# September Dashboard

## Total Patients

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## LWBS

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## LOS Median (D/C min)

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## LOS Median (All min)

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## LOS > 400min (#)

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## Admissions

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<th>13</th>
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## % Admitted

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## %1 Hour

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## Total Hold Hours

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## Psych Patients (#)

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## Total Psych Hold Hours

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## Psych Median LOS (min)

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## Psych ED Patients (#)

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## Kancho Springs Patients (#)

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<th>29</th>
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<th>1.9/4</th>
<th></th>
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Dr. John Kanegaye

Good Catch Safety Award for going above and beyond to maintain a safe environment for our patients, family, and staff.

Dr. Sarah Gomez

“I was working with Dr. Gomez and we had a patient who had been seizing throughout the night. While we were both in the room completing assessments, the patient began to seize and went apneic. She calmly, out loud summarized how we would bag the patient and the assessment findings throughout the seizure. She asked me how I wanted to get RN support, and quickly got in help and gave verbal medication orders to a support person outside the room. The patient care was incredibly smooth and timely, directly due to Dr. Gomez’s calm demeanor, closed loop communication, and strong sense of teamwork. She is a huge pleasure to work with!”

Clinical Director Update

Fareed Saleh, MD, MHA

- **Operations**
  - At time of patient hand-off / sign-out in Yellow/Blue zones, please make sure to flag any pertinent expected arrivals to the oncoming team
  - MRI Overnight: Sharp has very limited resources to perform MRI overnight (which leads to ED nursing accompanying patients, thus impacting ED staffing) → minimize non-urgent imaging (MRI appendix) when possible
  - All RCHSD US sonographers have been in-serviced and are able to perform all necessary vascular US that ED patients may need (i.e., US Doppler LE)
  - When making GI referrals for non-urgent workups (GER, chronic abdominal pain, constipation), many insurance providers require authorization and completion of prior workup with forms documenting this history → plan of care should be referral to PCP who then can refer to GI (when possible)
  - If patient with retained FB in foot that cannot be removed in ED, please refer to ORTHO (not General Surgery)
**Behavioral Health:**
- Once 'medically cleared' is selected 'Yes' → friendly prompt appears to call SW to screen for possible transfer to Psych ED
- Given limited Psychiatry coverage, the Psych ED will not be able to take any new patients from 20:00 to 08:00 for the time-being; once a patient is medically cleared and stable, please notify SW to screen for possible transfer to Psych ED ASAP

**IT:**
- COVID-19 testing section added to ED Fever non-specific template
- Friendly reminder: Please continue to use ED templates when applicable; if they are used expect more to come (ED Minor Injury in the works)

**PEM Conference Reminders:**
- As the division starts a new academic year and in light of the pandemic changing how we interact, please find below some helpful expectations for Zoom use. These expectations are not mandatory and meant to bolster communication, active participation from moderators, lecturers and participants.
  - For all participants:
    - Video to be turned on as much as possible with exceptions for when it is not safe to have it on (i.e., Zoom via hands-free smart phone while in car), taking a short break, large total number of participants (>60) as this may slow connectivity
    - Mute your microphone unless you would like to ask a question or add a comment
    - Active participation is strongly encouraged (if you want to stay on mute, please use the Chat option)
    - Minimize use of Zoom default backgrounds as this may interfere with your video screen view
    - Please remember to avoid unprofessional attire (i.e., pajamas) while on video
  - If you are assigned as the moderator:
    - Ensure that guest speakers are notified of start times or any adjustments to start/end times
    - Manage the Chat and relay any questions or comments to speakers
  - If you are a presenter:
    - Remember to select your screen when choosing 'Share Screen' (not a specific application such as Microsoft Excel or Power Point or else you can't share other applications without unsharing and then sharing your screen again)
Epic Updates: Marc Etkin, M.D., F.A.A.P.

**e-Consent Tip Sheet**

Obtaining consent for a procedure is now available in Epic. Parent/legal guardian, provider, witness, and translators will sign the consent electronically using the mouse and computer.

**e-Consent Workflow**

When a consent form is required for a procedure, navigate to the Review Visit or My Note tab in Epic. Click on the consents activity. This will open the consent form section. Click on the English or Spanish e-consent button. This will open the e-signature document collector.
Prior to obtaining the signatures, it is required to document all fields on the left of the screen under the yellow header. Once the signatures are started, the information in the form cannot be changed. This information will autopopulate in the consent form.

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**e-Consent Tip Sheet**

Once the required fields are entered, begin collecting the signatures. On the e-consent form, it indicates what signatures are required. ***The Witness and the Provider must log in to Epic under their own login to sign the form.***

- The first signature is if the patient/parent/guardian declines to be informed about the procedure. **This is not a required field and should only be used if the parent declines consent, but is still ok with the procedure.**
- The second signature is the patient/parent/legal guardian's signature. This is the person who you listed in the relationship field in the smartform.
- The third box is used if a translator is in person.
- The fourth box is the Witness Signature. The witness must log in under their own name in Epic to sign.
**e-Consent Tip Sheet**

- The last signature is for the Provider who is obtaining consent.

**Options in Signature Field**
- You can clear a signature by clicking on the eraser icon next to each signature field.
• You can enlarge the signature field by clicking on next to each signature field.
• Clicking the next to each signature field accepts signature and brings you to next field.

**Witness Signatures**

The ED nurse can locate the consent form activity in the ED narrator toolbar. When you click on the activity, it will open up the consent navigator.

Click on the blue hyperlink and sign the Witness Signature. Click accept and close the form.

**e-Consent Tip Sheet**

Once the e-Consent signature fields are completed, the users will click accept. To see the status of the consent form, users can navigate to the consent form activity. In the screen below, 2 of 3 required signatures have been obtained.

To see what signatures are needed, click the blue link in the Consent Form activity. The top task bar will identify which ones are needed to complete the form. You can also see what signatures are required to the right of the form.
Once all the signatures are obtained, the document will show as E-signed. You can preview the document by clicking the magnifying glass over the paper icon.

**e-Consent Tip Sheet**

Consent is also available in the media tab of Chart Review. Click on the File Link to view E-Consent.
Storyboard for ED Physicians

No matter where you are in the patient’s chart, you can see key information about that patient in Storyboard, such as new results, med status, and vitals. You can also take common actions, such as navigating to the Dispo and Workup activities.

Try It Out

Open your patient’s chart. Storyboard appears on the left side of the screen and the activity tabs appear at the top of the screen.

A. Review key patient information in Storyboard, including:
   - Name, age, and date of birth
   - Preferred Language
   - Acuity, location, and total time since arrival
   - Chief complaint
   - Disposition

B. See the patient’s assigned nurse in the Treatment Team section. Hover over the section to see the patient’s entire treatment team and their contact information. You can also send treatment team members an Epic Chat message by clicking on

   ![Chart Review](chart-review-icon)

   ![Snapshot](snapshot-icon)

C. Check the patient’s most recent vitals in the Vitals section. Hover over the section to review previously recorded vitals.
D. Review new lab and radiology results for your patient in the New Results section:

- Icons indicate the result type, and a red exclamation point icon appears when the result is abnormal.
- Additional information, such as the order's status, appears when you hover over the section.
- Clicking the New Results section takes you to the Workup activity.
- Clicking a resulted order in the hover bubble opens a report showing the results.

E. Track the status of a patient’s medications in the Med Status section. Hover over the header to see which medications are done, which are in progress, and which have not yet been started. Click the section to open the Workup activity.

F. Confidential patient yellow banner will display for “No Info” Patients
Storyboard Features

You can click on various areas of Storyboard to jump to different areas of chart.

- Click on name to jump to facesheet.
- Date of Birth time will display for patients that are less than 8 days old.
- Click on total time jumps you to patient events log.
- Clicking on code jumps you to Code status.
- Click on provider name jumps you to Care Teams where you can assign or unassign yourself from the treatment team.
- Clicking on isolation precautions brings you to patient infection status report.
- Click on allergies to add/review allergies.
- Click on Chief complaint jumps you to Triage Activity.
- Click on vitals to jump to dosing weight.
- Click on new results to be brought to Workup activity.
- Click on results to jump to results review.
- Clicking the new results brings you to Workup activity.
- Clicking on med status jumps you to Workup activity.
- Clicking on disposition jumps you to Dispo activity.

Navigate Activity Tabs and Menu

A. The main activities tabs for ED Physicians will be: Chart Review, Snapshot, Summary, Results Review, MAR, Notes, Review Visit, My Note, Manage Orders, Workup, Dispo, and Charge Capture. The activities you see are dependent on your monitor size. A smaller screen will have less activities visible. If you are in side by side track board view you may need to close side view to see more of your activities on top of screen.

B. Click on the ellipses to access additional tabs/activities if your screen is smaller or if you are using side by side trackboard view.

C. Click the down arrow to open more activities window. These activities are alphabetized. Click on star, to favorite an activity in more menu. All favorites will be a main activity tab. You will see these changes in each patient chart you open.
Hello folks, before I start on the ultrasound spotlight case, I would like to go over some ultrasound machine housekeeping issues that keep coming up –

PLEASE, PLEASE, PLEASE, DO NOT USE THE GEL FROM THE ULTRASOUND GEL BOTTLES FOR SCANNING.

USE OR HAVE THE RESIDENTS AND FELLOWS USE THE SINGLE USE LUBRICATING GEL PACKS THAT ARE KEPT IN ALL THE PATIENT ROOMS.

ALSO CLEAN THE ULTRASOUND MACHINE (SPECIAL FOCUS ON THE SCREEN, TOUCHPAD, PROBES, HANDLING BAR AND PROBE WIRES) BOTH BEFORE AND AFTER PATIENT CONTACT.

These are all part of the COVID-19 ultrasound machine cleaning protocol in place to help reduce transmission of the covid-19 virus. Let’s do what’s best for our patients and keep everyone safe. Thank you!

Moving on to the case...

Below is a cool finding that was noted on a cardiac point-of-care ultrasound that was performed recently. It was performed on a 4-month-old male with some African American heritage brought to the Emergency department due to concern for perioral cyanosis by the foster parent. The patient had no history of cardiac anomalies and nothing in the history suggested congenital heart disease. Exam findings were positive only for hyperpigmentation of the upper lips with no cyanosis. A chest X-ray had been performed and I added on a point-of-care cardiac ultrasound to further reassure the foster mother. This showed good cardiac contractility and no pericardial effusion but did have the finding shown below.

Image 1a and b: Parasternal short axis view of the heart with mass lying adjacent to left ventricle
Image 1a and b are parasternal short axis views of the heart showing mostly the circular thick-walled left ventricle (outlined in red). They also show a mass that is homogenous and has a similar/ slight hypo echogenicity to the cardiac muscle (blue star with green outline). It is seen lying close to the left ventricle with no obvious compression of the lateral ventricular wall. This mass was seen in all views though it was more obvious on the parasternal short axis. Differentials I considered included clotted blood in the pericardial space (unlikely; well appearing, no history of trauma), diaphragmatic hernia with liver intrusion in thoracic cavity (Also unlikely; the images were obtained from the left anterior chest wall, no bowel loops were seen and the Xray showed a RT sided liver and no abnormalities concerning for a diaphragmatic hernia. A mass is a possibility, but the patient also had a finding on Xray that helped guide our thoughts on what the ultrasound finding could be…. A large thymus.

Image 2 shows the different locations of the thymus and its relationship to mediastinal structures. Its exact location is variable and it’s easy to see how it can be seen on a cardiac ultrasound in a child. It appears as a homogenous mass similar in echogenicity to the liver or spleen.

I had to confer with others regarding the ultrasound images and concluded that it is most likely the thymus. I am still reviewing the images with other specialists and will bring an update if any new information is obtained. Till then, Happy scanning!!!!

References:
QI Abstracts - AAP Virtual conference
- Oral presentation: Mike Hazboun (asthma)
- Poster presentations: Heather Conrad (enemas), Lea Cohen (ortho)

QI Course (for fellows and faculty)
- 3rd Fridays 0830-1030 am
- Friday September 18th: QI Tools
- Friday November 20th: QI Data and QI Macros

Telemedicine consults:
- Consulting trainee or parent device workflows
- Neurology -> parent device workflow
Medication Reconciliation in ED and UC

Sarika Sheth MD, Amy Bryl MD, Mario Bialostozky MD

RN PORTION QUICK REVIEW:
Nursing will obtain a medication history and mark whether patients are taking their medications
Once nursing has marked whether each medication is being taken they will “mark as reviewed”

MD Med Rec:
Enter medication reconciliation from either the “Review Visit” navigator or the Dispo navigator
This will open the Med Rec activity. Review RN Med history and click next.

Reconcile medications by using the two icons: (1) continue meds that are being taken and (2) discontinue meds not taking, alternatively you can go through each medication.

Nothing will ever appear in this column since we do not reconcile inpatient medications.

Unfortunately, we are unable to remove this column.
When you click continue meds, all meds that were marked as being taken are marked for continuation.

When you click discontinue meds, it will discontinue all marked as not taking.
You can always individually modify each medication and update it as needed.

Once completed, sign on all actions by using the sidebar on the right.

This area also shows how things will appear on the AVS for patients.
AIMS

**SMART Aim:** To increase screening for Chlamydia and Gonorrhea among adolescents >12 years presenting to the ED with at risk chief complaints (abdominal pain, vaginal pain, vaginal discharge, vaginal bleeding, dysuria, groin pain, penile discharge, penile pain, behavioral health); from 10% to 50% over next 6 months

**Secondary Aims:** 1) To increase sexual history documentation from 40% to 75% among adolescents with at risk chief complaints, 2) To increase teen phone number documentation in tested patients from 23% to 75%

**Global Aim:** To improve testing, treatment, and follow up for adolescents evaluated for STI. To overall improve ED-based reproductive healthcare for adolescents
BASELINE DATA

- Mean weekly testing rate: 10% (3.2-21.7%)
- Positive rate: 8.8%
  - 2 males, 10 females
  - 11 chlamydia, 2 gonorrhea (1 patient with both)
  - Chief complaints: vaginal problem, vomiting, abdominal pain, dysuria, suicidal ideation
- Tested patients with phone number documented: 23%
- Patients with sexual history documentation: 40%

INTERVENTIONS

- Nursing standing order for urine GC/CT
- Inclusion criteria: >12 with abdominal pain, vaginal pain, vaginal discharge, vaginal bleeding, dysuria, groin pain, penile discharge, penile pain, behavioral health patients
  - Urine Chlamydia/GC RNA TMA (current PCR shortage) OR vaginal swab
    *The lab has been having shortages for urine specimen, so if unavailable please send vaginal swab. Provider or patient can collect the sample
  - You can still order the test or cancel it depending on your clinical discretion
- Single urine specimen
  - For symptomatic patients: wipe beforehand
  - For behavioral health patients, no wipe, can use same urine specimen for urine pregnancy test and urine drug screen

UPCOMING INTERVENTIONS

- Nursing education at September meeting
- Epic order set for STI testing and treatment
- Registration to document teen cell phone number
- Adolescent Note Smartform
- Indications for consult and referral to Adolescent Medicine
Urgent Care Updates

Gregory Longley, MD and Seema Mishra, MD

RCHSD Urgent Cares continue to see patients at three of our sites: Oceanside, MidCity, and South Bay. We are hoping to re-open other sites as volumes increase. Currently, our Murrieta, Escondido, and La Mesa sites are closed.

Weena Joshi has been with our Urgent Cares for 10 years and is now also the UCSD School of Medicine Thread Director of Health Equity. During the 2020 medical school commencement, she received the distinguished Kaiser Excellence in Teaching Award from the class of 2022. We are very proud of Weena and her accomplishments!

Mario Bialostozky has been with our Urgent Cares for almost 3 years and is also very active in informatics and data gathering. He has recently been accepted to present at several conferences and has been very instrumental in developing our Telehealth program. Special thanks to Mario for all he does for us!

Residency Updates

Please welcome Dr. Ashish Shah to our division! Ashish is a graduate of the Medical College of Wisconsin medical school, went onto pediatrics residency at University of Minnesota and finally completed PEM fellowship at Cincinnati Children’s in June 2020. During fellowship, Ashish also completed a Masters in Medical Education. Ashish will be assuming the role of Director of Resident Education for the pediatric and FP residents, partnering with Michele McDaniel.
Fellowship Updates

Paul Ishimine, MD and Kathryn Pade, MD

It’s almost Fall, which means that it’s almost time for fellowship interview season. Mirroring national trends, we’ve experienced a 50% increase in the number of fellowship applications for our three first-year fellowship spots. The fellowship selection committee (Mike, Amy, Scott, Kathryn and Paul) will be virtually interviewing candidates on six interview days in October and November. Our fellows will be participating as well, meeting with all of the candidates and answering their questions.

As always, please let us know if you want to get more involved with our fellowship program!

Paul and Kat

Research Update

Kathy Hollenbach PhD, John Kanegaye MD, Michael Gardiner MD, Margaret Nguyen MD

PECARN UPDATE

We have fallen significantly behind in enrollment and last month missed over 60% of eligible cases.

PLEASE do your best to enroll all head and/or abdominal injuries into the study. There is also a section on page 2 which was added in January to track where parents were if they were not in the ED to be told about the study.
Please be sure to:

- Complete your individual assessment of both patient’s race and ethnicity
- Complete the section pertaining to parent(s) presence in the ED when you assessed the patient
- Indicate that the letter of information and HIPAA forms were given to a parent/guardian
The research team is revising its calendar of research topics. All division members are welcome to attend (alternating with QI topics every third Friday following Trauma meetings). A survey monkey stool will be sent by group email. Please help us choose topics that best meet your academic needs by taking 1-2 minutes to rate your level of interest in the list of topics (or suggest others).

The admin team has established a new email (pemresearch@rchsd.org) where you can submit all items needing review. Please use this email for all forms of requested reviews, and the admin team will distribute to the appropriate members of the research team. We invite all request and queries and, in particular, encouraged the use of this email for:

- IRB submissions needing review prior to division director signature.
- Abstracts needing review prior to submission to regional and national meetings
- Posters and platform presentations being prepared for meetings
- Manuscript ready for submission to peer review journals
- Secondary contact address (after PI name and contact information) for IRB communications

Please reach out to the research team for assistance with your new or existing projects.

Resuscitation Corner

Matthew Murray, MD

This month I’ll be focusing on a few select medications and their uses. If you have any questions regarding these medications or topics you’d like me to address in future “Resuscitation Corners” please send me an email!

CVICU Code Medications Order Set

This is a fantastic and underutilized resource – we may develop an ED version in the future, but for now this a great list. It allows nursing to have meds at the bedside so you can be prepared in case of clinical decompensation.
Phenylephrine

Now available in all code carts in a 100mcg/ml concentration in a 5ml ampule.

**Standard Dosing**

- 5-20mcg/kg IV bolus

**Mechanism**

- Increases systemic/peripheral vascular resistance through peripheral vasoconstriction with no effect on heart rate

**Common Uses:**

1. **TET Spells**
2. **Spinal Shock** – severe spinal cord injury with hemodynamic pattern of low BP with no reflex tachycardia and are clinically peripherally vasodilated
3. **During electrical cardioversion** – hypotensive patient requiring cardioversion where you want to temporarily support and increase BP (especially if you are sedating the pt) but you don’t want to increase the HR with agents like epinephrine/norepinephrine

**Sugammadex (Bridion)**

- Reversal agent for Rocuronium
- Useful in the following situations:
  - “Can't Intubate Can't Ventilate” situations *where patient had respiratory drive prior to paralysis (altered mental status, agitation etc.)*
**VERY IMPORTANT**: Will not help in patients being intubated for respiratory failure – they will still be in respiratory failure once rocuronium reversed

- You must just progress down your failed airway algorithm in these situations
  - **Status epilepticus where you want to see if the patient is still seizing post intubation** – if they are still paralyzed you may be leaving the patients seizures undertreated
  - **Head trauma being intubated for airway protection** – reverse the rocuronium post intubation if neurosurgery team now at bedside and would like to perform their initial and serial exams

- Standard dosing is 4mg/kg for gradual reversal, however for immediate reversal of neuromuscular blockade in a “Can’t Intubate Can’t Ventilate” situation use 16mg/kg.
- 16mg/kg is dose on step 3 of the ED Airway Checklist

**Intranasal (IN) Medications**

- We are all now very comfortable using IN midazolam and fentanyl, however they are quite underutilized for seizures and TET spells.
- Very simple to use IN midazolam for seizure control in difficult IV access, especially in situations where you may not quite be at the point of placing an intraosseous line
- TET Spells – standard therapy for calming patient was morphine, however this is painful and can temporarily make patient even more agitated, worsening their clinical situation.
  - IN fentanyl has been used quite successfully, works quickly and is painless
  - However, any opiate risks respiratory depression, worrisome in an already severely hemodynamically compromised child
- Ketamine can be used intranasally
  - Very wide dosing range, 2-10mg/kg
  - Just need to stop severe agitation so start small with dosing, can always add more if needed
  - Much less risk of respiratory depression than opiates in the critically ill patient
  - Type “IN Ketamine” and the following order is available
Get to know your fellow Faculty!

Naomi Abe

- Made it to very remote places
- Taught a toddler how to read a map
- Almost actually done with a research project