patients during the challenges that lie ahead, and to remind us to take care of ourselves, and each other, so we will have the strength to serve our patients in the manner they deserve.

Many have had the opportunity for that pause, but too many of us in the Emergency Department have not. In addition to acknowledging this, I will also ask that if anything comes up that I can do to support you please let me know.

Thank you again for all you have done and continue to do for our patients!

Chris.

CELEBRATIONS

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

- Congrats to **Danielle Collins RN, Jordan Gunning RN, Nikolay Ivanov RN, Peter Scott Moller RN, Luis Ortiz Gonzalez RN, Julian Roy RN, Tetyana Wilson, RN** for completing your precepted Resus shifts! Thank you for your flexibility, maintained focus, and hard work over the past 2 months. - David Evans RN, CNE
- **Night shift** did a great job handling a very difficult patient/CODE 50 on 7/6. The team did a great job managing the patient and escorting the patient out of our department. – Jeff Schmidt, AOD
- **Great job night shift on 7/3/21**! Very busy night with 10 admissions to the ICU. Everyone worked together as a good team!- Rob Alvernaz, CN

WELLNESS MINUTE

Many spiritual traditions celebrate conditions of "falling apart." In Emergency Department work, falling apart is <u>not</u> what you do at any bedside. And yet, falling apart is the condition of our (big picture) mortal lives, and it frequently a condition we experience in our personal lives, outside of work. It's because it's such a human experience.

This poem celebrates "falling apart" as an extended metaphor for making contact with our deepest selves — those selves that bring us everyday to the hard work of being healers & and to standing in our wisdom and compassion in every room, whether it be a place of calm or of deep disturbance & existential upset.

— Chaplain M.C. (Mary-Cecile)