EMERGENCY!
When minutes count . . .
Emergency Department demonstrates excellence in nursing.
Happy New Year! We have had much to celebrate over the holidays! Recently our UC San Diego Medical Center was granted Magnet Recognition by the American Nurses Credentialing Center. Our Magnet status is an organization wide honor representing contributions from all staff and faculty at our hospitals. What a great way to kick off the New Year!

The Joint Commission (TJC) approved UC San Diego Health System’s Disease-Specific Care Certification for Ventricular Assist Device (VAD). TJC also recertified our Chronic Kidney Disease (CKD) Program and awarded it the Gold Seal of Approval for health care quality. The Health System was included for the first time in The Leapfrog Group’s annual class of top hospitals, which is a prestigious award that recognizes our Health System’s commitment to high quality-care.

Speaking of our accomplishments, our Emergency Departments have many of their own. This Journal will highlight not only the stimulating growth we have seen in our ED units but the innovative people that make up this department. In the last year, our Emergency Departments have been able to decrease our patient wait times from 164 minutes to 114 minutes and improve our patient satisfaction scores for likelihood to recommend by over 22% with nursing overall scores increasing 18.5% this last year. Using the continuous quality improvement (CQI) process, our health system has reduced average door-to-balloon times from 120 minutes to less than 60 minutes, and administrators are now aiming for further progress with STEMI’s.

The Emergency department has grown by leaps and bounds over the last 30 years including our most recent expansion of the La Jolla ED with the Sulpizio Cardiovascular Center. Our Hillcrest and Urgent care are now comprised of 24 beds and see over 38,000 patients yearly and our La Jolla sites recently expanded from 11 beds to 25 beds and provides care for over 24,000 patients a year.

Our emergency departments are patient centered and innovative. In these articles you will learn more about the ongoing research conducted in the ED, what a base station nurse is, STEMI and Stroke improvements, our community health boards, handling Psych patients in the ED, how we deal with disasters, the role of an ED nurse and the ever expanding expertise of our nursing staff.

To be a nurse in the Emergency Department you need compassion, empathy, strength, the capability to work autonomously, combined with the ability to think and act quickly in any situation. You need to be able to care for all types of patients, ranging in age from pediatric to geriatric, and from all walks of life, by offering kind words with gentle and comforting touches. I commend the ED nurse for having these characteristics and embodying our core values.

Thank you for your dedication and for being “shining stars” who consistently reach new goals. I look forward to working with you to make 2012 another stellar year.

Sincerely,

Margarita Baggett RN MSN
Chief Nursing Officer
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On the front cover: In the MICN radio room sit Jim Blair, RN, Juliet Sapida, RN and 2 EMS staff from San Diego.
It has been my distinct privilege to serve the patients and staff at the UC San Diego Health System for more than twenty-five years. Currently, I am the Nursing Director for Critical Care and the Emergency Department at Hillcrest and the Sulpizio Cardiovascular Center (SCVC) Emergency Department at our La Jolla campus. During this time I have come to understand the pivotal role our hospitals, and especially the emergency departments, play in our diverse community.

As an academic medical center, we set the standard for quality care, serving the community with two fully staffed emergency departments. Our Hillcrest location is the only comprehensive emergency department in San Diego County. It recently underwent a renovation resulting in an improved twenty bed unit with a four bed Urgent Care where approximately 38,000 patients are treated each year. Our La Jolla site is a state of the art facility that was recently relocated into the SCVC, where it underwent an expansion from eleven to twenty-five beds. It is primarily staffed by faculty emergency medicine physicians and nurses, treating in excess of 24,000 patients a year.

Our emergency departments are patient centered and innovative. Stroke Center certification was recently earned by the Neurology Department in collaboration with emergency departments. We are a Flolan and an LVAD receiving center at the La Jolla facility. In addition, we incorporated a “STEMI” (ST elevation MI) protocol that allows medics in the field to initiate a cardiology consultation prior to the patient arriving in the emergency department. This, in turn, triggers the rapid activation of the Cardiac Catheterization Team.

I have witnessed the tremendous growth of our emergency departments and the ever expanding expertise of our nurses which places them among the best in the area and industry as a whole. Our nurses do not have the luxury of controlling or choosing our patient population. We receive patients via many different means, from walk-ins to paramedic delivery, as well as responding to codes in the La Jolla facility. Our emergency nurses are skilled at treating patients prior to a diagnosis being made by a physician. They are experts at assessing and treating patients of all ages and have the acute ability to recognize symptoms as simple as a sore throat and as complex as a heart attack. They rapidly triage patients through the department based on the severity of their symptoms while keeping family members informed during a crisis. Our nurses also provide community education through a variety of programs that promote wellness and injury prevention.

Experience is critical in the emergency department. New grads are required to complete a rigorous six month training program under the direction of an experienced nurse before they are allowed to treat patients on their own. Fortunately, we have an abundance of highly qualified and experienced nurses. Recently our hospitals achieved Magnet status, demonstrating nursing excellence.

When minutes count our nurses are ready for any situation, fully prepared to respond and are never caught unaware. I am truly blessed to lead such a dedicated group of professional nurses who are singularly focused on delivering the highest quality care to our patients and families.

Sincerely,

Beverly Kress, BSN, RN
Nursing Director, Emergency Department/Critical Care
My career at UCSD started over 31 years ago in the Emergency Department. During that time I have witnessed tremendous growth, not only in the number of patients that we treat, but in staffing, in beds and in physical space. Thirty one years ago there were 17 beds in the emergency department at the Hillcrest campus and we saw an average of 35,000 patients per year. By 2012 we will have a total of 61 beds between 2 facilities and are now averaging over 60,000 patients per year.

It all started back in 1988 when we were asked as a department to open up and staff an Urgent Care Center at the UC, San Diego campus in La Jolla. The purpose of this Urgent Care Center was to establish a patient population base in the North for a brand new hospital, Thornton Hospital. During this time the Emergency Department at the Hillcrest campus was also undergoing renovations – it actually underwent several renovations – adding 3 beds in the Emergency Department and opening a 4 bed Urgent Care.

Thornton Hospital opened in 1993 on the UC San Diego La Jolla campus with an 11 bed Emergency Department. We soon outgrew the area and when clinic space opened up down the hall from the Emergency Department we quickly seized the opportunity to open a 4 bed Urgent Care there as well. However, we came to realize that was not enough space either. We were overflowing into the halls of both Emergency Departments! We needed more room.

Fast forward to 2011: A brand new 25 bed state-of-the-art Emergency Department recently opened in the Sulpizio Cardiovascular Center on the La Jolla campus and by the end of the same year the Emergency Department in Hillcrest would increase in size by approximately 50%, adding an additional 12 beds.

It has been both exciting and challenging to be a part of this growth process, however, I am confident that we are not done yet. With the ongoing expansion on the UC San Diego campus in La Jolla and the seismic requirements that need to be met at the Hillcrest facility there will be more opportunities for growth. We welcome you to be part of our ongoing journey.
Life as a New Graduate in the Emergency Department

By Jill Gillespie, RN

My name is Jill Gillespie and my life-long dream was to become a nurse. Even though there are many nurses, I feel that those who are capable of providing the latest and most advanced medical treatments in addition to the very best care, attention, patience, and love, are in need. The training provided by UCSD has prepared me to be fully qualified as I step into this role.

I’m a home-grown, Southern California girl. This is where I grew up and this is where my family and friends call home. Specifically, I spent a big chunk of my childhood in Point Loma with my Great Grandparents, Grandma and Papa, who all have since passed away.

In 1995, when I was ten years old, my grandmother, who was the most gentle and caring woman in the world, was diagnosed with lung cancer. I spent a lot of time with her, taking care of her as much as a ten year old could. It was my job to keep her company, comfortable, and well-loved. I also stayed with Papa while Grandma was in the hospital and took care of him, as he was very dependent on Grandma to make his meals, clean the house, etc. When Grandma came home from the hospital she only lasted about a month and passed away in January of 1998. It was the most devastating day of my life; I was truly heartbroken. After Grandma’s death, Papa, who had been living with emphysema for many years, did not last much longer as he became very forgetful and his breathing became more labored. He ended up passing away in August 1999 and finally Grandma and Papa were able to be together again.

A year later, during my sophomore year of high school, I decided I wanted to be a nurse. I treasured the days I had spent taking care of my great grandparents and I wanted to make it my life-long career to help other people in their time of sickness. So I started by volunteering at a convalescent home for the elderly. I worked in the activities department assisting with activities for the residents. I joined them in playing their favorite games such as bingo. I would read to them and watch some of their favorite classic movies with them. I truly enjoyed becoming part of their family as many did not have family or friends come to see them. I was glad to be able to put a smile on their face whenever I could.

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In 2003, I graduated from high school and began working toward my goals by enrolling at Palomar College and taking prerequisites to get into a nursing program. Due to family need and my great desire to comfort and care for the elderly, I moved to Point Loma, to live and take care of my 89 year-old great-great Uncle.

In the summer of 2005, I went to school and earned my EMT license. During those eight weeks of schooling, I was trained in taking blood pressures, listening to heartbeats, performing patient assessments, and basic triage of emergency situations. It was also my first opportunity to do ride along with the EMTs and paramedics at Fire Station 20 in Point Loma.

Jill Gillespie, RN, BSN is a new graduate nurse that successfully passed her Emergency Department specific orientation and is working on completing her first year as a RN at UC San Diego.
The most exciting call that I experienced that summer was for a self-inflicted GSW (Gun Shot Wound). We arrived just minutes after the call and paramedics were already down on the dock giving this woman CPR. After a few sessions, the fire fighter that was administering the CPR called out, “Gillespie we need you to do CPR now!” Although I was startled by the situation, I did not hesitate and immediately began compressions, counting one and two and three and four, until we received word to pronounce her time of death. That day was a deciding factor, I knew that once I became a registered nurse I wanted to work in the Emergency Department.

I graduated from the Grossmont College Nursing program in December of 2010. I was faced with a new challenge of finding a new grad position along with all of my fellow classmates. I applied to every hospital in San Diego, open to any position available, although I knew I wanted to work in the Emergency Department. When the phone rang for an interview with UCSD’s ED I was completely stunned, nervous and excited. I had heard from colleagues on how hard it was to get a job at UCSD, especially if you didn’t have a bachelor’s degree. I spent several hours preparing my resume and nursing portfolio. I went to the interview with a calm, positive attitude and every desire to get this position. A couple weeks went by, which felt like eternity, when I received a call offering me a position. I had gotten the job!

I was going to be a nurse at UCSD in the ER. I cannot even begin to describe the feeling I had as I knew how lucky and fortunate I was to have been offered this position. I made a commitment to myself that I was going to learn as much as I could and be the best nurse possible to my patients and colleague to my co-workers. I even delayed planning my wedding so I could completely dedicate myself to my new job.

On my first day of training, I was nervous and a little scared; I was entering a new world. Everyone always told me once you get that RN behind your name you are expected to know everything. I clearly knew very little as a new grad and am still learning new things every day. At the time, the scariest thing being new was not knowing anyone, meeting new people, trying to fit in, and making friends.

All of my preceptors were phenomenal during my 6-month training program. I had three preceptors on days, Mike, Tricia, and Eva, and one preceptor on nights, Bobbie. They were all patient, kind, and challenged my critical thinking skills in a non-threatening way.

The nurse preceptors are extremely important people, they guide new grads as they transition from student to nurse. Nurse preceptors at UCSD use standards of professional practice and patient care experience as a framework for clinical teaching. They are capable of drawing on their own experience of patient care to anticipate and understand patient conditions. In turn, they use this information to teach fellow nurses. The preceptor’s relationship with their preceptee is key to the successful functioning and socialization of the nurse on the unit. The support I have received by my preceptors, colleagues, and nurse managers has been extraordinary in helping me to meet the organization’s expectations and prepare me to function independently. I am so honored to be an RN at UCSD.
It seems like forever ago but the reality is that less than a year ago I was able to join a team of physicians, nurses, interpreters, and church volunteers on a medical mission to El Salvador. At the time, I had no idea just how profound the experience would be for me. This experience was so positive that I am certain that I will plan to go on many more medical missions in the future.

I am thankful for the daily journaling I had done on the trip. It reminds me of the reason why this trip was so powerful and had such an impact. Life is busy and remembering every detail is nearly impossible. I knew I wanted to remember everything about this trip and journaling has helped me to do so.

I have had a dream to go on a medical mission trip and provide care for those less fortunate from the time I first decided to become a nurse. The opportunity to give back and pay it forward to others through my nursing career is indeed an honor. I had only been working for UCSD’s emergency department for approximately 4 months when I received the invitation to go to El Salvador. There was so much to do to prepare for the trip that I knew the sooner I got started the better. I quickly received notification that my time off was approved. I was so grateful for my manager’s support and excitement for me. Passports, immunizations, costs, supplies, the list seemed endless as I prepared for this trip. Fortunately, everything fell into place, and before I knew it, it was time to go.

Our team was comprised of 19 people ready to work hard and to serve. We had the opportunity to set up clinics on multiple days in different locations in El Salvador. We set up clinics in La Angostura, Apopa, and San Martin. The team briefed before each clinic day. This included checking supplies and medications, and assigning duties. We all worked harmoniously together.

The people were waiting and ready to be seen before we even arrived. Some had walked for 1-2 days to come to the clinics. In the early part of the day, our patients consisted mostly of women and children, as the men were working. The average income is $8.00 a day and the men could not afford to miss a day of work. The children played nicely together while waiting patiently for their turn to be seen by the doctor. Most had never used a thermometer, so
sick child walk away with peace as she received the medications needed to help her son or daughter get well. It was the child initially terrified to have her wound treated for fear of pain, only to discover that it wasn't bad. Afterwards, she had a thoroughly cleaned wound with ample supplies and antibiotics and a big smile on her face when everything was done. The gentle touches, the kind words, the comforting hugs, the listening ear, the hard work in very hot conditions over long hours, and ultimately the giving hearts by all the team members was a beautiful picture of humanity working side by side with our gifts and talents to care for another. We were in a foreign country where many of us didn't speak the language. Although we had plenty of volunteers to interpret, it was the nature of human kindness that filled the gaps and caused everything to come together so smoothly for the patients and for us. I am so grateful for this experience, changed by the power of giving! This was all a possibility for me because of those who supported me and allowed me to see a dream come true and for that I will forever be thankful.

asking them to place the thermometer in their mouth was a strange experience for them. Likewise, placing a blood pressure cuff on their arm was just as odd for them as some had never had their vital signs assessed before this clinic. Even though it was strange, they never complained or refused. We saw many patients with chronic illnesses that had not been managed due to their limited resources. We handed out prescriptions to over 600 people. We also had an opportunity to visit the only children's hospital in Central America and were humbled by that experience. At the end of our trip we donated all of the left over medications to an El Salvadorian physician who worked with us and we donated all of our supplies to the children's hospital.

So what was it that made this mission trip so powerful or such an impact on me? It was witnessing the humble spirits of the people we served. None of them had a spirit of entitlement, only honest appreciation and gratitude for receiving care. It was the simple things, like watching the face of an elderly woman light up when we placed a pair of reading glasses on her face and she could read her bible for the first time in years. It was seeing the mother who was anxious and concerned over her asking them to place the thermometer in their mouth was a strange experience for them. Likewise, placing a blood pressure cuff on their arm was just as odd for them as some had never had their vital signs assessed before this clinic. Even though it was strange, they never complained or refused. We saw many patients with chronic illnesses that had not been managed due to their limited resources. We handed out prescriptions to over 600 people. We also had an opportunity to visit the only children's hospital in Central America and were humbled by that experience. At the end of our trip we donated all of the left over medications to an El Salvadorian physician who worked with us and we donated all of our supplies to the children's hospital.

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Patients in the emergency department waiting room often have to sit for a while before being admitted to their beds. They are not the only ones who wait, their families or friends often sit with them as well. Brian Lokar, RN, MSN saw this wait time as a great opportunity to provide health education to this somewhat captive audience. He noticed an unused bulletin board enclosed in glass. He also noticed some magazine racks in the room which could be used to hold health promotion materials. Joyce Dixon, RN, MSN, AN II, agreed to the idea, added more racks, and gave us the key to open the display boards for this project.

I agreed with Brian’s ideas and, therefore, we collaborated to provide regular themes for the board and placed handouts in the racks. The first board was launched in April 2009. This was to coincide with National Public Health Week and a report of this effort was published in the American Public Health Association's, National Public Health Week newsletter of June/July 2009.

There were numerous resources and we utilized whatever we could. The current evidenced based literature provided plenty of information, statistics, graphics, and printable brochures. The Center for Disease Control and Prevention's Health People 2020, was used as our primary guide for topics. The American Cancer Society and the World Health Organization’s materials were used. Local agencies, such as the San Diego County Health and Human Services, were contacted to solicit ideas and materials.

The Patient Education Coordinator at UCSD met with us and provided tips on how to create an effective and interesting board. San Diego State Graduate School of Public Health's Health Promotion Division resources on marketing for health were incorporated. This included the ‘think, feel, do’ concept of getting people to notice a message, think about it, get a feeling about it, then, hopefully do something that will be beneficial to their health, such as eating better or getting a mammogram. These concepts suggest that while some people will read, others may not be so inclined, but will respond to something interesting. Then they will be moved or motivated by the message and change their health behavior.

Not all people are medically or health literate and this was taken into consideration by keeping the messages brief, easy to read, visually interesting, and also bilingual. The hospital wanted to provide a nice waiting room experience and increase patient satisfaction so we were provided with pictures that were useful and instructive. The Magnet concept of nurses as teachers and nurses as problem solvers contributed to a wide range of health messages in the waiting room.

The boards were a success and interest soon followed, Caroline Chi our ED tech brought in more materials and designed health themes for a second bulletin board. Then, another ED tech, Lea Moellman, helped to design a poster that was dedicated to the 10th anniversary of 9-11 called, “Never Forget”.

Ruth Beauchamp, RN, BSN, MPH, CEN, CCRN, MICN is currently Clinical Nurse II at UCSD Emergency Department. With 25 years of experience in Critical Care and Emergency Nursing, Ruth is active in the Health Promotion for the Emergency Department Waiting Room working group.

Brian Lokar, RN, MSN, NP has been a registered nurse for the past 6 years and has worked at UCSD in the Emergency Department for the past 5 years.
Our displays are visually attractive, informative, and fun! We welcome you to stop by the ED waiting room from time to time to see the latest poster and welcome any ideas or materials you may have.
My Passion for Caring

By Bobbie Brothers, RN, BSN

In the early 1990’s, I was a wide-eyed nursing student at San Diego State University. My first semester of clinical rotations had been at a local hospital where I had been assigned to a medical floor that was primarily oncology patients. After several months of caring for my patients, who had such grace and courage battling diseases that were ravaging their bodies, I reflected back to what I had learned. Clinical practice and scholastics had come very easy to me. Maybe it was my strong will and years in 4-H caring for and “doctoring” my animals, but I knew nursing was much more than clinical expertise. It was at that point that I came to an epiphany that changed and formed my nursing philosophy and shaped me into the nurse I am today. I realized that perhaps I may not make a positive difference in their day or at that moment in time but I would try. So, from that time on, kindness and compassionate care combined with clinical excellence would be my mission.

Unbeknownst to me, the next semester would also be life changing as well as the start of my nursing career. I was assigned to my next clinical rotation at UCSD Medical Center Hillcrest. It was a great fit: busy, fast paced, with really sick patients. A majority of the patients were uninsured, underserved, and underprivileged. Many did not have a lot of compassion in their lives. Now with a year of training and clinical practice, I was able to grow and actually develop some clinical confidence. Toward the end of the semester several nurses on the unit encouraged me to apply for a job at UCSD and work as a nursing assistant or even do a nurse externship. With their encouragement I applied and a short time later I was called for an interview by a nurse manager named Nancy Johnson. By the end of the interview Nancy had offered me a job. I knew she was going to be the perfect boss for me because she made it very clear throughout the interview that customer service was also a huge priority for her as well. In fact, her parting words as I left the interview were, “Bobbie I expect that you will treat every patient as if they were my family.” I have never forgotten her words and that interview was the beginning of my nearly 20 year career at UCSD.

My extraordinary journey at UCSD has lead me to the emergency department where I have had the honor of working there for the last ten years. I have truly found my calling and my home. One of my fondest and most rewarding roles in the ED is serving as a preceptor to new graduate nurses. It is an opportunity to help form and shape our nursing practice. Not only does it involve helping them implement what they have learned into the real world but it is also an opportunity to be a role model of kindness and compassion; sometimes the greatest medicine is a soft voice and gentle touch.

In the emergency department I am able to combine my clinical expertise with compassion and kindness when patients are frightened and feel their most vulnerable. In the ED, I am well known for my mantra and routine with these patients. Whenever someone sick and frightened arrives in the ER, I lay my hand on their shoulder and say, “Look at my face, you are in a safe place, and we are going to take really good care of you.”

My greatest rewards come from my patients and their families. One of those touching moments came from the mother of a critically ill nineteen year old man I helped care for. Ultimately, the young man had a cardiac arrest and passed away on life support in our ICU. I was at the bedside as he suddenly declined and I could see the fear in his eyes. Although I knew the outlook was grim, I held his hand, looked at him, and said, “You’re in a safe place and we are going to take really good care of you.” He arrested seconds later and never regained consciousness. Two weeks later I received a card from his mother. In her note she said that she had comfort and peace knowing that the last face her son saw and the last voice he heard was mine. It is these experiences that keep me believing that nursing is just not about medicine, it is about people. I feel blessed to have a career that truly makes a difference in people’s lives. I still loving being a nurse after all these years!
EMA (Federal Emergency Management Agency) defines disaster as “an occurrence of a severity and magnitude that normally results in deaths, injuries, and property damage that cannot be managed thought the routine procedures and resources of the government. It usually develops suddenly and unexpectedly and requires an immediate, coordinated, and effective response by multiple government and private sector agencies to meet human needs and speed recovery.” An example would be the 2003 and 2007 fires in San Diego County.

I have been on the California DMAT 4 (Disaster Medical Assistance Team 4), San Diego, CA for 20 years with our first deployment being the 1994 Northridge Earthquake in Los Angeles County. When activated we responded to fires, earthquakes, floods, and are on call for a month at a time rotating with other DMAT’s nationwide. There are approximately 100 members on our team and we deploy with a platoon size of about 30. This includes nurses, physicians, EMT’s, paramedics, respiratory therapist, logistics, security, pharmacists, communications, and administration. We work 8 to 14 hour shifts and could work 12 days straight augmenting hospital staffing or being in our large portable tents doing triage and treatment of patients. Out meals vary from MRE’s (meals ready to eat) to hospital cafeteria food. Sleeping arrangements are from sleeping bags on the floor, cots in tents, or real beds. We have gone days at a time without showers (pretend your camping). The hospitals we have been to have been very gracious and accommodating. Dr Jake Jacoby, an UCSD Medical Center ED Physician, has been our team commander from the beginning. While deployed, a recorded phone message updates our mission’s progress and also for family members in the case the individuals aren’t able to contact them directly.
We are volunteers on the team and attend meetings and drills until activated then we become temporary federal employees under US Public Health. On location most of the injuries we treat are lacerations, sprains/strains and fractures. The medical needs are of people out of their medications, alcohol and drug withdrawal, or individual medical problems.

The DMATs are similar in many ways to fire departments, being streamlined, self-contained, paramilitary in organization and ready to travel to areas that have experienced great devastation, trauma, and loss of life.

UCSD’s emergency department disaster team consists of MD’s, RNs, LVNs, and ED Techs. We have team meetings and drills for various scenarios such as chemical, radiological, and biological exposures requiring decontamination using protective suits. The hospital disaster team trains for exposures, earthquakes, and mass casualties. The team consists of staff from departments such as laboratory, facilities engineering, pharmacy, communications, logistics, nursing, and physicians like a DMAT. The department has portable carts with supplies to take outdoors and triage (classify patients according to priority) and for the treatment of patients with lower acuity who do not need a bed immediately. We have been told by fire and police departments that the hospitals may be on their own for an unknown length of time in a disaster because the fire and police personnel may be too busy with other incidents to assist.

Some disaster plans call for a delay in evacuation of victims from the scene. This is so they can be triaged for orderly and rational field stabilization and transport. These plans do not always take into consideration the perception and motivations of the victims or the public which may be different from those of the planners.

Often the public’s perception of good emergency medical care is transportation to the hospital as quickly as possible. If medical care and transportation are not furnished promptly by official emergency organization victims do not usually sit idly by and await its arrival. Instead, they get themselves to the hospital by the most expedient means available. This contributes to two problems seen frequently in disaster situations: 1) Casualties with relatively minor injuries arrive (often unannounced) before those with serious conditions. The results are that when the more serious victims arrive the hospital emergency department is already inundated and its beds occupied. 2) Casualties arrive at the hospital without having been triaged or having received stabilizing first aid.

Often, they will go the nearest hospital, the one with which they are most familiar or the one in which they have the greatest trust.

In the past 20 some years 1/3 of the hospitals in San Diego County have closed. For those who have lived in the San Diego area for a while you may recall the hospitals named Scripps East, Villa View, Hillside, Sharp Cabrillo, College Park, Clairemont, Mission Bay and Harbor View for examples. The county population is increasing and that puts a demand on the remaining emergency department to provide service to the community. In the 2007 fire two hospitals, Fallbrook and Pomerado needed to be evacuated due to nearby fires.

I was also a volunteer firefighter for 15 years and on the ground in the 2003 fires so I have seen the effects from both field and hospital sides. As a nurse for the past 37 years, with 24 years being an RN at UCSD Hillcrest Emergency Department, I’ve seen numerous changes in training, treatment, equipment and dispositions.
A Profile of an Emergency Department Nurse

By Phil Moomjean, RN

At the age of 20 I was more prepared for death than I was for life. I went straight from my first year of college into the US Army, from US history class to the manual of small unit tactics, from the campus to Vietnam. I was taught the art of war and had acquired some expertise for combat. I was assigned to the 192nd Assault Helicopter Company, 10th Combat Aviation Brigade. I spent one year in the jungles of Viet Nam and the mountains of Laos. Late in my tour when we would participate in extrications and haul wounded out of combat after missions, and when we were out of small arms range, I was able to help care for the wounded. It was then that I realized I received more satisfaction from these rescue missions than from combat assaults. I realized that the helicopter played an important role in civilian life for good rather than for destruction. Now I was preparing for life instead of death.

Once out of the army I began searching for an opportunity to work for a rescue service. I really didn’t have much of a plan except possibly working as an EMT. Initially I thought it might happen with the fire department in San Diego but when that opportunity never materialized I applied to a nursing program. I was accepted, graduated from nursing school and took my first nursing job at UCSD Medical Center. After accepting a position in the emergency department I was able to be on the ground floor of the development of the San Diego Life Flight helicopter air medical program. I was one of the first five flight nurses in San Diego. We were the 11th air medical flight program in the US (there are now over 350 programs). I enjoyed a wonderful experience as a flight nurse trained to practice from an expanded scope (we did our own intubations, surgical cricothyroidotomy’s, central lines, chest tubes, etc.).

After 15 years of flying with Life Flight San Diego at UCSD I was selected to participate with the San Diego Board of Supervisors task force designing a follow up program to Life Flight since UCSD was not going to renew the hospital contract to continue the flight program. Hospitals across the country were divesting themselves of costly flight programs that were being outsourced to the private sector. I was recruited to help start the Critical Air San Diego helicopter program since Critical Air had been working in San Diego and internationally as a fixed wing flight program. I helped the expansion of the Critical Air helicopter flight program to 5 helicopter bases in Arizona and 15 helicopter bases in Texas.

At the conclusion of my air medical career I returned to UCSD back to the emergency department (full circle!). I became the assistant manager of the Thornton Emergency Department and now recently have become the new manager of the Sulpizio Cardiovascular Center Emergency department. The past 6 months has been the most challenging of my 34 year career. While I sat on the Steering Committee with all participating hospital departments, my staff has managed to successfully transition from a small 11 bed Thornton ED to a larger brand new 25 bed, state-of-the-art SCVC ED. We have highly productive teams of ‘super users’ that all participated in various components of designing the ED, which include supplies, equipment/carts, patient flow, triage rooms, patient care rooms, and processes for training and education. All of this was accomplished in a very busy work environment with the normal economic and regulatory issues. I have been proud to help lead autonomous, self-directed teams to meet the challenges of caring for our ED patients and help transition the staff to a better understanding of our magnet model.

Phil Moomjean, RN, BSN has over 30 years of flight/trauma/emergency nursing and is currently the Manager of the Sulpizio Cardiovascular Center in La Jolla.
When I transferred to the emergency department from our home care agency with a specialty in psychiatric nursing nine years ago, I was focused on learning emergency nursing. I attempted to sideline my previous specialty as I embarked on my new career path. While I played down my expertise in psychiatric nursing, my colleagues seemed intrigued by my unique knowledge base, and they soon began to utilize me as a resource for patient psychiatric concerns.

In the emergency department (ED) psychiatric patient visits have consistently increased and this has introduced challenges in the treatment of safe patient behavior. According to the Emergency Nurse’s Association (ENA) other factors contributing to changes in patient behavior may be fear of the unknown, pain, family member stress, long wait times, and anger at the healthcare system in general. The ED staff brought up the issue of the potential for increased workplace violence to the forefront during our ED Day Away training last year. They identified a need for increased staff presence and the recognition of challenging patient behaviors for optimal patient outcomes and the safety of all involved.

Literature shows an increase in patient agitation and violence within emergency departments (ED) results in patient and staff injuries. The ENA recognizes systems problems, rather than singular perpetrator issues, as widely responsible. While there is a need for increase in staff education on the prevention and early diffusion of increasing patient agitation, there is minimal evidence supporting specific proven processes that help diffuse violence and prevent injuries. Nurses and physicians utilizing a variety of de-escalating processes and techniques with agitated patients may decrease the risk for injury.

To confront this issue an ED committee composed of nurses, physicians, and trauma technicians was formed and round table discussions were held. While the hospital has a disruptive patient code, named Code Grey, we felt there was a need for a rapid response team within the ED to mobilize staff quickly to the bedside when disruptive patient behavior is first identified in order to help diffuse it before it becomes problematic. We agreed a drug kit was needed to bring to the bedside to offer patients de-escalation medications when ordered by the physician at the bedside. The medication classifications agreed upon by ED and psychiatric nurses and physicians included first generation antipsychotic medications, newer atypical antipsychotic medications, benzodiazepines, and nicotine lozenges. We decided to call our internal code grey, Code Armstrong. We also decided there was a significant need to educate all ED staff on proactive de-escalation and evasive techniques through the activation of Code Armstrong to promote positive patient outcomes and safety.
We adopted the Richmond Assessment and Sedation Scale from our inpatient psychiatric unit as a performance improvement project tool to monitor the effectiveness of our interventions.

After identifying the need for de-escalation training, we realized we needed a tool to assess patient behavior before and after interventions were provided. We adopted the Richmond Assessment and Sedation Scale from our inpatient psychiatric unit as a performance improvement project tool to monitor the effectiveness of our interventions.

At a significant cost to the department, the ED staff training sessions were fully supported by our nursing manager, Susan Watson, to promote safety and positive patient outcomes. In July of this year we held multiple eight hour mandatory training sessions for all ED staff. The training sessions included causative factors and potential treatment options for agitated patient behavior, de-escalation techniques early in the agitation cycle, evasive techniques, activating a Code Armstrong, and assessing patient behavior before and after patient interventions were provided. The training was taught by a combination of ED staff, physicians, and security personnel.

While it is too early to secure data on the effectiveness of our interventions in the prevention of workplace violence, the staff has verbalized an increased sense of cohesiveness and empowerment to promote safety in a supportive climate. Our use of behavioral restraints has also steadily declined since we implemented the training. The staff is clearly using the de-escalation techniques they learned and least restrictive measures with patients to keep restraint use as a measure of last resort. In addition, staff injuries have decreased since the training sessions.

To continue monitoring the effectiveness of our intentions we perform chart audits on 100% of the RASS assessments completed. The Code Armstrong Committee continues meeting regularly and the number of frontline staff volunteering for this committee has increased in our shared governance format following the training. Several ED staff and administrative RNs will also be attending additional education specific to the effective management of psychiatric patients in the emergency department this coming December, thereby increasing a proactive knowledge base to promote positive patient outcomes.

### Richmond Agitation and Sedation Scale (RASS)

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
<td>Violent, immediate danger to staff</td>
</tr>
<tr>
<td>+3</td>
<td>Very Agitated</td>
<td>Pulls or removes tube(s) or catheter(s), aggressive</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent non-purposeful movement, fights ventilator</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
<td>Anxious, apprehensive but movements not aggressive or vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
<td></td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
<td>Not fully alert, but has sustained awakening to voice (eye-opening and contact ≥ 10 sec)</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation</td>
<td>Briefly awakens to voice (eye-opening and contact &lt; 10 sec)</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation</td>
<td>Movement or eye-opening to voice (but no eye contact)</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation</td>
<td>No response to voice, but movement or eye-opening to physical stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unarousable</td>
<td>No response to voice or physical stimulation</td>
</tr>
</tbody>
</table>

Source: Pain Management Nursing © 2009 W.B. Sanders
When we think of academic institutions we think research, and as in any academic center research is the left hand while teaching and learning is the right. Researchers are always asking:


The Emergency Department at UCSD is no different. There are several challenges that face the Clinical Research Nurse in the ED, limited enrollment time (only Monday through Friday’s, preferably during business hours), the data gathering process (filling out numerous forms), and being able to multi-task to name a few.

The Clinical Research arm for the Emergency Department is supported through the Department of Emergency Medicine under the direction of Gary M. Vilke, MD. Numerous research projects are running concurrently in collaboration with the medical center faculty. We conduct research with faculty and sponsors, and assist medical in recruiting patients. There are seven IRB-approved research projects actively enrolling patients at this time.

Jean Marshall, RN, MSN has over 30 years of nursing experience, with the past 4 years focusing on the area of research at UC San Diego Medical Center.
**ACEDATODE-EF STUDY**
This is testing an "EDTA-free" form of IV acetadote to treat hepatotoxicity related to acetaminophen poisoning.

**ACE-REACT STUDY**
This is a double blind study using the drug "ecallantide" (or placebo) in the treatment of angioedema of the head and neck related to the use of angiotensin converting enzyme (ACE) inhibitors. A very small population, but important to identify and enroll.

**AKINESIS STUDY**
Acute heart failure also impacts renal functioning. This study is to identify and follow patients treated with diuretics in the ED and following a specific biomarker to predict worsening renal function. This biomarker will provide information sooner than the current creatinine study, to determine kidney function. The patient is identified in the ED and, when consented, will be followed for 7 days through hospitalization, and phone follow up for one year after.

**CALDOLOR STUDY**
IV ibuprofen is currently on the market. This study is looking at the effects of a shortened infusion time for ibuprofen. Patients presenting with pain and/or fever are potential candidates. The study closely monitors the patient for up to six hours.

**RAPAFLO/SILODOSIN STUDY**
In partnership with the Urology department, we identify patients presenting with unilateral ureteral calculus of 4mm or greater. This is a new drug that would help relax the ureter and assist in the passage of the stone.

**REAL-ICU STUDY**
This study is looking for an earlier marker of impending renal failure, and will follow patients admitted to the ICU. Any ICU admissions, regardless of diagnosis are potential candidates for participation. The patients are followed through their hospitalization for 4 days.

**ANALATRO TRIAL**
This studies the efficacy and safety of antivenin Latrodectus Equine Immune F(ab)2, also known as Black Widow Spider invenomations. Each subject is randomized and closely monitored. The results are remarkable. We have additional studies that are run with Research Associates (RA). This program is available for university credit and has become quite popular among the pre-med students. We train college students in obtaining informed consents, HIPAA, and performing good clinical practice. They approach ED patients and gather information on different topics such as:

- Animal bite history among ED patients
- Cell phone use and preferences among ED patients
- Abdominal pain
- Asthma
- Diving-related presentations
- Syncope
- Urine toxicology screening
- Identification of ethanol withdrawal
- Referrals to Cardiology and Pulmonary medicine

The RA program is managed by the Research Study Specialist, who also screens and enrolls patients. They increase awareness among the faculty and staff regarding these studies continuously throughout the shift.

As the Clinical Research Nurse for both UCSD Hillcrest and UCSD La Jolla, it is vital that I am highly familiar with all of these studies and that they are managed well. Staff nurses are also kept aware of research studies usually via our presence in the ED. We work with the nursing staff closely in identifying patients, conducting our studies, and assisting staff whenever possible to facilitate the flow and workload of the department.

Self-direction and independence is a must for this position. Also high levels of multi-tasking and flexibility are critical. Nevertheless, I enjoy my continued involvement with emergency nursing by interacting with the staff and assisting whenever I can. More so, it is intellectually rewarding and challenging to be involved with new ideas, new techniques, and new therapies through the management of UCSD ED’s research trials.
I have been a practicing emergency nurse for over 28 years, and I have seen the role of the ER nurse evolve into one of great autonomy and pride. I have also witnessed procedures that would “never be done by a nurse,” now done by an ED nurse with competence and professionalism. I would like to share my story.

I became a RN at the tender age of 19. Coming from a very rural area of Wisconsin, I dreamed of the big city and all the excitement that I would be exposed to. I only knew of the bigger cities from what I would glean off television; it looked so exciting and stimulating.

Unfortunately, when I graduated with my Associates Degree, nursing jobs were few and far between. I had to place my goal of working in a large metropolitan emergency department on the back burner and accept whatever job I could. Fortunate for me, I found a job in a nursing home in Racine, Wisconsin. I was the night shift supervisor for a 250 bed skilled care facility. It was in this position that I developed organization and prioritization and worked on my clinical assessment skills. While I was disappointed that I could not find a job in an emergency department, at least I had a steady income of $10.00/hour and could practice and keep current on my nursing skills.

I was thirteen months out of nursing school when my golden opportunity arrived. Through working at the nursing home, I developed a good rapport with the paramedics that would provide transportation for the residents residing in the home. One of the medics informed me that there was a hospital in Kenosha, Wisconsin that was hiring new nurses and he had recommended me to the director of the ICU and ED there! My goal was within eyesight; I could be working in a large urban ED and have my dream of becoming a top notch ED RN!

So I began my job in a level 2 acute care hospital. I soon learned that becoming a strong ED nurse would take a lot of effort on my part. It would require the development of a 6th sense; that idea of there might be something wrong but I cannot identify it at that moment. I had to think fast on my feet and learn that sometimes there would be no warning before a tragedy would arrive. I had to develop a very “thick skin” to those patient’s that would attempt to rattle my self-confidence by hurling insults. I learned very quickly that life was a gift and that it could be taken away with the blink of an eye. I also learned that I loved the adrenaline rush I would experience when someone arrived with a blunt force trauma.

That adrenaline rush pointed me in the direction of fixed and rotor wing nursing. How exciting that would be, going to a scene call, transporting the patient to a trauma center and then caring for them upon arrival. How much more excitement could one ask for? It seemed like the best of both worlds and I was more than geared up for the challenge of it all. Little did I know that this thirst for trauma would forever change my outlook on life, and on myself as a nurse.

I was lucky enough to receive a chance to work in Germany as a fixed/rotor trauma nurse. I was assigned to the ED at the 97th General Hospital in Frankfurt, Germany. It was a very old building, used in WW II as a hospital for the Nazi’s. I remember looking on the walls and still seeing swastikas and Aryan paintings. While there were no pictures of Adolf Hitler present, the air still lingered with his presence.

I had only been in Germany for a short while when a call came that an airplane had crashed in Landstuhl and that we were being mobilized to go and assist. My heart was pounding and at that time I knew I would be put to the test. My heightened awareness and keen clinical assessment skills...
were needed more than ever. This was my chance to shine and I was ready.

We arrived in a BK-117 rotor ship, a large helicopter that can transport 2 patients at one time. It was a short 30 minute flight down to Landstuhl and during the flight I worked with my doctor and medic to plan how we would rapidly triage assessments and deliver care. We had grabbed a bunch of random supplies from the storage unit prior to our leaving Frankfurt, not knowing what we needed but planned for what we might.

Upon arrival, the wreckage of the plane was still engulfed in smoke and flame and there were people strewn about. Some were moaning in pain and others were obviously deceased. Immediately, the 3 of us went into MASH mode (Mobile Army Surgical Hospital). We delegated people to set up our triage tent and I went around to the various injured and triaged them. The triage was easy because there were only three categories to choose from: alive, requiring emergent treatment, alive but treatment could be delayed, or dead.

There was a lady that had a nearly severed leg just above the knee. She was in shock and had lost a lot of blood. I acted and found the bleeding artery, then quickly clamped it off. This action is what I believe saved her life. Yes, she did end up having her leg amputated while in the field, however, her blood loss was decreased due to the rapid intervention of a nurse.

There were many casualties that day and there were many lives saved because of a nurse's quick assessment of the situation and intervention. Every nurse that day was required to go back to a survival type of mentality and accept that we could not heal everyone. There were going to be some fatalities no matter what was done or how we did it. "Do your clinical best" was what the physicians were telling us. "Use your gut instinct" was a common statement among the nurses that day. That day is forever etched in my mind.

After almost 6 years in Germany, I decided to return to the US and continue working as a flight/trauma nurse. That was my passion and that is where I found I had the best chance to make an impact on someone's life. So, I returned to Houston, Texas and worked for Hermann's Life Flight Trauma Service. What an exciting time that was.

Houston is what I consider to be one of the knife and gun capitals of the nation. We would transport penetrating and blunt traumas daily. Unstable open book pelvic fractures, gunshot wounds to the head, impaled objects, the list was endless. This level of practice allowed me to become more autonomous in my career. Many times it was just me and a paramedic on the ship. We would land at the scene, jump out, and assess the situation. I would radio the scene back to the hospital and the interventions we had performed. I was in charge of the clinical judgments and delivery of care. If I messed up or inaccurately assessed a patient, their outcome could be altered based on my decisions and care! I thrived on the autonomy and pressure. I had finally achieved what I dreamed of when I was a new nurse; I was a true emergency nurse!

My career continues on today. I look back at the development of the nurse's role in emergency medicine. When I started out, ER nurses could not intubate, place chest tubes, make fly or no fly decisions based on the probable morbidity/mortality. During my career, we were mentored and taught to do these competencies and we became experts at it. Blindly intubating a patient from the back seat was my specialty! It was rare that I could not access a vein in the dark by just using landmarks. I developed a heighten sense of awareness of 'what could go wrong' and use this ability to critically think so that I prevented this 'what could go wrong' from actually occurring.

One of my "McGuiver" moments was when we had intubated a patient involved in a car crash. She was a rather large female and it was a challenge for us to transport because of the weight in the air ambulance. We left a couple of pieces of equipment with the ground transport staff and planned on picking it up upon our arrival to the hospital. We had just reached a decent altitude and had about a 15 minute flight to the trauma center. All of a sudden, I notice that we were losing air volume on the ventilator and she required this volume due to her chest trauma! I checked the circuits, all were patent. I checked her lungs, I could not hear anything suspicious. Then, I looked at the ETT…there was no pilot balloon! While in the process of strapping her onto the gurney the pilot balloon was somehow severed from the endotracheal tube! I had to think fast…..

So, I grabbed a 20 gauge angio catheter, took the plastic cannula off the needle and inserted the cannula into the pilot tubing. I taped the angio securely to the pilot tubing and then screwed a syringe to the cannula. I inserted air into the cuff until I was able to stop the air leak. While this was not a long term solution, it did remedy the issue until we landed and could exchange the endotracheal tube for a patent one.

There are many moments I can recall in my career that impacted the way I look at life in several different aspects. For one, I learned to be non-judgmental of others because I could never tell why a person made the decisions they did. I also learned to treasure each and every day because one cannot tell what tomorrow may bring. I learned to accept fate for what it is; sometimes there is nothing a person can do to alter the outcome. However, the biggest and most important thing I learned is to make sure I teach new nurses how to become strong and competent. There will be a day where I will be asking one of them to take care of my needs and I want to make sure they take care of me properly!
Emergency Department Expansion

By Joyce Dixon, RN

The planning was initiated in 2008 and after three years of demolition and construction, the Hillcrest Emergency Department and Urgent Care expansion was complete in December 2011. The California Department of Public Health approved and licensed our new beds on December 14, 2011. This expansion was essential (and welcomed!) and brings our ED capacity from 24 to 36 beds.

The new area encompasses 6,900 gsf (gross square feet) at a cost of 9.8 million dollars!

We are far from finished! A third phase to the expansion is in progress and includes a space for an ED 320 slice CT scanner. Its projected opening date is May 2012. This brings the entire project to 8,400 gsf and at a cost of 14 million dollars.

The new area is beautifully designed with soft pleasing colors and restful overhead lights. Most of the rooms are single providing privacy for patients and families with glass enclosed doors. Each bed has its own TV, patient controlled remote, bedside telephone, and individual room controlled temperature dials. More importantly, nurses can spend more time at the bedside as each room is equipped with bedside computers.

The new area also fosters cohesion between nurses and physicians as they share a collective space, improving RN/MD communication and collaboration.

A special note of appreciation goes out to our ED patients who endured the construction noise but acknowledged it was for a good cause. Also, to the wonderful ED staff for being flexible and patient with all the disruptions and changes encountered almost daily during the three phases of the construction project.

A personal note of thanks goes to our Senior Planner, Janice Davis, for being the point person. She acknowledged our concerns several times and arranged, re-arranged, and yet re-arranged again the construction schedules to fit the needs of the Emergency Department. She was an invaluable resource.

Please come visit our new ED! We would love to show you how beautiful it is.

Joyce Dixon, RN, MSN has over 30 years of nursing experience, with the vast majority being at UC San Diego.
Academic Achievement:
Sara Couch: Graduated 5/2011 from SDSU with MSN. Became board certified in Nurse Practitioner/Adult Family Medicine 8/2011. Wants to work in clinic or hospital setting as NP
Ruth Beauchamp: Has MPH degree
Kathy Harper: Has CNS/MSN from USD
Tia Jensen: Has CNE/MSN from University of Nebraska: Omaha.
Chin-Yee Chang: Will graduate May 2012 with MSN. Wants to obtain NP certification in fall 2012
Melody Dotson: MSN from University of Phoenix
Leo Domingo: MSN from USD anticipated May 2013

Certifications in Professional Service Nursing Areas:
- Aaron Williams—CEN
- Angie Crus—CEN
- Annette Champlin—CEN
- Brian Lokar—CEN
- Cathy Meathe-Lokar—CEN
- Chantelle Hicks—CEN
- Corri Owenby—CEN
- Damne Myers—CEN
- Efren Fuerte—CEN
- Hsin-Yee Chang—CEN
- Ivan Chavez—CEN
- James Blair—CEN
- Jasjeet Dhillion—CEN
- Jeanne Swilum—CEN
- Juliet Sapida—CEN/CCRN
- Justin Hepler—CEN/CCRN
- Kathy Harper—CEN
- Karen Bishop—CEN
- Laura Earp—CEN
- Laurel Ramussen—CEN
- Linda Broyles—CEN
- Maggie Jacobson—CEN
- Maggie Morgan—CEN
- Mark Datuin—CEN
- Martha Pamp—CEN
- Mary Enriquez—CEN
- Mary Sorenson—CEN
- Michael Hughes-Davies—CEN
- Michael Jackson—CEN
- Renae Nichols—CEN
- Ruth Beauchamp—CEN
- Sara Couch—CEN
- Semone Sexton—CEN
- Tia Valentine—CEN/CCRN
- Traci Baustian—CEN
- Laura Boerner—CEN
- Melissa Cayon—CEN
- Wilmar Flores—CEN
- Phillip Moomje—CEN
- Marlena Montgomery—CEN
- Linda Ojeda—CEN
- Valerie Scalzetti—CEN
- Lesley Stillwater—CEN

Professional Presentations:
By Tia Jensen, RN, MSN, CEN
April 2011 ED Nursing “Never assume an ED patient is just intoxicated!” - Publication
January 2011 ED Nursing “Caring for a psych patient? Careful assessment may reveal otherwise!” - Publication
October 2010 ED Nursing “How ED nurses can avoid misleading oximeter readings” - Publication

Professional Publications:

Certification definitions;
CCRN = Certified Critical Care Registered Nurse
CEN = Certified Emergency Nurse
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